WILLARD CITY SCHOOLS

WILLARD ELEMENTARY SCHOOL
ONE FLASHES AVENUE
WILLARD, OHIO 44890
PH. (419) 935-5341 - FAX (419) 935-8312

Dear Parents,

This is the Preschool Application that you have requested for your child. Please be sure to fill the Preschool Application out completely including the doctor and dentist's names and phone numbers on the Medical Emergency Form.

Below are a few requirements that you will need to know before returning the application.

1) Verification of Income (W-2 or 1040 tax form) **must** be sent with the application. **Applications WILL NOT be processed without this information.** Preschool tuition is based on a sliding fee schedule according to family size and income. Enrollment priority is given to income eligible families. Income eligibility is based on the income earned and total number of family members living in your home.

2) **The Medical/Physical Form and Dental Health Record must be turned in within 30 days of enrollment and every 13 months thereafter while your child attends preschool.** If these are not turned in within 30 days, your child will not be able to attend preschool. You can send the preschool application in before these forms are completed. If your child is returning to the preschool program for a second year, the Dental Health Record is not required.

   This includes a medical statement and current list of immunizations. We hope your child has a regular medical provider from whom he/she receives on-going medical care and follow-up. If your child does NOT have a regular medical provider, please inform your child's teacher so that we may assist, as appropriate, in helping you locate a local provider.

   We have enclosed a copy of Lead Testing Requirements and Medical Management Recommendations per Ohio Department of Health. If your child has already been screened, please provide a copy of the results for your child's file as required for preschool licensing. If your child has NOT yet been screened as required, please discuss with your child's physician/health care provider the need to do so and forward results to our office. The purpose of this policy is to ensure the children's safety as much as possible.

3) Send copies of your child's shot record, certified birth certificate, and custody papers (if applicable). Returning students do not need to turn in this information unless custody has changed since the previous school year.

4) Preschool students must follow the Campus Wear Policy that is adopted by the Willard City School Board of Education.

Please return the application and verification of income document to:

Willard Elementary School
Attn: Anni Goodsite
One Flashes Avenue
Willard, OH 44890

or

Willard City Schools
Attn: Shelley Holden
123 Whisler Drive
Willard, OH 44890
(during summer months)

If you have any questions, please call Shelley at 419-935-1541.

Sincerely,

Brenda Ooten
Principal

PRESCHOOL APPLICATION
2023 - 2024 School Year

Willard Preschool
One Flashes Avenue
Willard, OH 44890
419-935-5341

For office use:
Date received: _____
Returning student: yes no

Class choice is not guaranteed.

Please circle the preferred choice: **½ Day AM Class** **½ Day PM Class**
All Day Class – Child must be 4 by August 1st.

Child's Full Name _____
First Full Middle Name Last

Child's nickname (name to be called in class)_____

Birthdate_____ Age_____ ____ Male or _____ Female

Address_____
Street City Zip Code

City and State of child's birth_____

County of residence_____ School district_____

Father/Guardian's Name _____	Mother/Guardian's Name _____
Address_____	Address _____
City/Zip Code _____	City/Zip Code _____
Phone Number _____	Phone Number _____
Email Address_____	Email Address _____
Father's Employer _____	Mother's Employer _____
Employer's Phone _____	Employer's Phone _____
Shift Schedule _____	Shift Schedule _____

List names of people authorized to pick your child up from school (must be over 18 years of age)

_____ _____
_____ _____
_____ _____

FAMILY INFORMATION

Names of others who reside in the home	Relationship to child
_____	_____
_____	_____
_____	_____
_____	_____

How long has your son/daughter attended school in the United States? _____

VERIFICATION OF INCOME

Name of Child _____ Birthdate _____

Verification of current employment and salary is needed in order to determine the preschool program tuition for your child. List you or the people in your home who receive income this month. Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Worker's Compensation, Social Security, SSI, Veterans Benefits, etc.

Name	Type of Income	Amount of Income (before taxes)	How Often Received (weekly, bi-weekly, etc.)

Total yearly salary_____

Please attach one of the following:
_____W-2
_____1040 Tax Form
_____Other_____

_____
Print Name of Parent/Guardian

_____
Street Address, City, Zip

_____
Cell Phone Number

Penalties for misrepresentation
I certify that all of the about information is true and correct and that all income is reported. I understand that this information is being given for receipt of state funds, that program officials may verify the information on the application, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

_____ _____
Signature of parent/guardian Date

For Office Use

_____ _____
Signature of person verifying income Date

INTEREST SURVEY

Dear Families,

To help us understand and better communicate with your child, please take a few minutes to complete this Interest Survey. The information will help us be able to make your child feel more at ease at school. (And besides that, it's fun for us to read!)

Child's Name: _____

Nickname: _____ (Child's name as you want them to recognize it in print.)

Brother's/Sister's Name(s) and Ages: _____

_____

Babysitter's Name: _____

Friend's Name(s): _____

Favorite Toy(s): _____

_____

Favorite Food(s): _____

_____

What does he/she call grandparents? _____

_____

Any pets and their names: _____

What language does your son/daughter use most frequently at home? _____

What language do the adults at home most often speak? _____

Any other people, events, etc. your child especially likes/dislikes to talk about: _____

_____

_____

Is there anything of which your child is fearful? If so, what are some ways he/she is calmed?

_____

_____

_____

What are your hopes for your child's preschool experience this year? (What is most important to you, such as experiences, opportunities, skills, etc.?) _____

_____

_____

What hobbies or special skills would you be willing to share? _____

_____

CONSENT TO RELEASE CHILD'S PHOTO/VIDEO AND OTHER INFORMATION

To publicize the achievements of our preschool students and the great work they do, we like to occasionally publish our students' names, photos, and/or achievements in our school publications or release the information to local newspapers. We may also post the information on the school's website.

We understand that you may not want to have your child's name, photo, and/or achievements published. Please fill out this form to let us know your wishes.

School district_____ Classroom teacher_____

Student's name_____

☐ I consent to have my child's name, photo, and/or achievements published in school newspapers/newsletters, release to local newspapers, and posted on the school's website as it relates to activities and participation in the preschool program.

☐ I do not want my child's name, photo, and/or achievements published in school newspapers and/or newsletters, released to local newspapers or posted on the school's website.

_____ _____

Parent/Guardian Signature Date

CONSENT FOR PARENT ROSTER

In accordance with Rule 3301-37-04 of the Ohio Revised Code, a roster for each classroom, which includes names, addresses and telephone numbers of parent(s)/guardian(s) of children attending the preschool program must be prepared annually and given to parents/guardians upon request, but to no other person.

_____I would like my name and telephone number to be included in this roster.

_____I would not like my name and telephone number to be included in this roster.

_____ _____

Parent/Guardian Signature Date

CONSENT FOR FIELD TRIPS

_____ My child has permission to attend all school-sponsored field trips during the present school year. Written notice of each field trip will be sent home with your child.

_____ _____

Parent/Guardian Signature Date

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL

How do I apply for Early Childhood Education Services (ECE)?	• Complete the screening tool, JFS 01121. • Submit this form to **your provider.** • **Do not** submit the form to the Ohio Department of Education. • Your provider will let you know if you qualify.
How do I apply for Publicly Funded Child Care?	• Complete the screening tool, JFS 01121, and the JFS 01122 Publicly Funded Child Care Supplemental Application, answering as many questions as you can. **Be sure to sign both forms.** • Submit both the JFS 01121 and JFS 01122 to your local county agency. • Attach verifications to the JFS 01122 (see verification requirements below). • A verifications checklist will be mailed to you within 10 days of your application date if more information is needed to make a decision on your case. • **You will have 30 days** from the date the county receives your application to provide all needed information.
What verifications do I need for publicly funded child care?	• **Proof of income:** Verification of income includes but is not limited to paystubs, tax records, award letters, child support orders, etc. • **Proof of any child support paid.** • **Proof of citizenship or qualified alien status for children in need of care:** If the county agency verifies that you have already provided proof of citizenship to qualify for OWF, you will not have to provide it a second time. • **Proof of a qualifying activity for all caretakers in the household:** Verification of a qualifying activity includes but is not limited to an official school schedule, work schedule, employment verification, self-sufficiency contract, etc. • **Provide the name and address of an eligible child care provider chosen for each child in need of care. (See below for tips on choosing a provider).**
What is Step Up To Quality?	**Step Up To Quality helps families identify child care programs that go beyond the minimum standards of licensing. Star rated programs demonstrate higher levels of quality in a variety of ways. For more information, visit the ODJFS child care website at http://jfs.ohio.gov/cdc/index.stm and click on "Step Up To Quality."**
How do I choose a Provider?	**ECE:** If you would like to view a map of early childhood education providers, visit http://education.ohio.gov/Topics/Early-Learning/Early-Childhood-Education-Grant. **Publicly Funded Child Care:** Parents may select any program approved to offer publicly funded child care. These programs include centers, family child care homes and in-home aides located throughout the state of Ohio. • If you would like assistance with selecting a publicly funded child care provider, you may contact your local Child Care Resource and Referral Agency. Visit http://jfs.ohio.gov/cdc/families.stm for contact information. • You may use the ODJFS Child Care Directory to look for programs that fit your child care needs at http://childcaresearch.ohio.gov/. The directory allows you to search by location, type of program, services offered and days and hours of operation. Information is provided about each program including Step Up To Quality rating, any additional accreditation or affiliation, licensing inspections and substantiated complaints.

Continued on next page

When will my eligibility begin?	**ECE:** You will be notified by your provider when you may begin care. **Publicly Funded Child Care:** Your eligibility for the publicly funded child care program is determined within 30 days from the date the signed application is received by the county. If this application is approved and you are eligible for child care benefits, the county agency may authorize payment for child care from the date the county received this application.
How do I get help with completing this application?	**ECE:** If you need assistance with this application, ask your provider. **Publicly Funded Child Care:** If English is not your primary language, the county agency will provide someone who can help you understand the questions on this application. If you have a disability, are hearing impaired or visually impaired, the county agency will help you complete this application.
What if my child has a disability or I suspect my child may be developmentally delayed?	• To learn more about Medicaid health screenings and early intervention services for your child, please visit the Ohio Department of Job and Family Services child care website at http://jfs.ohio.gov/CDC/childcare.stm and click on "Families." • **Publicly Funded Child Care:** Your child care provider may qualify for additional assistance if they must make special adaptations for your child. Your provider may contact your county agency for more information.
How do I make a complaint about a provider?	**ECE (ODE):** If the program is licensed by ODE, call 614-466-0224. **Publicly Funded Child Care (ODJFS):** If the program is licensed by ODJFS, call 1-877-302-2347, option 4

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBLITY SCREENING TOOL

Tell us about you (the applicant)

First Name	MI	Last Name	
Address			Today's Date
City	State	County	Zip Code
Phone Number ( )	Additional Phone Number ( )	E-mail Address	

Tell us about the people in your home

Name *(First, Middle, Last)*	Relationship to You *(spouse, son, friend, etc.)*	Race	Hispanic or Latino *Y or N*	Spoken Language	Date of Birth	Gender *M or F*	U.S. Citizen *Y or N*
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					

Child 1	Provider Name and Address	What hours/days do you need services? (i.e. child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Child 2	Provider Name and Address	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Child 3	Provider Name and Address	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Tell us about your finances

Will you or the people in your home receive income this month? ☐ Yes ☐ No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

Name	Type of Income	Amount of Income *(before taxes)*	How Often Received *(weekly, bi-weekly, etc)*	Date Last Received	Work or School Schedule *(please list times)*
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____

Do you or anyone in your household pay Child or Spousal Support? ☐ Yes ☐ No

How Much?

Signature of Applicant	**Date**

EMERGENCY/MEDICAL/TRANSPORTATION AUTHORIZATION FORM

Child's name_____ Grade_____ Telephone_____
Address_____
School district_____ Building_____

The purpose of this form is to enable parent(s)/guardian(s) to authorize the provision of emergency treatment for your child who becomes ill or injured while under school authority, when you cannot be reached.

Residential parent(s)/guardian(s)
Mother/guardian name_____ Work Phone_____ Cell Phone _____
Father/guardian name_____ Work Phone_____ Cell Phone _____

Contact information if parents cannot be reached in case of emergency: **(2 contacts required)**

Name_____ Phone_____
Address_____

Name_____ Phone_____
Address_____

PART I OR PART II MUST BE COMPLETED

Part I: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called.

Physician_____ Phone _____
Dentist_____ Phone _____
Medical specialist_____ Phone _____
Local hospital_____ Emergency room phone_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to 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.

List all allergies and any special precautions or treatments indicated for these allergies. _____
_____

List any medications, food supplements, modified diets, or fluoride supplements currently being administered to the child.
_____

List any chronic physical problems and any history of hospitalizations. _____
_____

List any diseases the child has had. _____

Has your child had chicken pox?_____

Signature of parent/guardian_____ Date_____
Address_____

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 the following action_____
_____

Signature of parent/guardian_____Date_____
Address_____

Rev. 1/22/13

MEDICAL/PHYSICAL FORM

Child's Name_____ DOB_____ School_____
Parent/Guardian Name_____ Phone_____
Address_____

Required For Children Enrolled In An Early Childhood Education Grant Program Or Preschool Special Education Program				**Reason Not Completed (Check Which Applies)**	
Assessments/Screenings	Completed **(Circle One)**		Date Completed	Health Professional Decision	Examples: religious conviction, insurance coverage, other
Lead	Yes	No			
Hemoglobin	Yes	No			

PHYSICAL ASSESSMENT

HEIGHT: _____ WEIGHT: _____

Did the examination reveal any abnormalities in the following areas?

	YES	NO		YES	NO
General Appearance	☐	☐	Heart/BP_____	☐	☐
Skin	☐	☐	Lungs	☐	☐
Lymph Nodes	☐	☐	Abdomen	☐	☐
Eyes/Vision	☐	☐	Genitalia	☐	☐
Ears/Hearing	☐	☐	Skeletal system	☐	☐
Nose/Throat	☐	☐	Neuro muscular	☐	☐
Teeth/Gums/Dental	☐	☐	Allergies	☐	☐
Tongue/Palate	☐	☐	Specify_____		

Immunizations	**Circle One**	
Complete For Age	Yes	No
In Process	Yes	No

****IMMUNIZATION RECORD MUST BE ATTACHED.****

EXEMPT FROM IMMUNIZATIONS	**Circle One**	
Religious Conviction	Yes	No
Health Concern	Yes	No
Other:		

Limitations or Health Condition (including allergies, medications, dietary restrictions)_____

_____

_____

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

_____
Signature of Examining Physician or Physician's Assistant or Advanced Practice Nurse **(circle one)**

Address: _____

Phone: _____

Date of Exam

DENTAL HEALTH RECORD

Child's name_____ DOB_____ School_____
Parent/guardian name_____ Phone_____
Address_____

1. Has the child previously seen a dentist? ☐ No ☐ Yes Dentist's Name_____

2. Does the child have any trouble with teeth, gums, or mouth? ☐ No ☐ Yes

3. Oral condition before treatment: Missing ☐ Decayed ☐ Filled ☐

4. Examination and treatment record:

tooth letter or number	surface	description of work	date service performed	procedure number

8. Is baby bottle tooth decay present? ☐ No ☐ Yes

9. Is the child receiving: Topical Fluoride Application? ☐ No ☐ Yes
Fluoride Supplement Diet? ☐ No ☐ Yes If yes, tablets ___ liquid____
Fluoridated water? ☐ No ☐ Yes

10. Is all planned treatment complete? ☐ No ☐ Yes If not, itemize on chart below.

tooth letter	surface	description of work

11. Approximate number of visits required for treatment? _____

12. Next scheduled appointment_____

13. Comments:
_____

Dentist's Name_____
Street Address_____
City, State, Zip_____ Phone_____

Dentist's Signature_____ **Date of examination**_____