2015-2016
Preschool
Enrollment Packet

Welcome to the Licking Heights and YMCA Preschool Program. We look forward to an exciting new school year together and getting to know our new students and families. Please complete the attached Preschool Enrollment Packet and contact Licking Heights South Elementary to schedule an appointment to register for preschool, 740-964-1674 or 740-404-6631.

When you arrive for your registration appointment please bring the complete Preschool Enrollment Packet, along with the following documents:

- **Original Birth Certificate**
- **Proof of Residence, if you reside in Licking Heights School District (copy of lease, deed, mortgage and copy of current utility bill)**
- **Custody Paperwork, if applicable**
- **Medical/Dental paperwork completed and signed by the physician and dentist**
- **All other attached documents**

Our enrollment packet is available on our website: http://www.lhschools.org/Preschool.aspx

Licking Heights South Elementary
6623 Summit Rd
Pataskala, OH 43062
740-964-1674

YMCA at South Elementary
740-404-6631
bwhite@laca.org or jill.little@lcfymca.org

If any information is falsified-withdrawal will result and tuition charged. Law enforcement may be notified as per "Missing Children's Act" Legislation. The School District may use legal means to verify residence-including, but not limited to, random check by our truancy officer.

2015-2016 Preschool Enrollment Packet

South Elementary Principal: Kurt Scheiderer
6623 Summit Road Assistant Principal: Tricia Myers
Pataskala, OH 43062 Preschool Secretary: Linda Aitken
School: 740-964-1674 YMCA Child Coordinator: Brittany White
YMCA: 740-404-6631 YMCA Assistant Child Coordinator: Jill Little

Internal office use only:

Start Date: ____/____/____

Deposit Check # _____ ___Wkly Tuition $_____

Processed by: _____

Completion Date: _____ Incomplete:_____

_____ _____ _____Female _____Male
Child's Last Name (please print) First MI Date of Birth

_____ _____
Mother's Name (please print) Cell Phone Father's Name (please print) Cell Phone

_____ _____
Street Address Home Phone

_____ _____
City State Zip Code Email Mom Email Dad

Care Options: $35.00 non refundable enrollment fee for each enrollee (check or money order made out to the YMCA)

Resident in Licking Heights Local School District
$10.00 non-resident fee, non-resident participants will be enrolled into the YMCA preschool only
___5 Day Full Care (LH/Y Preschool and/or YMCA)= 150.00/week **Choose one: ____ LH preschool/YMCA ____ YMCA only**
___4 Day Full Care (LH preschool) with before & after care with YMCA=$120.00/week
___4 Day Half Day (LH preschool)=$55.00/week
___4 Day Half Day YMCA (a.m. only)=$55.00/week

I request _____ AM or _____ PM

Does your child require an afternoon nap? ___yes ___ no
LH Preschool classes have a ratio of special needs students and typical role models

Are you currently a Licking Heights Local School District employee? No _____ Yes _____

Financial assistance is available through the YMCA preschool only. If you are an approved Title XX participant or scholarship participant, you will be enrolled in the YMCA Full Care program.

Is your child currently enrolled in a Preschool Program? If yes, where _____

Method of Payment

___**Weekly Payment** (using check, credit card or money order, NO CASH)
___**ODJFS Weekly Co-Pay** $_____ Minimum of 25 hours of attendance is required for enrollment in this program. Lack of minimum required attendance will result in removal from this program.
___**Bank Draft** * Will begin the Thursday prior to the start of participation in the program. Weekly bank draft will be deducted the Thursday prior to the week of care. *Information available upon request*

SPONSER: Name and number of person responsible for child's account: _____
Name **Phone number**

_____ **(Initial)** I agree to pay my child's weekly tuition no later than the **Monday of the current week of care**. I understand a late fee of $15.00 may be assessed if payment is not made on time and by 5:00 p.m. Tuesday. Tuition can be paid by check made out to the YMCA, or by the online payment option. I understand that returned checks for insufficient funds or declined credit cards are assessed a $20.00 processing fee. I also understand that a two-week, advanced written notice must be given prior to withdrawing my child from the YMCA child care program.
_____ **(Initial)** I understand that there is a $35.00 deposit required in order to hold my spot in the Preschool program. This deposit is non-refundable and non-transferable fee.
_____ **(Initial)** Two key fobs will be assigned per family; each fob cost $10. The maximum number fobs assigned to families will not exceed two. I understand there will be a $25 charge for lost cards. I also understand in the event I do have my fob with me at time on drop-off/pick-up I may have a small wait time to be let into the building and be asked to see my I.D.

Licking Heights Local Schools

District IRN 048009

Request for Records

Please circle the school you are enrolling in:

Licking Heights West
1490 Climbing Fig Drive
Blacklick, OH 43004
Telephone: (614) 864-9089
Fax: (614) 501-4672

Licking Heights South
6623 Summit Road SW
Pataskala, OH 43062
Telephone: (740) 964-1674
Fax: (740) 964-1625

Licking Heights North
6507 Summit Road SW
Pataskala, OH 43062
Telephone: (740) 927-3268
Fax: (740) 927-5736

Licking Heights Central
6565 Summit Road SW
Pataskala, OH 43062
Telephone: (740) 927-3365
Fax: (740) 927-5845

Licking Heights High School
4000 Mink Street SW
Pataskala, OH 43062
Telephone: (740) 927-9046
Fax: (740) 927-3197

Date _____

Student's Full Name _____ Date of Birth _____ Grade_____

I authorize the release of any school records and information concerning the above person to Licking Heights Local School.

Please send all the appropriate school records including:

1. Birth Certificate
2. Date of Withdrawal
3. Complete transcript of all grades and credits
4. Latest IEP, MFE, if a special education student
5. All test scores (OGT tests, included scaled scores)
6. Health and Immunization records
7. Attendance Records (showing excuse and unexcused days)
8. SSID Number for Student
9. Academic Grades
10. Custody Documents
11. Discipline Records

PREVIOUS School Information (last school attended)

School Name _____

Number/Street _____

City/State/Zip _____

Phone# _____ Fax# _____

Is this student currently under suspension, Recommended for expulsion, or expelled? _____Yes _____No

Anticipated Start Date @ LH:

_____

Signature of Parent, Guardian, or Student is 18 years of age

Lisa Todd, District Registrar
740-927-6926 email: ltodd@laca.org

_____
(date mailed or faxed)

Note: Federal law 99.31 allows for educational records to be sent to other educational agencies without the parent's signature requirement.Law 815-828 states a copy of the requested records to be forwarded within five school days after the receipt of the request, not withstanding any financial debt owed by the pupil.

LICKING HEIGHTS LOCAL SCHOOL DISTRICT
Enrollment Form

PLEASE PRINT – PARENT/GUARDIAN SHOULD COMPLETE ALL INFORMATION EXCEPT FOR SCHOOL USE ONLY BOX

STUDENT'S DATA
(LEGAL NAME AS IT APPEARS ON BIRTH CERTIFICATE)

Last Name _____ Last Name Suffix _____

First Name _____ Middle Name _____

Called Name: _____

Gender (circle one) F or M

Street Address _____

P.O. Box # _____ City: _____ Zip Code: _____

Home Phone: _____ Area Code: _____

Unlisted? Yes _____ No _____

County of Residence: Licking _____ Franklin _____

Indicate the school, if student was enrolled in LH before: _____

Has student ever attended a public school in Ohio? ____ Yes ____ No

Name of school (if yes): _____

STUDENT'S BIRTH DATA

Date of Birth: Month _____ /Day _____ / Year _____

Birth City _____

Citizenship: _____
(If different than U.S. Citizenship)

Indicate country, if child was born outside the U.S. _____

If child was born outside the U.S., how many years has he/she been in an U.S. school? _____

Native Language _____ Language spoken in home _____
(If different than English) (If different than English)

PARENT INFORMATION:

Mother's Maiden Name: _____

ETHNIC DATA

Hispanic/Latino ____ Y ____ N

If the student is from one or more races, CIRCLE all that applies:

American-Indian or Alaska Native

Asian

Black or African American (Non-Hispanic)

Native Hawaiian or Other Pacific Islander

White (Non-Hispanic)

OFFICE NOTES:

Has student ever been evaluated/tested for special programs?
____ Yes _____ When _____ No

504 ___ Speech Therapy ____ Counseling ____ (IEP/MFE) ____

Please indicate any characteristics relating to the health and personality of your child which would help the teacher(s) and nurse to understand your child:

_____
_____

Will student ride a school bus? __ Yes __ No

Is this student under an expulsion from previous school? Yes __ No __

Names, Birthdates & Ages of Other School Age Children:

Name	Birthdate	Age	Grade
	__/__/__		
	__/__/__		
	__/__/__		
	__/__/__		
	__/__/__		
	__/__/__		

STUDENT'S CUSTODIAL FAMILY (circle one)

Biological Parental Status: Never Married Parents Married Parents Separated Parents Divorced Spouse Deceased

MALE	FEMALE
__ Biological Father __ Step-Father __ Other _____	__ Biological Mother __ Step-Mother __ Other _____
Last Name: _____ First Name: _____	Last Name: _____ First Name: _____
Address if different than student's: _____	Address if different than student's: _____
Place of Employment/Occupation: _____	Place of Employment/Occupation: _____
Cell Number: _____ Work Number: _____	Cell Number: _____ Work Number: _____

RESIDENCY

Student lives with (check one)

__ Mother Only
__ Father Only
__ Mother & Father
__ Mother & Stepfather
__ Father & Stepmother
__ Foster Parent
__ Court Appointed Guardian(s)
__ Host Parent
__ Court Approved Grandparent Power of Attorney or Caretaker Affidavit
__ Other (specify) _____

COURT ORDERED PLACEMENT

No child will be admitted until current proof of legal custody is received

__ Mother Only
__ Father Only
__ Joint Custody
__ Guardian
__ Foster Parent
__ Grandparent (under Grandparent Power of Attorney or Grandparent Caretaker Legislation)

School district where natural parent resided _____

GUARDIAN FOSTER STUDENT ENROLLMENT INFORMATION

Information regarding the natural parent(s) with whom the student does NOT reside, and school district that is fiscally responsible for education costs.

Birth Parent(s) Name: _____

Address: _____

School District of Residence: _____

Name of Previous School: _____

LEGAL GUARDIAN INFORMATION

Legal Guardian Name: _____ Emergency Contact's Name: _____

Address (if different from student): _____ Relationship to Student: _____

_____ Phone Number: _____ Unlisted: __ Y __ N

_____

Place of Employment/Occupation: _____

Cell Number: _____ Work Number: _____

FOR FOSTER/COURT PLACEMENTS

Case Worker/Contact Person: _____

Journal Entry/Court Case Number: _____

Office Address: _____

Phone Number: _____ Fax Number: _____

Children Services Document Received Court Order Received House Bill 130 Received
(circle all that applies)

Signature of Parent/Legal Guardian: X_____ Date: X_____

Rev: 8/1/13

LICKING HEIGHTS LOCAL SCHOOLS **5341 F1**
EMERGENCY MEDICAL AUTHORIZATION

_____ _____ _____ _____
School Building Grade Teacher Student's Name

_____ _____ _____ _____
County where child lives Male/Female Birth Date Street Address

( ) _____ _____
Telephone Number City Zip

RESIDENTIAL PARENT (Circle one): Both Mother Father Legal Guardian

_____ _____
Name (circle one) Mother Father Legal Guardian Name (circle one) Mother Father Legal Guardian

_____ _____
Address (if different from child) Address (if different from child)

Telephone No._____/_____ Telephone No._____/_____
(Home) (Work) (Home) (Work)

_____ _____
Place of Employment Occupation Place of Employment Occupation

_____ _____
Cell Phone Number Cell Phone Number

_____ _____
E-Mail Address E-Mail Address

Below please list relatives or friends who can provide transportation in case of student illness, injury or parent/guardian not able to pick up a child from school (e.g., stuck in traffic or at work). You must provide the name and contact information for at least one other person.

	Name	Relationship	Daytime Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

ALLERGIES –Please list and describe allergies or reactions to:

Medication allergy_____ Type of Reaction_____

Foods/plants/animals/other_____ Type of Reaction_____

_____

Recommended treatment if allergy is severe_____

Bee/Insect/sting allergy_____ Type of reaction_____Treatment_____

MEDICATIONS (Home <u>and</u> School)

Now taking_____ Reasons_____

Side Effects_____

MEDICAL PROBLEMS/RESTRICTIONS (Your child's teacher(s) and special area teachers will be notified of any restrictions.)

_____

_____

PLEASE BE ADVISED information on this form may be reviewed by authorized school staff only for confidential use in meeting your child's health and educational needs.

If your child requires taking any over the counter or prescription medication during the school day, a Medication Administration Form must be filled out by the parent and a physician. You can find this form on the schools website or get one from the front office of your child's building.

PART I OR II MUST BE COMPLETED

Purpose – To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I

I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITAL TO BE CALLED:

Doctor_____ **Telephone**_____

Dentist_____ **Telephone**_____

Preferred Hospital_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physician or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____

Date **Signature of Parent or Guardian**

SECTION 3312.712, OHIO REVISED CODE
(Pursuant to H.B. 811 and H.B. 639)
(Effective 6-11-92)

(A) Annually the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, provide to the parent of every student enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any student into a public school in this state for the first time, provided his parent either as part of any registration form which is in use in the district, or as a separate form, an identical copy of the form contained in division (B) of this section. When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school or a city, exempted village, local or joint vocational school district to which the student transferred. Upon request of his/her parent, authorities of the school in which the student is enrolled may permit the parent to make changes in a previously filed form, or to file a new form.

If a parent does not wish to give such written permission, he shall indicate in the proper place on the form the procedure he wishes school authorities to follow in the event of a medical emergency involving his child.

Even if a parent gives written consent for emergency medical treatment, when a student becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extra-curricular activity authorized by the appropriate school authorities, and authorities of his/her school shall make reasonable attempts to contact the parent before treatment is given. The school shall present the student's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.

(B) The emergency medical authorization form provided for the Division (A) of this section is as follows:

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II (REFUSAL TO CONSENT)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____ _____

Date **Signature of Parent or Guardian**

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE CENTERS AND TYPE A HOMES

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Center
Home Address		City
State / Zip Code	Home Telephone Number	
Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City / State / Zip		
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address (if applicable)	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the center/type A home's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**OR**	**Do not sign both**	**_Do Not Give Permission_ to Transport**	
Center or Type A Home Name					Center or Type A Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.					**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date				Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the center's or type A home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/ guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

Preschool Permission

STUDENT NETWORK & INTERNET ACCEPTABLE USE & SAFETY AGREEMENT

To the Parents/Guardians of Licking Heights Student,

This agreement gives Licking Heights the permission to allow/deny network and internet permissions as specified in the policies required by the Board of Education. This document is to be completed, signed & returned to the school in a timely fashion. The policies are:

7540.03 – Covers student access to Local Area Network (LAN), Wide Area Network (WAN), email and/or internet. Please be aware that students are not allowed to search the Internet at Licking Heights, but they may be using other software on a computer that is connected to the internet. Any student accessing the internet will be denied future computer privileges.

7540.04 – Covers permission to photograph or videotape a child's schoolwork or picture as part of an educational program & to use those pictures as a part of media presentations.

Internet, LAN & WAN Safety Agreement 7540.03

The Board has implemented technology protection measures which block/filter internet access to visual displays that are obscene, child pornography, or harmful to minors. The Board also monitors online activity of students in an effort to restrict access to child pornography & other materials that are obscene, objectionable, inappropriate, and/or harmful to minors. Nevertheless, parents/guardians are advised that determined users may be able to gain access to information, communication and/or services on the internet which the Board of Education has not authorized for educational purposes and/or which they and/or their parents/guardians may find inappropriate, offensive, objectionable or controversial. Parents/guardians assume this risk by consenting to allow their students to participate in the use of the internet. Student's accessing the internet through the school's computers assumes personal responsibility & liability, both civil & criminal, for unauthorized use of the internet.

The Board has the right to monitor, review, & inspect any directories, files and/or messages residing on or sent using the Board's computers/network. Messages relating to or in support of illegal activities will be reported to the appropriate authorities. **Use of the internet is a privilege, not a right. The Board's internet connection is provided for educational purposes only. Unauthorized & inappropriate use will result in a cancellation of this privilege. To access email and/or the internet at school, students under the age of eighteen (18) must obtain parent/guardian permission.**

Photo & Videotape Agreement 7540.04

The Board recognizes the value of the audio-visual & other types of electronic communication in providing your child with an effective education & hereby grants permission for your child and/or his/her schoolwork products to be photographed or videotaped as part of an education program produced by the district or coalition of districts. The Board further grants permission for the photographs and/or videotapes to be used in media presentations that are made available to other educational institutions, cable television stations, or network. This includes that your child's image, name, work product, school & grade may be revealed in the presentation(s) but that no further information about your child or his/her schoolwork will be revealed without the parents/guardians prior consent. **It is the policy of this District that no student shall be discriminated against on the basis of race, color, religion, national origin, or citizenship status, creed or ancestry, age, gender, disability, height, weight, or other protected characteristics.**

Photography Release

Printed Child's Name:_____ Grade: _____ Teacher:_____

Please check each permission you wish to allow Student ID: _____

_____ Permission to use the Internet
_____ Permission to use live images
_____ Promotional material/Brochure
_____ Permission to display class work
_____ Permission to use photo online
_____ Permission to use for classroom

Parent/Guardian Signature: _____ Date: _____

Parent Roster Permission

The Ohio Department of Education, Early Learning Program Guidelines requires us to make available class rosters to parents (upon request). The rosters will include the names, addresses, and phone numbers of parents/guardians of children in the preschool classroom. The rosters will not include the name or telephone number, etc. of any person who requests that his/her name, and other information not be included.

Please complete the bottom of this form to indicate your preference and return to your child's teacher.

_____ _____

Student Name (please print) Teacher Name (please print)

I authorize the following to be listed on the parent roster:

	Please circle one	
My child's name	Yes	No
Parent(s)/Guardian name	Yes	No
Phone number	Work Cell Home	No

Work Number: _____

Cell Number: _____

Home Number: _____

_____ _____

Signature of parent/guardian Date

Licking Heights Registration Health Information

I would like to inform you of important health information for preschool students. As instructed in your enrollment packet, we must have current immunizations for each student. This is a requirement of the State of Ohio. Following are the requirements for preschool entry for Fall 2015.

4 doses of DTP
3 does of polio
1 dose of MMR
3 doses of Hepatitis B
3 doses Hib
1 dose Varicella

Please be aware that students may be excluded from school by Ohio law if a complete immunization record is not on file at school after 15 days.

I also encourage parents to inform us of any medical concerns such as allergies, medications, conditions/diseases, surgeries, or anything that will help us help your child. If your child must have any medication (prescription and/or over the counter) at school, we must have a medication authorization form on file, signed by parent/guardian, and physician, with a supply of the medication.

It is important to be aware that head lice (pediculosis) will occur in school settings. To assist in controlling this nuisance, it is helpful to screen your children at home regularly!

Please feel free to contact me with any questions or concerns, and thank you in advance for your help.

Peggy Auer, R.N.
740-927-3365
pauer@laca.org

CHILD MEDICAL STATEMENT

For Child Care Centers and Type A Family Child Care Homes

Child's Name *(print or type)*	Date of Birth

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) _____

Recommended Immunizations (*enter month, day, and year***)**

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

Recommended Assessments/Screenings:

Vision: ☐ Yes ☐ No Date: _____ Hearing: ☐ Yes ☐ No Date: _____

Dental: ☐ Yes ☐ No Date: _____ Lead: ☐ Yes ☐ No Date: _____

BMI: ☐ Yes ☐ No Date: _____ Other: _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination

Ohio Administrative Code rules 5101:2-12-37 and 5101:2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care center or type A home.

Name of Physician /Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State and Zip Code	

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37 of the Administrative Code.

MEDICAL DIAGNOSTIC EVALUATION FORM

Child's Name:_____ Date of Birth _____

Parent's Name: _____ **DATE OF EXAM**:_____

I. General Findings

Significant findings on (describe any abnormalities):

A. General Physical Examination

Height* _____	Weight* _____	BP _____	Lymphatics _____
Skin _____	Head _____	Eyes _____	Ears _____
Nose _____	Teeth _____	Neck _____	Chest _____
Back _____	Abdomen _____	Genitalia _____	Extremities _____

***Required by Ohio Revised Code**

B. Lead Screening* (needed one time for enrollment only)

C. Hematocrit Screening*

***Required by Ohio Revised Code to be completed for preschool children ages 3 through 5**

II. Specific Findings

Significant findings:

A. General neurological examination

Gait _____ Station _____ Muscle Power _____

Muscle Tone _____ Reflexes _____ Cranial Nerves _____

B. Motor abnormalities

Gross Motor Coordination _____

Fine Motor Coordination _____

C. Sensory abnormalities_____

III. Behavioral Problems (check if observed or reported by informant)

___ Hyperactive ___ Withdrawn ___ Short attention span ___ Disturbed sleep pattern

___ Distracted ___ Other (please describe) _____

IV. Medical Diagnosis _____

V. Medical Recommendations (include medication as prescribed)_____

_____

VI. This is to certify that the above-named child has had a complete physical examination.

_____ _____

Physicians Signature **Date**

DENTAL SCREENING

Student's Name: _____ Date of Birth: _____

Telephone Numbers: _____ Sex __ Male __ Female

DATE OF DENTAL EXAM: _____

____ No treatment needed at this time

____ Treatment completed

____ Further treatment indicated

____ Appointments have been scheduled

____ Please note any special needs

_____ _____

Dentist's Signature Dentist's Name (please print or type)

_____ _____

Date Address

_____ _____

Phone Number City, State, Zip Code

Please return to: Licking Heights South, 6623 Summit Road, Pataskala, Ohio 43062, Fax: 740-964-1625, Telephone: 740-964-1674

Licking Heights Local Schools

RESIDENCE VERIFICATION

I, _____, (parent/legal guardian's name - please print)

certify that I reside and occupy the dwelling within the Licking Heights Local School District as listed below:

Street Number/Name _____

City / Zip Code _____

Date of Occupancy _____

Verification of above residence must be provided to school officials before the student is considered registered and allowed to begin classes. Please supply appropriate information as listed:

_____ **Own or Purchasing a Home**	_____ **Lease/Renting a Home or Apartment**
Statement on lender's letterhead including owner's name, address of home and a current date, or current payment coupon. Closing papers (HUD settlement pages with signatures) *if purchased within 2 months of this registration.*	All residents must be listed on the lease. Contact information for the rental agent must be provided, including a telephone number _____. *If the lease has rolled over to a month to month, you must provide a letter from the rental agent verifying current occupancy before your child may begin school.*

____	**Friends & Family** (to be completed if the custodial/residential parent does NOT have a lease or mortgage in their name for the Licking Heights address listed above) I certify I reside with Friends/Family at the address listed above and it is my **only residence**.

I further certify that all information provided is true and accurate. Should any of this information be false, I agree to pay penalty tuition as established by the State of Ohio for each student listed below while illegally attending the Licking Heights School District and understand that immediate withdrawal will occur. I am aware that the Licking Heights School District may use legal means to verify my residence, including, but not limited to, random checks by the Attendance Officer. I hereby give my permission for release of information concerning my residency from employers, realtors, rental offices, and my utility providers.

_____ ***Please initial that you have read the above statement.***

List all individuals residing in the home: *(*Please do not use the term "step-parent" if you are not legally married)

Children	Grade

Adults	Relationship

_____
(Signature of Student's Resident Parent / Guardian)

_____
(Date)

_____Copy of residence verification information attached. _____
(Registrar)