



FLYING COLORS PUBLIC SCHOOL PRESCHOOL - 2009-2010

Child's (Legal) First Name: (Middle Name): (Last Name):
Child's Nick Name or Name known by: Date of Birth: / /
PO Box & Mailing Address: City: , OH
Zip Code: Home Phone: ( ) - Male / Female:
Kindergarten your child may attend: Child's School District:

Is your child potty/toilet trained: Yes or No Does your child drink from a cup: Yes or No

INFORMATION REQUIRED BY THE STATE OF OHIO

Ethnicity "Race" (Please circle one) American Indian Asian or Pacific Islander Hispanic Multi-Racial White Black
Native Language: City child was born "Birth City":

Mother's Maiden Name: Child's Social Security Number: - -

Male Parent/Guardian: H-Phone: ( ) -
Address (if different): Cell Phone: ( ) -
Place of Employment: Work Phone: ( ) -

The parent named above may be contacted and the child may be released to in case of an emergency: YES NO
(If the parent can not be contacted there needs to be legal documentation supporting this request)

Female Parent/Guardian: H-Phone: ( ) -
Address (if different): Cell Phone: ( ) -
Place of Employment: Work Phone: ( ) -

The parent named above may be contacted and the child may be released to in case of an emergency: YES NO
(If the parent can not be contacted there needs to be legal documentation supporting this request)

CONTACT INFORMATION

I, give permission for the following people to be contacted
In-case of an emergency and/or my child may be released to the people named below: (Please list the relationship of the contact person to the
child) \*\*Contact person needs to be someone other than the parents\*\* Two (2) contacts are necessary:

Name #1: Relationship Phone

Name #2: Relationship Phone

FOSTER CARE

Temporary Custody: Permanent Custody:

Biological Mother: Biological Father:

Biological Mother's Home Address: Home #:

Biological Father's Home Address: Home #:

Case Worker: Address: Phone:

HEALTH RECORD

Allergies: Medications:

Special Needs:

Anything That Anyone Should Be Aware of

Start Date

AM Teacher: PM Teacher: Full Day Teacher:

Registration PD: \$ General Education: ( ) Special Education: ( ) Time: AM ( ) PM ( ) FULL DAY STUDENT ( )

**TRANSPORTATION**

Transportation To & From School by bus from student's school district, **only**  
(EXCLUDING: Newark City Children-no transportation provided by Newark School District)

*My child will be riding the bus: Yes or No (Circle One)*

Bus Pick-Up Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Bus Drop-Off Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Please check if the child is being transported by someone other than a bus:

Parent Pick-Up: \_\_\_\_Y \_\_\_\_N Parent Drop-Off: \_\_\_\_Y \_\_\_\_N

**EMERGENCY SITUATIONS**

\_\_\_\_ I GIVE PERMISSION \_\_\_\_ I DO NOT GIVE PERMISSION

for my child, \_\_\_\_\_ to be transported to Licking Memorial Hospital or to the nearest available source of assistance for emergency medical and/or dental care.

\_\_\_\_\_  
\*\*Parent/Guardian's Signature

\_\_\_\_\_  
Date

**Permission For Emergency Situations at Licking Heights:**

\_\_\_\_ I GIVE PERMISSION \_\_\_\_ I DO NOT GIVE PERMISSION

for my child, \_\_\_\_\_ to be transported to Mt. Carmel East Hospital or to the nearest available source of assistance for emergency medical and/or dental care.

**X** \_\_\_\_\_  
\*\*Parent/Guardian's Signature

\_\_\_\_\_  
Date

**SIGNATURE AREA MUST BE SIGNED FOR EVERY STUDENT**

If you did not give permission, you understand that you must make other arrangements for your child to be transported and this is at your expense and you must give a copy of the signed agreement to the school before the first day of class.

**Exchange of Information**

I hereby give permission for the Licking County Educational Service Center, Early Education Department and my child's school district to exchange medical, transportation, educational and/or psychological information concerning my child. All permissions will be in effect for one (1) calendar year from the date of my signature.

**X** \_\_\_\_\_  
\*\*Parent/Guardian's Signature

\_\_\_\_\_  
Date

▶▶ Do NOT place an (X) in the boxes below, **PLEASE INITIAL**

\*\*PLACE INITIALS IN BOXES BELOW\*\* ◀◀

- For school bus drivers and/or the LCESC staff to administer first-aid to my child should any injury and/or illness occur.
- For the LCESC staff to verbally exchange information with my child's physician and office staff.  
Physician's Name \_\_\_\_\_  
Phone Number \_\_\_\_\_
- For the LCESC staff to verbally exchange information with my child's dentist and office staff.  
Dentist's Name \_\_\_\_\_  
Phone Number \_\_\_\_\_
- For my name, my child's name, our home phone number and school district to be listed on the Parent Roster. **(Circle all that apply)**
- For my child to be audio and/or video recorded, appear in printed materials and/or appear in still photography for classroom use, program use and/or publication.

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

# Household

Indicate siblings or any other individuals living in the household with the child:

<u>Names</u>	<u>Ages</u>	<u>Relationship To Child</u>
_____ / _____ / _____		Mother _____
_____ / _____ / _____		Father _____
_____ / _____ / _____		
_____ / _____ / _____		

## Miscellaneous

Will your child be attending a child care facility/daycare before or after preschool? \_\_\_\_\_ If yes, how many hours per week? \_\_\_\_\_

I need additional information on: \_\_\_\_\_  
 (Examples: Clothing, Food, GED, Dealing with Death/Loss, Anger Control, Child Discipline, etc.).

I would like to volunteer in the following ways: \_\_\_\_\_  
 (Examples: Read books, help with field trips and special events, repair toys, paint or repair building items).

## LEAD SCREENING QUESTIONNAIRE

- Does your child play in dirt near heavy traveled roads? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Does your child drink out of lead glazed pottery containers? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Does your child eat paint chips or soil? \_\_\_\_\_ Yes \_\_\_\_\_ No

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**HOW DID YOU HEAR ABOUT FLYING COLORS PRESCHOOL?**  
 (Billboard) (School Flyer) (School) (Physician) (Friend) (Radio) (Relative) (Other)  
 .....

### MONTHLY FEES

**\$35.00 REGISTRATION FEE – NEW ENROLLMENT**

**\$20.00 REGISTRATION FEE – RE-ENROLLMENT OR SPECIAL NEEDS**

**FOR ALL STUDENTS:** PLEASE CIRCLE YOUR ESTIMATED HOUSEHOLD INCOME ACCORDING TO FAMILY SIZE **REGARDLESS** IF YOUR CHILD IS GENERAL EDUCATION OR SPECIAL EDUCATION

Family Size	<i>A</i> Free 0%	<i>B</i> R1 101-125%	<i>C</i> R2 126-150%	<i>D</i> R3 151-175%	<i>D</i> R4 176-185%	<i>E</i> R5 186-200%	<i>F</i> O1 201-225%	<i>G</i> O2 224-250%	<i>G</i> O3 251-275%	<i>G</i> O4 276-300%	<i>G</i> O5 301-325%
1	10,830.00	13,537.50	16,245.00	18,952.50	20,035.50	21,660.00	24,367.50	27,075.00	29,782.50	32,490.00	35,197.50
2	14,570.00	18,212.50	21,855.00	25,497.50	26,954.50	29,140.00	32,782.50	36,425.00	40,067.50	43,710.00	47,352.50
3	18,310.00	22,887.50	27,465.00	32,042.50	33,873.50	36,620.00	41,197.50	45,775.00	50,352.50	54,930.00	59,507.50
4	22,050.00	27,562.50	33,075.00	38,587.50	40,792.50	44,100.00	49,612.50	55,125.00	60,637.50	66,150.00	71,662.50
5	25,790.00	32,237.50	38,685.00	45,132.50	47,711.50	51,580.00	58,027.50	64,475.00	70,922.50	77,370.00	83,817.50
6	29,530.00	36,912.50	44,295.00	51,677.50	54,630.50	59,060.00	66,442.50	73,825.00	81,207.50	88,590.00	95,972.50
7	33,270.00	41,587.50	49,905.00	58,222.50	61,549.50	66,540.00	74,857.50	83,175.00	91,492.50	99,810.00	108,127.50
8	37,010.00	46,262.50	55,515.00	64,767.50	68,468.50	74,020.00	83,272.50	92,525.00	101,777.50	111,030.00	120,282.50

HALF-DAY	FREE	\$70.00	\$80.00	\$90.00	\$110.00	\$125.00	\$145.00	\$170.00	\$200.00	\$230.00	\$285.00
FULL DAY	No Free Full-Day	\$140.00	\$160.00	\$180.00	\$220.00	\$250.00	\$290.00	\$325.00	\$325.00	\$325.00	\$325.00

For family units of more than 8 members, add \$3,740.00

**50% off is given for the second sibling enrolled into the Program at the same time**

**Foster Children:** Income is based on foster earned outside income, excluding daily Per Diem for foster child.

**Reminder:** Pay check stubs and child support stubs are the only forms of income accepted unless you are self-employed.

**PLEASE DON'T FORGET TO SEND IN INCOME VERIFICATION**

**DOCUMENTATION PROVIDED**

**(Required by the state of Ohio)**

- 1) Type of income provided for our records: **a)** copy of pay stub  
**b)** self employed: (copy of last year's tax return)  
**c)** other: \_\_\_\_\_

**(We can only accept a Tax Return from Self-Employed Parents)**

Do you receive a pay check weekly \_\_\_\_\_ bi-weekly (every other week) \_\_\_\_\_ or twice a month \_\_\_\_\_

Mothers gross income: \$ \_\_\_\_\_ (per hour), (per week), (per month) **(gross is before taxes)**

**Mother's Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Fathers gross income: \$ \_\_\_\_\_ (per hour), (per week), (per month) **(gross is before taxes)**

**Father's Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

2) Additional Income: \_\_\_\_\_ \$ \_\_\_\_\_ (weekly/bi-weekly/monthly)  
 (See gross income includes below)

3) Allowed Deductions: \_\_\_\_\_ \$ \_\_\_\_\_ (weekly/bi-weekly/monthly)  
 (See allowed deductions below)

4) Number of people living in the household: \_\_\_\_\_

5) **GROSS ANNUAL INCOME** \$ \_\_\_\_\_

6) **SELF-EMPLOYMENT GROSS EARNINGS PER YEAR:** \$ \_\_\_\_\_

**Family requests:** \_\_\_\_ AM \_\_\_\_ PM \_\_\_\_ FULL-DAY but understands no guarantee can be made due to may circumstances.

**If an account is more than 60 days past due it may be sent to our collection agent with or without notification to you. (First notification will be dis-enrollment of child)**

The information given above and documents provided are true and correct to the best of my knowledge.

\_\_\_\_\_  
**\*\*Parent/Guardian's Signature**

\_\_\_\_\_  
**Date**

**Gross Income Deductions:**

- 1) Child Support Payments (paid by a family member for a child outside the family. The amount paid, up to the amount ordered, is excluded.
- 2) Alimony Paid pursuant to a court order.
- 3) Earned Income Tax Credit (EITC) payments when added to the individual's wages.
- 4) Any other income amounts that federal statutes or regulations require to be excluded.

**Gross Income Includes:**

- 1) Income from all employed individuals in the family (except a minor who is a full time student as defined by the school, unless the minor is a parent).  
*(These include payments received before taxes and other deductions, for services performed as an employee or by an individual as a result of self-employment.)*
- 2) State Temporary Disability Insurance.
- 3) Temporary Workers' Compensation Payments.

***Self-Employed Gross Earning, please contact our office and ask for Laurie Vance for a list.***

**(OFFICE STAFF ONLY)**

I certify that I have examined the above presented income documentation and it is determined that the family is eligible for the following category:

**Free / R1 / R2 / R3 / R4 / R5 / O1 / O2 / O3 / O4 / O5**

**(½ Day) \$ \_\_\_\_\_ per month OR (Full-day) \$ \_\_\_\_\_ per month**

\_\_\_\_\_  
 Flying Colors Staff Signature

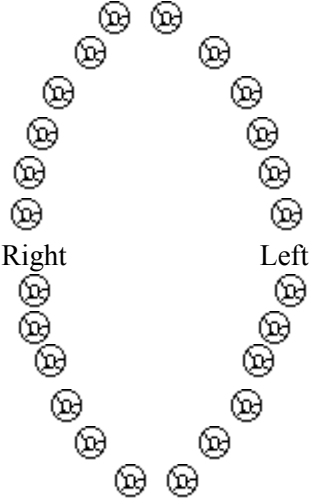
\_\_\_\_\_  
 Date

**SENT TO COLLECTIONS**

**CHILD DENTAL RECORD-DENTAL SCREENING**

*\*\*\* Please complete all information \*\*\**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Parent's Name(s): \_\_\_\_\_

<p>ORAL CONDITIONS BEFORE TREATMENT: Missing (☺) Decayed (●), or filled (☹)</p> 	<p>DENTAL NEEDS (Check one or more and return to LCESC, Early Education Department, Flying Colors Public School Preschool)</p> <p><input type="checkbox"/> A. TREATMENT (restoration, pulp therapy, extraction) <input type="checkbox"/> B. CLEANING <input type="checkbox"/> C. FLUORIDE, NOT MANDATORY. ONLY BY PARENT CONSENT <input type="checkbox"/> D. OTHER <input type="checkbox"/> E. NO PROBLEMS</p> <p>Approximate number of visits: _____</p>
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<b>CHILD ORAL HEALTH SUMMARY</b>		
All planned treatment _____ is / _____ is not completed. If not, explain here as well as items checked:		
<input type="checkbox"/> a. Routine recall visits	<input type="checkbox"/> c. Dietary problem(s)	<input type="checkbox"/> e. Harmful oral habits
<input type="checkbox"/> b. Special home emphasis, oral hygiene	<input type="checkbox"/> d. Developmental problem(s)	<input type="checkbox"/> f. Needs fluoride supplement
Please check here if child was unable to be examined but did appear for scheduled appointment: _____		
<b>Signature of Dentist:</b> _____		<b>Date of Examination:</b> _____

Flying Colors Public School Preschool  
119 Union Street, Newark, OH 43055  
Phone: 740-349-1629 Fax: 740-349-1644

For Dental Stamp with Name, Address & Phone #:
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***All dental exams expire 1 year from the date of examination***  
**This is the responsibility of the parent/guardian**  
***Flying Colors Public School Preschool***

**PHYSICIAN'S REPORT – MEDICAL FORM**

*\*\*\* Please complete all information \*\*\**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Parent's Name(s): \_\_\_\_\_

**IS THIS CHILD FREE FROM COMMUNICABLE DISEASE? ( ) YES ( ) NO**

(If NO, please describe) \_\_\_\_\_

**REQUIRED HEALTH INFORMATION**

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEMATOCRIT: \_\_\_\_\_ LEAD: \_\_\_\_\_

**VISION:**

Right Eye... ( ) Adequate ( ) Inadequate  
Left Eye..... ( ) Adequate ( ) Inadequate

**HEARING:**

Right Ear... ( ) Adequate ( ) Inadequate  
Left Ear.... ( ) Adequate ( ) Inadequate

Current medications? \_\_\_\_ Yes \_\_\_\_ No – If yes, please describe type, schedule and purpose: \_\_\_\_\_

ALLERGIES: Please give type, reaction and treatment: \_\_\_\_\_

**Please check all illnesses the child had or currently has:**

- ( ) Hypoglycemia    ( ) Pneumonia    ( ) Convulsion    ( ) Diphtheria    ( ) Heart Disease
- ( ) Kidney Disease    ( ) Allergies    ( ) Whooping Cough    ( ) Diabetes    ( ) Tonsillitis
- ( ) Rubella    ( ) Smallpox    ( ) Chicken Pox    ( ) Mumps    ( ) Meningitis
- ( ) Influenza    ( ) Other: \_\_\_\_\_

**IMMUNIZATION DATES**

<b>DPT:</b>	_____
<b>POLIO:</b>	_____
<b>MMR:</b>	_____
<b>TB:</b>	_____ <b>HB:</b> _____
<b>OTHERS:</b>	_____
<b>HEB. B:</b>	_____

**AN EXAMINATION OF THIS CHILD WAS CONDUCTED WITHIN THE LAST TWELVE (12) MONTHS AND I AFFIRM THAT THIS CHILD IS IN SUITABLE CONDITION FOR ENROLLMENT IN A PUBLIC SCHOOL PRESCHOOL PROGRAM.**

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Date of Child's Examination**

Flying Colors Public School Preschool  
119 Union Street, Newark, OH 43055  
Phone: 740-349-1629 Fax: 740-349-1644

For Physician's Stamp with Name, Address & Phone #:

***All physical exams expire 1 year from the date of examination***  
**This is the responsibility of the parent/guardian**