Auglaize County Educational Service Center

Shawn Brown, *Superintendent*

Telephone: (419) 738-3422 Fax #: (419) 738-1267

1045 Dearbaugh, Suite 2
Wapakoneta, OH 45895

www.auglaizeesc.org

Enrollment Checklist

_______ Preschool application
_______ Medical & Family History
_______ Emergency Information and Medical Authorization
_______ Physician's Request for Medication Administration by School Personnel
_______ Parent Consent Statements
_______ Kid Facts
_______ Dental Examination Form (Due by September 28, 2018)
_______ Child Medical Statement (Due by September 28, 2018)
_______ Parent Tuition Agreement—Typicals Only
_______ Application for Reduced Tuition—if applicable

Copies of documents to submit with your Enrollment Packet

_______ Birth Certificate
_______ Social Security Card
_______ Immunization Records
_______ Divorce Decree (if applicable)
_______ Custody Orders (if applicable)

Enrollment packet and copies of documents are due **before** your child starts school. Dental and Medical forms are due within the first 30 days of attendance.

All Enrollment packets should be sent/dropped off to:

Auglaize Co. Preschool
1045 Dearbaugh Ave., Suite 2
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Lisa Tobin, Preschool Director
Email: ltobin@auglaizeesc.org

Jenny Berning, Secretary
Email: jberning@auglaizeesc.org

Preschool Application 2018-19

Today's Date: ______________________________ Grade: ☒ Preschool

Residential School District: ☐ Minster ☐ New Bremen ☐ New Knoxville ☐ St. Marys

Child's First Name:______________________ **Middle Name:**________________ **Last Name:**____________________
(as it appears on Birth Certificate)

Date of Birth:_________ **Age:**____ **Gender:** ☐ Male ☐ Female **City of Birth:**________________ **SS#:**_______________

Size of Family: (adults and children) _____ **Gross Income of entire household:**________________

Is your child currently covered by Medicaid? ☐ Yes ☐ No

Is the student of Hispanic/Latino Heritage? ☐ Yes ☐ No

(check all that apply)
Ethnicity ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian/Alaskan Native

Native Language: ☐ English ☐ Other: _____________

Address (residence):____
Street City State Zip

Mailing Address:____ **Home Phone:** ( ) ________________

Previous Preschools (if any):____

☐ **private therapy services currently in place**____

Father/Guardian: ______________________________ Mother/Guardian: ____________________________________

Address:_______________________________________ Address:____
Street City Street City

Home Phone: ( ) ______________________________ Home Phone: ( ) ______________________________________

Father's Employer:_____________________________ Mother's Employer:___________________________________

Work Phone: ( ) ________ Cell Phone: ( ) ______ Work Phone: ( ) __________ Cell Phone: ( ) __________

Email:_____________________________________ **Email:**____

Do you live with relative or other acquaintances at this time? ☐ Yes ☐ No
If yes, please explain:____
Parents: ☐ married ☐ separated ☐ divorced ☐ never married
Is someone else designated as legal guardian for this child? ☐ Yes ☐ No If yes, whom?_______________

....

I understand that I am responsible for transporting my child to and from preschool unless my child has an identifying handicapping condition and then the district is required to provide transportation. I will pick up my child at the designated times or supply the school with a note stating who will pick up my child. If my child is left at the school after school hours, I know that the school will call a local agency to take care of my child. I also realize that I am responsible for my own child's tuition payments. Failure to pay on time will result in my child being dismissed from preschool.

______________________________________ ___________________________
Signature of Responsible Party Date
Check one: ☐ Parent ☐ Guardian

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CONFIDENTIAL AND PRIVILEGED MEDICAL AND FAMILY HISTORY FORM

The information requested in this form is needed in order to plan adequately to meet the needs of the individual child. If you object to any of the questions asked it is your privilege to omit those.

Child's Name: ____ Date of Birth: ____________

Location: ☐ ABC Center ☐ St. Marys Preschool

Is the child adopted? ☐ Yes ☐ No If yes, please provide court documents.

Is there a step-parent living in the home? ☐Yes ☐No

If yes, please specify and provide current custody papers____

Are there any other relative(s)/persons living in the home? ☐Yes ☐No

Is someone else appointed legal guardian of this child? ☐Yes ☐ No

If yes, please specify and provide current legal documents____

Name and address of family doctor:____

____

Number of children in family__________ Names and ages of:

Brother(s):____

Sister(s):____

Have any of the children had any serious illness? ☐ Yes ☐ No If yes, please explain briefly:

____

____

Has your child attended any of the following types of structured activities? (check all that apply)

☐ Sunday School ☐ Head Start ☐ Early Intervention ☐ Preschool

Family History – Please check any of the following diseases which parents, grandparents, aunts, uncles, brothers, or sisters have had and indicate which family member had the disease.

☐ Seizures ☐ Allergies ☐ Nervous Breakdown ☐ High Blood Pressure ☐ Heart Disease
☐ Cancer ☐ Diabetes ☐ Hay Fever ☐ Blindness ☐ Tuberculosis
☐ Deafness ☐ Asthma ☐ Mental Retardation ☐ Serious Skin Disease ☐ Kidney Disease

Infections, Illness, Etc.

Has your child had three attacks of severe headaches in the last year? ☐ Yes ☐ No

Has your child had at least three throat infections with a fever in the last year? ☐ Yes ☐ No

Has your child ever had a convulsion (seizure)? ☐ Yes ☐ No A high fever? ☐ Yes ☐ No

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CONFIDENTIAL AND PRIVILEGED MEDICAL AND FAMILY HISTORY FORM (cont'd)

Has your child ever had any of the following? (check all that apply)

☐Measles	☐Scarlet Fever	☐ Pneumonia	☐Broken Bones
☐Rubella	☐Rheumatic Fever	☐ Seizures	☐An Operation
☐Allergies	☐Poisoning	☐ Chicken Pox	☐Asthma, Hay Fever
☐Hives	☐Mumps	☐ Whooping Cough	☐Wheezing
☐Impetigo	☐Serious Injury	☐ Meningitis	☐Encephalitis

Explain briefly:____

Is your child currently taking medication on a regular basis? ☐Yes ☐No
If yes, detail name, dosage and reason for each medication ____________________
____

Will your child need to take medication while at school? ☐Yes ☐No
If yes, please explain and enclose "Physicians' Request for Medication Form" ____________
____

Is your child allergic to bee/wasp stings? ☐Yes☐No
Did your child have difficulty breathing? ________
What other reactions does the child have? ________
Was it necessary to go to the emergency room or doctor's office for treatment? ________
What was the treatment? ____________________
Does your child have an emergency bee sting kit prescribed by the doctor? ____________

Developmental History – Please give the approximate age at which your child did the following things:

Sat alone ______ Crawled ______ Walked ______ Rode Tricycle ______ Babbled ______

Spoke 1st word ______ Said 3-word sentence ______

How has your child developed compared to brothers/sisters?____________________

Please describe the general behavior of your child?____________________
____

Does your child have any of the following behavior traits?

☐Nightmares	☐ Toilet training problems	☐ Carries security object in public
☐Thumb sucking	☐ Nail biting	☐ Stuttering
☐Discipline problems	☐ Temper tantrums	☐ Unusual sleep habits

Does your child have a regular bedtime? ☐Yes ☐ No Average hours of sleep per night ______

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EMERGENCY INFORMATION AND MEDICAL AUTHORIZATION

Student's Name________________________________ Date of Birth: ______________

For your child's protection Auglaize County Preschool Programs will NOT release a child to anyone other than to the parents or to the adults that the child's parents/guardians designate to do so. **Both parents are automatically included on this list unless custody documents are in place. If so, please enclose a copy of legal documentation.**

If your child is injured or we face an early dismissal due to inclement weather and/or another unforeseen calamity we need the following information: Please rank in order (1,2) who is to be called for illness or in an emergency situation.

____Mother/Guardian ______________________	____Father/Guardian ______________________
Home Address (if different)	Home Address (if different)
Home Phone (if different)	Home Phone (if different)
Cell Phone	Cell Phone
Employer	Employer
Work Phone	Work Phone

List neighbors or nearby relatives who will know your whereabouts and assume temporary care of your child if you cannot be reached. We must have two (2) alternative contacts. Please notify us *immediately* **in writing** if you desire to make changes to this information.

Name ____________________ Address ________________________ Telephone ______________

Name ____________________ Address ________________________ Telephone ______________

**Please inform the people above that they may be asked to show a picture identification card when picking up your child.

List 5 Emergency Contacts (other than parents):

1. Name: ____________________________ Relationship: ______________________________
   Phone:____________________ Address: ____
2. Name: ____________________________ Relationship: ______________________________
   Phone:____________________ Address: ____
3. Name: ____________________________ Relationship: ______________________________
   Phone:____________________ Address: ____
4. Name: ____________________________ Relationship: ______________________________
   Phone:____________________ Address: ____
5. Name: ____________________________ Relationship: ______________________________
   Phone:____________________ Address: ____

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EMERGENCY INFORMATION AND MEDICAL AUTHORIZATIO (cont'd)

Purpose of the following information: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under authority, when parents or guardians cannot be reached. Fill out only Part I or Part II.

PART I – MEDICAL CONSENT

In the event reasonable attempts to contact me at (Tel. No.)____________________ have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by (Physician) Dr. ______________________ at (Tel. No.) ___________ at (address) _______________________or (Dentist) Dr. _______________________ at (Tel. No.) _______________ at (address) _______________________, or in the event the designated preferred practitioner is not available, by another physician or dentist; and (2) the transfer of the child to (preferred hospital) _______________________________ at (address) ________________ _____________or any hospital reasonably accessible.

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

Facts concerning my child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: ____

____

Signature of Parent/Guardian ______________________________________ Date: _____________

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 no action but to do the following: ________________________________

____

Signature of Parent/Guardian ______________________________________ Date: _____________

Request for Administration of Prescription and Non-Prescription Medication, Food Supplement, Fluoride Supplement or Modified Diet

Note: Please complete a separate form for each medication.

Section I: Parent Request for Administration of Medication or Supplement
I hereby request and give permission to the authorized staff member to administer the following medication to my child:

Name of Child ______________________________ Age of Child ______________

Name of Medication or Supplement to be administered ______________________________

Dosage ______________ Time(s) of Dosage ______________________________

______________________________ ______________________________
Signature of Parent/Guardian Date

Section II: Physician's or Dentist's Instructions:

Name of Child: ______________________________
is under my care and should receive (Name or medication or supplement)

______________________________ Dosage: ______________

Specific instructions for administration: ______________________________

____

Possible side effects: ______________________________

____
Signature of Physician/Physician Assistant/Clinical Nurse Specialist/Certified Nurse or Dentist

Date ______________________________ Phone ______________________________

Please Print Physician's/Dentist Name ______________________________

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Medication or Supplement Log for ____________________
Student Name

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Staff Member

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Parent Consent Statements
2018-2019 School Year

Child's Name:____

Center: ☐ABC Center ☐ St. Marys Preschool

Classroom Information Consent

This information will be for the current school year and will not be furnished to any person other than a parent or staff member of the Auglaize County Preschool Program.

☐**Yes,** I give permission for my name, my child's name, phone number and address to appear on a roster to be given to parents of children in his/her class.
☐**No,** I do not authorize the above information printed on the roster.

Field Trip Consent

Our classes will be taking various field trips throughout the school year. To try to eliminate excessive paperwork, we are requesting that each parent/guardian sign this consent, which will be valid for the entire school year. We will continue to send home the information of dates, times, and locations for each of these events.

☐**Yes,** my child may attend field trips approved by the Auglaize County Preschool Program.
☐**No,** my child may not attend field trips and they will not attend school on those days.

____ ____________________

Signature of Parent/Guardian Date

Auglaize County Preschool

Child's name (Last)	(First)	Nickname (if any)
By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff who care for your child.		
Who is in the child's family(siblings, parents, etc.)?		
Who lives at home with your child(other than siblings or parents)?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc? ☐ Yes ☐ No? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) ☐ Yes ☐ No? Additional Details?		
Are there any cultural or religious practices of your family of which we should be aware? (dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? ☐ Yes ☐ No? Additional Details? (center based, in home, with family, with parents, etc.)		
How often does your child drink during the day (milk, juice, water, etc.)?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Child Care Licensing requires a form be completed for children with food allergies and/or dietary restrictions)		

OVER

What are your child's favorite TV shows?
What are your child's favorite chores?
Who are your child's favorite people?
Please circle all of the words that best describe your child's personality and behavior: active, adventurous, affectionate, anxious, bossy, bright, busy, calm, cautious, cheerful, content, creative, curious, easily-angered, emotional, energetic, excitable, friendly, gives-in-easily, happy hesitant, insecure, jealous, likes structure/routines, loud, loving, mellow, outgoing, prefers adult attention, quiet, sensitive, serious, shares-well, social, spontaneous, stubborn, tentative, other:
Are there additional personality and behavior characteristics that would be useful to know about your child?
Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?
What routines/actions or items do you use to comfort your child?
What causes your child to feel angry or frustrated?
What methods do you use to respond to your child's negative behavior?
Does your child use any special comfort or support items that help them go to sleep? If so, what?
What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?
Where does your child sit at the table? (high-chair, booster seat, etc.)
Is your child toilet trained? If not, have your started the toilet training process? Please explain the process used.
Does your child need assistance when using the toilet? If so, how?
What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?	
What time(s) and for how long does your child usually nap?	
Does your child have trouble sleeping? (Night terrors, trouble going to sleep, etc.) ☐ Yes ☐ No? Please explain.	
What might you and/or child be anxious about as he/she starts in this program?	
What are you and/or your child excited about as he/she starts in this program?	
What are your expectations of this program?	
What other information would be helpful for the staff caring for your child to know?	
Parent/Guardian's Signature	Date

Parent Permission to Display Photographs, Video, or Electronic Images, Artwork and Stories

I give consent (or do not give consent) for photographs, audio, video or electronic images of my student; original written materials, artwork, or other work created by my child during the course of instruction; to be used by the Auglaize County ESC and St. Marys City School District for exhibition, public display, publication, publicity materials, news media stories, video, audio, or other electronic media such as district/building website. I understand that my child's full name may also be used with such display.

Student Name: ____

_________ I give consent for photographs, audio, video or electronic images of my students, original written materials, artwork, or other work created by my child during the course of instruction; to be used by the Auglaize County ESC and St. Marys City School District for media publications such as the **district/building website**, **Facebook**, and/or community news media.

_________ I do not give consent for photographs, audio, video or electronic images of my students, original written materials, artwork, or other work created by my child during the course of instruction; to be used by the Auglaize County ESC and St. Marys City School District for media publications such as the district/building website, Facebook, and/**or community news media (The Evening Leader, Community Post, and The Daily Standard).**

Parent/Guardian Name **Printed** ____

Parent/Guardian **Signature** ____

Date Signed ____________________