

**FLYING COLORS PUBLIC SCHOOL PRESCHOOL 2010-2011
JERSEY**

Child's (**Legal**) First Name: _____ (Middle Name): _____ (Last Name): _____
Child's Nick Name or Name known by: _____
PO Box & Mailing Address: _____ City: _____, OH Zip Code: _____
Home Phone: (____) _____ - _____ Male / Female **Date of Birth:** ____/____/____
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**

RESIDENTIAL PARENT (circle all that applies): **Mother** **Father** **Legal Guardian** **Foster** **Step-Parent**

Father/Legal Guardian

Name _____

Address (if different than child) _____

Phone No. Home: _____

Work: _____

Cell: _____

Email: _____

Place of employment _____

**The parent named above may be contacted and the child
May be released to in case of an emergency: YES NO**

If no, there must be legal documentation supporting this request.

Mother/Legal Guardian

Name _____

Address (if different than child) _____

Phone No. Home: _____

Work: _____

Cell: _____

Email: _____

Place of employment _____

**The parent named above may be contacted and the child
may be released to in case of an emergency: YES NO**

If no, there must be legal documentation supporting this request.

EMERGENCY CONTACTS

I, _____, give permission for the following people to be contacted in case of an emergency. My child may be released to the people named below. Please list the relationship to the child. **Contacts should be someone other than parents.** Two contacts are required by the Ohio Department of Education.

1. Name _____ Relationship _____ Phone Number _____

2. Name _____ Relationship _____ Phone Number _____

TRANSPORTATION

Transportation to & from school by bus may be provided by student's residential 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

Office Use Only:

START DATE _____

AM Teacher: _____ PM Teacher: _____ Full Day Teacher: _____

Registration PD: \$ _____ General Education () Special Education () Time: AM () PM () Full Day ()

FOSTER CARE

Agency Name: _____ Temporary Custody: _____ OR Permanent Custody: _____
Biological Mother: _____ Biological Father: _____
Biological Mother's Home Address: _____ Home #: _____
Biological Father's Home Address: _____ Home #: _____
Case Worker: _____ Address: _____ Phone: _____
Who did child live with at time of removal: _____

EMERGENCY/MEDICAL

Part I – Permission to Treat

I hereby consent for my child, _____ to be transported to Children's Hospital or to the nearest available source of assistance for emergency medical and/or dental care.

Parent/Guardian's Signature

Date

Part II – Refusal to Treat

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 take the following actions:

Parent/Guardian's Signature

Date

Allergies: _____

Health Concerns: _____

Current Medications: _____

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.

Parent/Guardian's Signature

Date

INITIAL YES OR NO BOXES

- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| 1. For school bus drivers and/or the LCESC staff to administer first-aid to my child should any injury and/or illness occur. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. For the LCESC staff to verbally exchange information with my child's physician and office staff.
Physician's Name _____ Phone: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. For the LCESC staff to verbally exchange information with my child's dentist and office staff.
Dentist's Name _____ Phone: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. For my name, my child's name, our home phone number and school district to be listed on the Parent Roster. <i>(Circle all that apply)</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. 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. | <input type="checkbox"/> | <input type="checkbox"/> |

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).

THE FOLLOWING IS INFORMATION REQUIRED BY THE STATE OF OHIO. ALL QUESTIONS MUST BE COMPLETED.

City child was born "Birth City": _____ Mother's Maiden Name: _____

Child's Social Security Number: _____ - _____ - _____

Native Language (the first language of the student): _____

Home Language (the main language spoken at home by the student): _____

Ethnicity "Race" Part I: Is your child Hispanic/Latino Yes No

Part II: Is your child American Indian /Alaskan Native Asian Black/African American

Native Hawaiian/Other Pacific Islander White (Circle no more than 2)

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

MONTHLY FEES
\$35.00 REGISTRATION FEE – NEW ENROLLMENT
\$20.00 REGISTRATION FEE – RE-ENROLLMENT OR SPECIAL NEEDS

	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>	<i>D</i>	<i>E</i>	<i>F</i>	<i>G</i>	<i>G</i>	<i>G</i>	<i>G</i>
<i>Family Size</i>	<i>Free 0%</i>	<i>R1 101-125%</i>	<i>R2 126-150%</i>	<i>R3 151-175%</i>	<i>R4 176-185%</i>	<i>R5 186-200%</i>	<i>O1 201-225%</i>	<i>O2 224-250%</i>	<i>O3 251-275%</i>	<i>O4 276-300%</i>	<i>O5 301-325%</i>
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	18310.00	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.

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

LICKING COUNTY EDUCATIONAL SERVICE CENTER EARLY EDUCATION DEPARTMENT
Flying Colors Public School Preschool
PLEASE DON'T FORGET INCOME VERIFICATION

LIST ALL PEOPLE, AGES AND RELATIONSHIP TO STUDENT LIVING IN THE HOUSEHOLD:

DOCUMENTATION PROVIDED (Required by the state of Ohio)

1) Type of income provided: **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:** \$ _____

**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 withdrawal 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.

(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

FLYING COLORS PUBLIC PRESCHOOL
Physician's Report – Medical Form

Child's Name _____

DOB: _____ Current Age: _____

Exam Date: _____

Return to:
 Flying Colors Public Preschool
 119 Union St.
 Newark, OH 43055
 Phone: (740) 349-1629 FAX: (740) 349-1644

MANDATORY EPSDT Healthcheck SCREENINGS

IMMUNIZATION DATES

	Date	Result		1	2	3	4	5
Height			DTaP					
Weight			Polio-Type					
BMI			MMR					
Blood Pressure			HIB					
Hct/Hgb			Hep B					
Lead Level			Varicella					
<i>Please indicate Pass or Fail</i>			Prevnar					
Hearing		P F	Other					
Vision		P F	Other					

PHYSICAL EXAMINATION	NORMAL	ABNORMAL	NOT EVAL.	
A. General Appearance				Yes No N/A
B. Posture, Gait				1. Does the child need treatment? _____
C. Speech				2. Is the treatment complete? _____
D. Head				3. Does the child need further treatment? _____
E. Skin				4. Is optional testing indicated? _____
F. Eyes				(If yes, please list in comments)
a. External Aspects				Comments:
b. Cover Test				
G. Ears				
a. External & Canals				
b. Tympanic Membrane				
H. Nose, Mouth, Pharynx				
I. Teeth				
J. Heart				
K. Lungs				
M. Genitalia				
N. Bones, Joints, Muscles				
O. Neurological/Social				
a. Gross Motor				
b. Fine Motor				
c. Communication				
d. Cognitive				
e. Self-Help Skills				
f. Social Skills				
P. Glands (Lymphatic/Thyroid)				
Q. Muscular Coordination				
R. Other				

This child has had the immunizations required by Sec. 3313.67 of the Revised Code for admission to school or has had the immunizations required by the State Department of Health for Infants & Toddlers.

GENERAL STATEMENT OF CHILD'S PHYSICAL STATUS: *This child is up-to-date according to the EPSDT schedule of preventative and primary health care. At the time of the examination, this child was found to be free of apparent communicable disease and is able to attend a childcare center.*

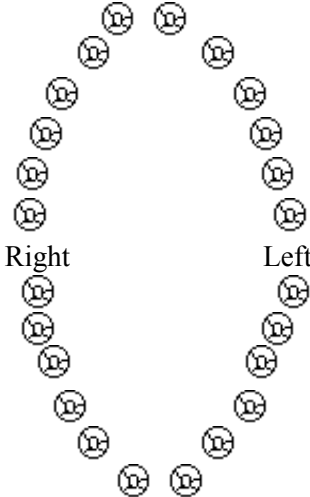
Signature of Physician _____
 Address _____

Phone Number: _____
 Date of Exam: _____

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> <div style="text-align: center;"></div>	<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 style="text-align: right;">Approximate number of visits: _____</p>
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<p>CHILD ORAL HEALTH SUMMARY</p> <p>All planned treatment _____ is / _____ is not completed. If not, explain here as well as items checked:</p> <table style="width: 100%;"><tr><td><input type="checkbox"/> a. Routine recall visits</td><td><input type="checkbox"/> c. Dietary problem(s)</td><td><input type="checkbox"/> e. Harmful oral habits</td></tr><tr><td><input type="checkbox"/> b. Special home emphasis, oral hygiene</td><td><input type="checkbox"/> d. Developmental problem(s)</td><td><input type="checkbox"/> f. Needs fluoride supplement</td></tr></table> <p>Please check here if child was unable to be examined but did appear for scheduled appointment: ____</p> <p>Signature of Dentist: _____ Date of Examination: _____</p>	<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
<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				

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