

**FLYING COLORS PUBLIC SCHOOL PRESCHOOL 2011-2012**

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 Licking Memorial 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"/>
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2. For the LCESC staff to verbally exchange information with my child's physician and office staff.

<input type="checkbox"/>	<input type="checkbox"/>
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Physician's Name \_\_\_\_\_ Phone: \_\_\_\_\_

3. For the LCESC staff to verbally exchange information with my child's dentist and office staff.

<input type="checkbox"/>	<input type="checkbox"/>
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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)*

<input type="checkbox"/>	<input type="checkbox"/>
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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"/>
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**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**

**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**

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%	O4 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
<b>Half-Day Free</b>		<b>\$80.00</b>	<b>\$90.00</b>	<b>\$100.00</b>	<b>\$115.00</b>	<b>\$130.00</b>	<b>\$150.00</b>	<b>\$175.00</b>	<b>\$205.00</b>	<b>\$240.00</b>	<b>\$300.00</b>
<b>NO Full-Day</b>		<b>\$160.00</b>	<b>\$180.00</b>	<b>\$200.00</b>	<b>\$230.00</b>	<b>\$260.00</b>	<b>\$300.00</b>	<b>\$350.00</b>	<b>\$350.00</b>	<b>\$350.00</b>	<b>\$350.00</b>

For family units of more than 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.

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

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 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				Current Medications:
a. External & Canals				
b. Tympanic Membrane				
H. Nose, Mouth, Pharynx				Specific Diagnosis:
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 \_\_\_\_\_

Phone Number: \_\_\_\_\_

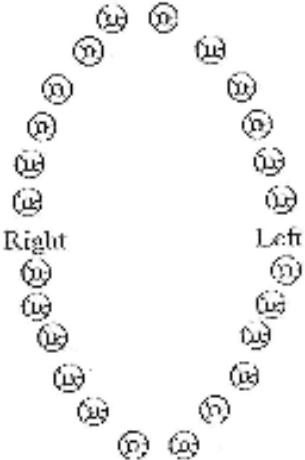
Address \_\_\_\_\_

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><b>ORAL CONDITIONS BEFORE TREATMENT:</b> Missing (⊖) Decayed (●), or filled (⊙)</p> 	<p><b>DENTAL NEEDS</b> (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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**CHILD ORAL HEALTH SUMMARY**

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

a. Routine recall visits                       c. Dietary problem(s)                       e. Harmful oral habits  
 b. Special home emphasis, oral hygiene    d. Developmental problem(s)            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