FLYING COLORS PUBLIC SCHOOL PRESCHOOL 2011-2012
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.		
2. For the LCESC staff to verbally exchange information with my child's physician and office staff. Physician's Name_________________________________ Phone: _________________________		
3. For the LCESC staff to verbally exchange information with my child's dentist and office staff. Dentist's Name __________________________________ Phone:__________________________		
4. 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)***		
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.		

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)

The above information is true to the best of my knowledge. ________________________________

Parent Signature

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

MONTHYLY FEES

$35.00 REGISTRATION FEE – NEW ENROLLMENT

$20.00 REGISTRATION FEE – RE-ENROLLMENT OR SPECIAL NEEDS

Family Size	*Free 0%*	*R1 101-125%*	*R2 126-150%*	*R3 151-175%*	*R4 176-185%*	*R5 186-200%*	*O1 201-225%*	*O2 224-250%*	*O3 251-275%*	*04 276-300%*	*O5 301-325%*
1	**10,890**	**13,612**	**16,335**	**19,057**	**20,146**	**21,780**	**24,502**	**27,225**	**29,947**	**32,670**	**35,392**
2	**14,710**	**18,387**	**22,065**	**25,742**	**27,213**	**29,420**	**33,097**	**36,775**	**40,452**	**44,130**	**47,807**
3	**18,530**	**23,162**	**27,795**	**32,427**	**34,280**	**37,060**	**41,692**	**46,325**	**50,957**	**55,590**	**60,222**
4	**22,350**	**27,937**	**33,525**	**39,112**	**41,347**	**44,700**	**50,287**	**55,875**	**61,462**	**67,050**	**72,637**
5	**26,170**	**32,712**	**39,255**	**45,797**	**48,414**	**52,340**	**58,882**	**65,425**	**71,967**	**78,510**	**85,052**
6	**29,990**	**37,487**	**44,985**	**52,482**	**55,481**	**59,980**	**67,477**	**74,975**	**82,472**	**89,970**	**97,467**
7	**33,810**	**41,475**	**50,715**	**59,167**	**62,548**	**67,620**	**76,072**	**84,525**	**92,977**	**101,430**	**109,882**
8	**37,630**	**47,037**	**56,445**	**65,852**	**69,615**	**75,260**	**84,667**	**94,075**	**103,482**	**112,890**	**122,297**
Half-Day Free		**$80.00**	**$90.00**	**$100.00**	**$115.00**	**$130.00**	**$150.00**	**$175.00**	**$205.00**	**$240.00**	**$300.00**
NO Full-Day		**$160.00**	**$180.00**	**$200.00**	**$230.00**	**$260.00**	**$300.00**	**$350.00**	**$350.00**	**$350.00**	**$350.00**

For family units of more that 8 members, add $3,820.00
Full-Day students are no more than $350.00 due to R-S-G

50% off is given for the second child enrolled into the Program at the same time.

The cost for the full day classroom at Jersey is $350 per month. This classroom is funded by fees only.

For general education students: I understand that transportation is a privilege and can be discontinued at any time.

____

Parent Signature

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

LICKING COUNTY EDUCATIONAL SERVICE CENTER
Evaluation & Early Education Department
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 Healthchek SCREENINGS

	Date	Result
Height		
Weight		
BMI		
Blood Pressure		
Hct/Hgb		
Lead Level		
Please indicate Pass or Fail		
Hearing		P F
Vision		P F

IMMUNIZATION DATES

	1	2	3	4	5
DTaP					
Polio-Type					
MMR					
HIB					
Hep B					
Varicella					
Prevnar					
Other					
Other					

PHYSICAL EXAMINATION	**NORMAL**	**ABNORMAL**	**NOT EVAL.**
A. General Appearance			
B. Posture, Gait			
C. Speech			
D. Head			
E. Skin			
F. Eyes			
a. External Aspects			
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			

	Yes	No	N/A
1. Does the child need treatment?	_____	_____	_____
2. Is the treatment complete?	_____	_____	_____
3. Does the child need further treatment?	_____	_____	_____
4. Is optional testing indicated? (If yes, please list in comments)	_____	_____	_____

Comments:

Current Medications:

Specific Diagnosis:

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______________________________________ Phone Number: ________________________________

Address ____ Date of Exam: _________________________________

LICKING COUNTY EDUCATIONAL SERVICE CENTER EARLY EDUCATION DEPARTMENT

CHILD DENTAL RECORD-DENTAL SCREENING

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

Name of Child: ______________________ Date of Birth: ____/____/____

Address: ______________________ City: ____________ Zip: ____________

Home Phone: ____________ Parent's Name(s): ______________________

ORAL CONDITIONS BEFORE TREATMENT: Missing (⊗), Decayed (●), or filled (⊙)

Right | Left

DENTAL NEEDS (Check one or more and return to LCESC, Early Education Department, Flying Colors Public School Preschool)

- ☐ A. TREATMENT (restoration, pulp therapy, extraction)
- ☐ B. CLEANING
- ☐ C. FLUORIDE, NOT MANDATORY. ONLY BY PARENT CONSENT
- ☐ D. OTHER
- ☐ E. NO PROBLEMS

Approximate number of visits: ____________

CHILD ORAL HEALTH SUMMARY

All planned treatment ________ is / ________ is not completed. If not, explain here as well as items checked:

- ☐ a. Routine recall visits
- ☐ b. Special home emphasis, oral hygiene
- ☐ c. Dietary problem(s)
- ☐ d. Developmental problem(s)
- ☐ e. Harmful oral habits
- ☐ f. Needs fluoride supplement

Please check here if child was unable to be examined but did appear for scheduled appointment: ___

Signature of Dentist: ____________ **Date of Examination:** ____________

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 #:

All dental exams expire 1 year from the date of examination

This is the **responsibility** of the **parent/guardian**

Flying Colors Public School Preschool