

# Auglaize County Preschool Enrollment Packet 2024-25



**Preschool Locations:**  
Auglaize County Preschool at  
the New Bremen Location  
Auglaize County Preschool at  
St. Marys Primary School  
Little Rider Preschool  
located on Holly Street



**Auglaize County ESC**  
1045 Dearbaugh Ave., Suite 2  
Wapakoneta, OH 45895  
(419) 738-3422



# Auglaize County Educational Service Center

Shawn Brown, *Superintendent*

Telephone: (419) 738-3422

Fax #: (419) 738-1267

[www.auglaizeesc.org](http://www.auglaizeesc.org)

1045 Dearbaugh, Suite 2  
Wapakoneta, OH 45895

## 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 First Day of School/or note stating date of appointment)
- \_\_\_\_\_ Child Medical Statement (Due by First Day of School/or note stating date of appointment)
- \_\_\_\_\_ 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.

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](mailto:ltobin@auglaizeesc.org)

Jenny Berning, Secretary  
Email: [jberning@auglaizeesc.org](mailto:jberning@auglaizeesc.org)

## Preschool Application 2024-25

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 @ Primary  Little Rider 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 Over

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

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

- |                                    |  |   |  |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Measles   | <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Broken Bones      |
| <input type="checkbox"/> Rubella   | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Seizures       | <input type="checkbox"/> An Operation      |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Poisoning       | <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Asthma, Hay Fever |
| <input type="checkbox"/> Hives     | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Wheezing          |
| <input type="checkbox"/> Impetigo  | <input type="checkbox"/> Serious Injury  | <input type="checkbox"/> Meningitis     | <input type="checkbox"/> 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 1<sup>st</sup> 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?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Nightmares          | <input type="checkbox"/> Toilet training problems | <input type="checkbox"/> Carries security object in public |
| <input type="checkbox"/> Thumb sucking       | <input type="checkbox"/> Nail biting              | <input type="checkbox"/> Stuttering                        |
| <input type="checkbox"/> Discipline problems | <input type="checkbox"/> Temper tantrums          | <input type="checkbox"/> 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: \_\_\_\_\_

## EMERGENCY INFORMATION AND MEDICAL AUTHORIZATION (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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## **Parent Consent Statements** **2024-2025 School Year**

Child's Name: \_\_\_\_\_

Center:  ABC Center       St. Marys Preschool @ Primary       Little Rider 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)
<b>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.</b>		
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)		

What are your child's favorite TV shows?
What are your child's favorite chores?
Who are your child's favorite people?
Please circle <u>all</u> 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 you 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 \_\_\_\_\_

Dear Parent(s),

Districts are required to identify students whose parents or legal guardians have been an active member of the Armed Forces, National Guard, or Reserves at any time throughout the **current** school year. Please put a check mark by the one that pertains to your student. If your status changes during the school year, please let your teacher know.

\_\_\_\_\_ Not applicable (Not a Military Student)

\_\_\_\_\_ Active Duty – Student is a dependent of a member of the Active Duty Forces  
(Army, Navy, Air Force, Marines Corp or Coast Guard)

\_\_\_\_\_ National Guard – Student is a dependent of a member of the National Guard  
(Army or Air)

\_\_\_\_\_ Reserves

# Auglaize County Preschool – Typical Program Parent Tuition Agreement

We agree to pay the fee of **\$140.00 or \$80 (if qualified) per month** to the Auglaize County Educational Service Center. For this payment, our child will be eligible to attend the ABC Center or the St. Marys Preschool for four (4) days per week (2 ½ hours each day). Services included in this agreement include, but may not be limited to:

- ◆ Full time teacher
- ◆ Full time teacher assistant
- ◆ Field trips
- ◆ Snacks
- ◆ Preschool program
- ◆ Arts/crafts

**All Children must be potty trained before entering the program**

**Transportation of the child is the parent's responsibility!**

---

Child's Name (please print)

\* Registration will include submission of all forms and payment of the 1<sup>st</sup> month's tuition. If you paid tuition when you signed your child up, this will also pay for the first months tuition(September). Thereafter, payment is due by the 1<sup>st</sup> of each month. **A \$5 late fee will be assessed to all late payments received after the first day of the month. Continuous late payments (without prior notification) will result in your child being withdrawn from the program.** Tuition must be paid in full even if the child misses school due to illness, weather calamity or family vacation. Cash, money order or check payable to "Auglaize County Educational Service Center" must be sent or delivered to:

Auglaize County Educational Service Center  
Attention: Jenny Berning  
1045 Dearbaugh Ave., Suite 2  
Wapakoneta, OH 45895

**Return Policy:** First month's tuition may only be refunded if our programming needs change and preschool is discontinued or if classroom space has already been filled.

**\*\*Personal checks returned for non-sufficient funds will be assessed an extra \$30 fee.**

I REQUEST THAT THE ABOVE-NAMED APPLICANT BE ACCEPTED INTO THE AUGLAIZE COUNTY PRESCHOOL PROGRAM AT

\_\_\_\_\_  
(Building location)

**I agree to the terms and conditions set forth in this Tuition Agreement.**

---

Signature of Parent/Guardian

Date



# Auglaize County Preschool

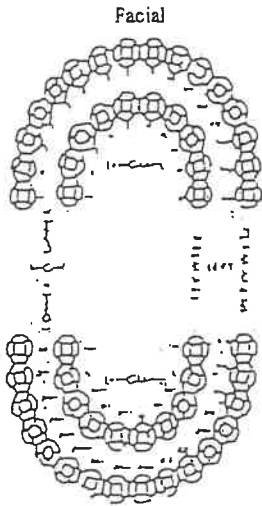
1045 Dearbaugh Avenue, Suite 2, Wapakoneta, OH 45895  
 Phone: (419) 738-3422 Fax: (419) 738-1267

## DENTAL FORM


Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ D.O.B. \_\_\_\_\_


Parent/Guardian's Name \_\_\_\_\_ Phone \_\_\_\_\_


Address \_\_\_\_\_ Zip Code \_\_\_\_\_ Center \_\_\_\_\_




**DIAGNOSTIC CODE:**

 Solid area indicates filling present

 Zebra stripes indicate decay present

 Vertical line indicates to be extracted

 Indicates missing tooth

If follow-up is needed, please explain the treatment plan.

Is there any indication of baby bottle tooth decays?  
 \_\_\_\_\_ Yes \_\_\_\_\_ No

1. How many restorations are needed? \_\_\_\_\_
2. How many visits will be needed to complete the follow-up? \_\_\_\_\_
3. Date of next appointment? \_\_\_\_\_

**PRIORITY GROUP:**  
 \_\_\_\_\_ Needs Attention Immediately  
 \_\_\_\_\_ Needs Attention Soon \_\_\_\_\_ Needs Routine Care

**PLEASE CHECK SERVICES PROVIDED:**

Fluoride     Prophylaxis     Instruction in oral hygiene  
 Restoration of decayed teeth     Pulp therapy  
 Extraction

SERVICES PROVIDED: (Please record each treatment on a separate line)

Month	Day	Year	Tooth	Surface	Material	Description of Work

\*Treatment code: Surfaces, M=Mesial, Distal, O=Occlusal, L=Lingual, I=Incisal, B=Buccal or Labial, A=Amalgam, S=Silicate, P=Arcylic, C=Steel Crown, O=Other

Important: \_\_\_\_\_ Check if additional work required    \_\_\_\_\_ Check if all work for this child has been completed  
 \_\_\_\_\_ Check if treatment discontinued: explain above

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

Date of Examination \_\_\_\_\_

Dentist Signature \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Reason for objection to completing the dental examination: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_



Department of Education

Office of Early Learning and School Readiness
Child Medical Statement

Revised 2/23/2017

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name

Date of Birth Height Weight

Table with 2 columns: Immunizations and Exempt from Immunization. Rows include Complete for Age, In Process, Religious Conviction, and Health, each with Yes/No radio buttons.

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name Provider Address

Provider Phone Number Provider City Provider State Provider Zip

Check box of examining medical professional:

- Physician
Physician's Assistant
Advanced Practice Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional Date of Exam

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

**INSTRUCTIONS FOR APPLYING FOR REDUCED TUITION**

For verification of eligibility for reduced rate at the Auglaize County Preschool, please complete this application and attach the requested documentation. This form should be completed, signed and dated by the parent or guardian responsible for the tuition of the child/children attending the preschool. If the parents/guardians are divorced or separated, only the parent responsible for the tuition and any other adult residing in the household should fill out the form. If tuition is shared, each responsible party must provide the proper documentation.

Please attach a photocopy of your 2023 Federal Tax Return Form 1040, 1040A or 1040EZ with dependents listed. If you receive non-taxable income you must submit photocopies of your 2023 year-end Cash Assistance documentation. Housing Assistance documentation and/or Social Security Income statement, showing the total amount received in 2023 for all members of the household

\_\_\_\_\_

Child's full name: \_\_\_\_\_

\*\*\*\*\*

Parent's name living in the home \_\_\_\_\_

Sibling's name living in the home \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Total number of family members living in the home \_\_\_\_\_

Total combined gross family income for 1 full year \_\_\_\_\_

**REFUSAL** \_\_\_\_\_  
(If you refuse you will not be eligible for a reduced rate)

\_\_\_\_\_  
I, \_\_\_\_\_, attest that the information supplied on this page is accurate, true and complete.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only**

\_\_\_\_\_ Eligible for reduced rate \_\_\_\_\_ Not eligible to receive  
\$80.00 per month reduced rate

**INCOME CHART ON BACK**

**FEDERAL INCOME CHART  
For School Year 2023-24**

<b>Household size</b>	<b>Yearly</b>	<b>Monthly</b>	<b>Twice Per Month</b>	<b>Every Two Weeks</b>	<b>Weekly</b>
<b>1</b>	26,973	2,248	1,124	1,038	519
<b>2</b>	36,482	3,041	1,521	1,404	702
<b>3</b>	45,991	3,833	1,917	1,769	885
<b>4</b>	55,500	4,625	2,313	2,135	1,068
<b>5</b>	65,009	5,418	2,709	2,501	1,251
<b>6</b>	74,518	6,210	3,105	2,867	1,434
<b>7</b>	84,027	7,003	3,502	3,232	1,616
<b>8</b>	93,536	7,795	3,898	3,598	1,799
<b>Each additional person:</b>	9,509	793	397	366	183