Flying Colors Public Preschool

Licking County Educational Service Center, Early Education & Evaluation Department

STUDENT ENROLLMENT APPLICATION

Student ID: ______________________ **Attending Building:** Central North **Enrollment Date:** _______________

Students Legal Name:____
First Name Middle Name Last Name Called Name

Physical Address: _____________________________ _________________ _________________________ _______ _____
Street Address Apt#/Lot# City State Zip

Mailing Address: ____
(if different from above): Street Address Apt#/Lot# City State Zip

Home Phone: _________________________ Gender: Male ☐ Female ☐ Age:________ Date of Birth:_________________

City of Birth: _________________________ (as stated on Birth Certificate) Mothers Maiden Name:_________________________________

Is your child potty/toilet trained: Yes or No School District your child lives in currently: ______________________________

PARENT/GUARDIAN INFORMATION

1) Father: ____Parent/Foster Parent/Guardian/Step-Parent/Other
(Circle One)

Living with student: Yes ☐ No ☐

Same address as student: Yes ☐ No ☐ Emergency Contact: Yes ☐ No ☐

Father deceased: Yes ☐ No ☐

Address (if different): Address:

____

Street Address Apt#/Lot# City State Zip

Employer: ____Work Phone #:____________________________

Cell Phone #:____Home Phone #:______________________________________

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

2) Mother: ____Parent/Foster Parent/Guardian/Step-Parent/Other
(Circle One)

Living with student: Yes ☐ No ☐

Same address as student: Yes ☐ No ☐ Emergency Contact: Yes ☐ No ☐

Mother deceased: Yes ☐ No ☐

Address (if different): Address:

____

Street Address Apt#/Lot# City State Zip

Employer: ____Work Phone #:____________________________

Cell Phone #:____Home Phone #:______________________________________

Parent/Family E-Mail Address(s): ____

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Office Use Only: Date of Speed Dial: ________________ Standard Score: ________________

AM Teacher ___________________________ **PM Teacher** ___________________________ **Other** _________________

General Education ☐ **Special Education** ☐ **AM** ☐ **Income Level** ________

ECE Grant ☐ **Itinerant** ☐ **PM** ☐ **Transportation: Parent** ☐

Newark Grant ☐ **Related Only** ☐ **Full Day** ☐ **Bus: (if available)** ☐

Incomplete Packet (page numbers): ________________ **Date Packet Completed:** ______________

FAMILY/CUSTODY INFORMATION

Custody: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Relative_____________ ☐ Were/Are the Parents Married

Student Lives With: Please check every box that applies:

☐ Both Biological Parents ☐ Mother Only ☐ Father Only ☐ Foster Parent ☐ Legal Guardian

☐ Mother & Stepfather ☐ Father & Stepmother ☐ Grandparents ☐ Court Appointed

☐ Other: ____

If a divorce or guardianship situation exists, we must have a certified full copy of the order or decree. This is per State of Ohio Law (ORC 3313.672) and the Missing Children's Act.

If divorced, who has residential custody? Mother ☐ Father ☐

LEGAL COURT PLACEMENT-Court documents are required to enroll a student

If the student is foster placed, please provide name and address of biological parents in this section below:

Name of Placement Agency: ____________________________________ Biological Parent(s') ___________________________________

Case Workers Name: ____ Biological Parent(s') Phone #: __________________________

Case Workers Phone#: ____ Biological Parent(s') Address: __________________________
____

Other Individuals Permitted to be Contacted & Allowed to Pick-Up My Child (other than parent or guardian)

Individuals will need to show driver's license or some form of picture identification; your contacts will be called if we cannot reach you for any reason

1st Contact (Name): ____
Relationship to student: ____
Phone Number: ____
Emergency Contact: Yes ☐ No ☐
Student can be released to: Yes ☐ No ☐

2nd Contact (Name): _____________________________________
Relationship to student: ______________________________________
Phone Number: ____
Emergency Contact: Yes ☐ No ☐
Student can be released to: Yes ☐ No ☐

3rd Contact (Name): ____
Relationship to student: ____
Phone Number: ____
Emergency Contact: Yes ☐ No ☐
Student can be released to: Yes ☐ No ☐

4th Contact (Name); ______________________________________
Relationship to student: ______________________________________
Phone Number: ____
Emergency Contact: Yes ☐ No ☐
Student can be released to: Yes ☐ No ☐

TRANSPORTATION

If you should move to another address it is very important that you notify us immediately

Please understand that transportation is a **privilege** and can be discontinued at any time during the school year

Your school district may or may not have specific pickup and drop-off areas

☐ *My child **will** be riding the bus.* **If you said "Yes" to your child riding the bus, please complete below,** however, keep in mind, if child care or a babysitter is the drop off or pick up point, they ***must*** be in your school district.

(Transportation will not be scheduled if this area is not completed)

Bus Pick-Up Address: ____

Bus Drop-Off Address: ____

Will your child be attending a child care facility/daycare before or after preschool? ________ If yes, how many hours per week? __________

I understand that my local school district provides transportation dependent on school policy. I also understand transportation may or may not be offered by a district to typical peers at the preschool level. I further understand that the district develops bus routes in August. I agree to follow the rules and regulations as outlined by my district if my child is eligible for transportation. I assure that there will be an adult present prior to my child boarding the bus as well as when my child is dropped off. I will assist the bus driver as necessary by helping my child on/off the bus. If I am unable to be present I assure that another responsible adult will be assigned to meet these requirements.

☐ My child will be personally transported by vehicle. If valet is provided I understand that if I am transporting I will have to use valet.

Signature of Understanding regarding transportation: ____Date:__________________

MEDICAL INFORMATION

Do you anticipate your child will need medication administered at school? ☐ Yes ☐ No

List:____ ______________________________________

Does your child have any health care needs? ☐ Yes ☐ No

If YES, explain: ____

Does your child have any life threatening allergies or dietary restrictions? ☐ Yes ☐ No

List:____

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

PART I OR PART II-MUST BE COMPLETED

PART I- I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor: ____ Phone: ____________________________________

Dentist: ____ Phone: ____________________________________

Local Hospital: ___________________________________ Phone: ____________________________________

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any medical treatment deemed necessary by the above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; (2) the transfer of the child to any hospital reasonably accessible and (3) Flying Colors to share my child’s medical information with EMT and/or hospital emergency room staff. This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

____ ________________________________

Signature of Parent/Guardian Date

PART II- I do **NOT** consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school to take the following action: ____

____

____ ________________________________

Signature of Parent/Guardian Date

I state the information provided is true and correct. I am aware that the Flying Colors Preschool may use any legal means to verify my residence. I understand that falsification of information may be cause for withdrawal of my child from Flying Colors Preschool and subject me to the applicable civil and criminal penalties.

____ ____

Legal Parent/Guardian Signature Date Legal Parent/Guardian Signature Date

____

Enrolling Personnel Signature Date

Flying Colors Public Preschool

Licking County Educational Service Center, Early Education & Evaluation Department
119 Union Street
Newark, Oh 43055
Phone (740)349-1629 Fax (740)349-1644

PARENT PERMISSION FOR THE DISTRICT TO COMMUNICATE ABOUT A STUDENT WITH THE PARENT VIA E-MAIL or TEXT

Student's Name: ____

Parent's Name: ____ Parent's Number for Text Message: ____

Parent's E-Mail Address: ____

I give permission for staff members from Flying Colors Preschool to communicate with me, concerning school events and/or the above identified student,

☐ Via e-mail at the e-mail address(es) provided above

☐ Via text message at the phone number(s) provided above

☐ I understand I can obtain information on Flying Colors Preschool website and on its Facebook site.

☐ I understand that Flying Colors is unable to guarantee the confidentiality of any information sent using e-mail or text during the transmission of the message. I further agree that I am the only one with access to the e-mail or text account listed above, and that if other individuals have access to the e-mail address or text number listed above, that I hereby release Flying Colors from any responsibility and liability for any disclosure of student personally identifiable information to anyone who accesses the e-mail address listed above.

I further acknowledge it is my responsibility to notify Flying Colors of any changes in the e-mail address and/or text number listed above. Finally, I agree to promptly respond to any "test" e-mail message sent from Flying Colors to my e-mail address to confirm that the address provided has been properly inputted into Flying Color's/staff member's address book.

____ ______________________________

Parent/Guardian Signature Date

Permission to be contacted by email or text shall remain in effect until Flying Colors receives written direction from the parent to the contrary, or the child graduates or is withdrawn from Flying Colors.

EXCHANGE OF INFORMATION

I hereby give permission for the Licking County Educational Service Center, Early Education & Evaluation 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 Signature Date

Please check correct box:

Yes No

☐ ☐ For school bus drivers <u>and</u> the LCESC staff to administer first-aid to my child should an injury or illness occur

☐ ☐ For the LCESC staff to verbally and electronically exchange information with my child's physician and office staff.

Physician's Name____ Phone: ___________________________________

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

Dentist's Name ____ Phone: ___________________________________

☐ ☐ 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)***

☐ ☐ For my child to be audio and/or video recorded, appear in printed materials and/or appear in still photography for classroom use, social media (classroom and school wide Facebook page), and program use and/or publication.

THE FEDERAL GOVERNMENT REQUIRES US TO COLLECT THE FOLLOWING INFORMATION:

PART A: Student's Ethnicity: Is this student Hispanic/Latino? *(Choose only one)*

☐ NO, not Hispanic/Latino

☐ YES, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central America, or other Spanish culture or origin, regardless of race)

The part of the question above is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your child's race to be.

☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North & South American (including Central America), and who maintains tribal affiliation or community attachment.)

☐ Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian sub- continent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ Black or African American (A person having origins in any of the black racial groups of Africa.)

☐ Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific islands.)

☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Is your child "Limited English Proficient?

☐ No- The student is not Limited English Proficient

☐ Yes- Limited English Proficient student who has been enrolled in US schools for more than 180 days OR previously exempted from taking the spring administration of either of the State's English language arts assessments (reading or writing).

☐ LEP – enrolled in US schools for the first time

A recently arrived Limited English Proficient student who has been enrolled in US schools for no more than 180 school days AND NOT previously exempted from taking the spring administration of either of the State's English language arts assessments.

Native Language, (required, check one): *This is often the language spoken at home but should denote the primary language spoken by the student at the onset of speech.*

☐ English	☐ Cantonese	☐ Korean	☐ Russian	☐ Trigriyan
☐ Albanian	☐ Creole (French)	☐ Laotian	☐ Serbo Croat	☐ Ukrainian
☐ Amharic	☐ German	☐ Navajo	☐ Somali	☐ Vietnamese
☐ Arabic	☐ Hmong	☐ Portuguese	☐ Spanish	☐ Other
☐ Cambodian	☐ Japanese	☐ Romanian	☐ Tagalog	

List the languages that your child speaks: ____

Is your child an "Immigrant Student"? ☐ Yes ☐ No

Per Section 3301 (6) of the Elementary and Secondary Education Act, an immigrant student is a student who is age 3 through 21; that was not born in any State; and has not been attending one or more schools in any one or more States for more than 3 full academic years.

AFFIDAVIT OF CURRENT RESIDENCY

1. My name is____

   Guardian/Parent of: ____

2. My current home address is ____
   Street Address & PO Box

   ____
   City State Zip

3. My home phone number is ___________________________ Cell phone is _____________________________________

4. County of Residence: ________________________________

Please mark the following statements as True or False.

	True	False	
5.	☐	☐	The above address is where I eat and sleep overnight a majority of the time.
6.	☐	☐	The above address is where my child/children eat and sleep overnight a majority of the time.
7.	☐	☐	The above address is the center of our family activities and recreation time.
8.	☐	☐	There is no other address where I sleep overnight on a regular basis.
9.	☐	☐	There is no other address where my child/children sleep overnight on a regular basis.

If you marked "False" on any of the above statements, please explain below:

____ _______________________________

Signature Date

Allowable Proof of Residency Forms:

Lease/Mortgage Statement/Property Tax Bill/ Voter Registration Card

NOTICE OF PLACEMENT OPTIONS

I give permission for my child _________________________________ to be placed as a "peer model" in a special education-taught classroom where 50% of the children may have a disability. (Max class size: 16 children with at least three adults)

____ _______________________________

Signature Date

FEE INFORMATION

- **Monthly Fees:** Tuition is due the 15th of each month beginning September 15th. The monthly tuition is an average of the number of days in the school year divided by nine months. Shorter months, five-week months, holidays and school breaks have been included in the average. You would pay the same amount each month.
- **Discount:** For families paying full tuition that have more than one (1) child attending during the same school year, a 25% discount is applied to the second child.
  No discount is applied to child who is eligible for the Early Education Grant.
- **Grant Eligibility:** To be eligible for the Early Childhood Education Grant your family must meet the following criteria:
  - **Age 4 before September 30th**
  - **Family income at or below 200% poverty level**
- If your monthly payments are more than 60 days past due, your account will be sent to a collection agency with or without notification to you and your child will be withdrawn from school.
- **Please find your family size in the left column. Find your household gross income range. If your income is $0.01 higher than the shown amount, move to the next column. To determine school fee-see monthly fee amount at the bottom of the apporpriate column.**

<u>FOR ALL STUDENTS</u>: Please circle your estimated household income according to your family size regardless if your child is on an IEP or not.

Number of People in your Household (Circle)	R1-A 100% Free	R2=B 125%	R3=C 150%	R4=D 175%	R5=E 185%	R6=F 200%	Over=G
2	$16,240	$20,300	$24,360	$28,420	$30,044	$32,480	
3	$20,420	$25,525	$30,630	$35,735	$37,777	$40,840	
4	$24,600	$30,750	$36,900	$43,050	$45,510	$49,200	
5	$28,780	$35,975	$43,170	$50,365	$53,243	$57,560	
6	$32,960	$41,200	$49,440	$57,680	$60,976	$65,920	
7	$37,140	$46,425	$55,710	$64,995	$68,709	$74,280	
8	$41,320	$51,650	$61,980	$72,310	$76,440	$82,640	
Monthly Fee	**FREE**	**$40.00**	**$61.00**	**$85.00**	**$96.00**	**$115.00**	**$205.00**
Family units with more than 8 members		Add $4,180 for each additional	Add $4,807 for each additional	Add $5,225 for each additional	Add $7,838 for each additional	Add $8,360 for each additional	

- If JFS Child Care Assistance eligible, no other discounts apply for half day program.

If you would like to sign an Income Waiver and not present household income, please sign the next page. This is stating that you realize you are willing to pay the $205.00 per month, per half day session, September thru May and we will not request income from you.

❖ Please tell us how you heard of Flying Colors Early Evaluation and Early Education Program

____

OVER-INCOME WAVIER

The state of Ohio requests that all children enrolled in Flying Colors Public School Preschool provide a copy of Gross Income Verification (monies earned before taxes/deductions are taken out) per household/family. If the parent/guardians income falls in the "Over-G" column on the Sliding Fee Schedule above or for whatever reason you wish not to provide your income; you may opt out by signing this income waiver.

> By signing this waiver you are in agreement that you are responsible for the full fee of **$205.00** for a half-day preschool session per month.

You do not have to submit Gross Household income Verification if you sign below.

Please Sign Below

I, _____________________________________ do not wish to provide income
(Parents Signature)
verification to Flying Colors Preschool. Therefore, I understand that I am responsible

for **$205.00** for a half-day session per month for my child ______________________.
(Student's name)

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 | 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					
Please indicate Pass or Fail			Prevnar					
Hearing		P F	Other					
Vision		P F	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

Evaluation & Early Education Department

Child Dental Record-Dental Screening

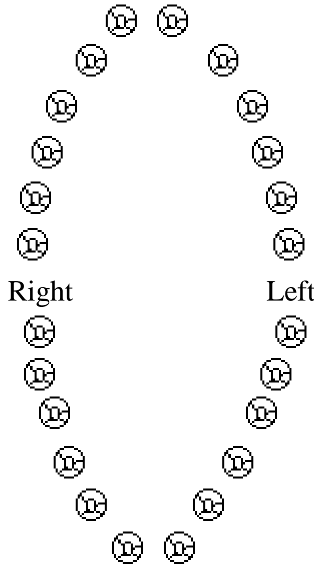
***** Please complete all information*****

Name of Child: ____ Date of Birth: _____/______/_____

Address: ____ City: _________________ Zip: _____________

Home Phone: _________________________ Parent's Name(s): ____

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



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
- ☐ 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 Preschool

119 Union Street, Newark OH 43055

Phone: 740-349-1629 Fax: 740-349-1644

For Dental Stamp with Name, Address & Phone Number

All dental exams expire 1 year from the date of examination