Clark Early Learning Center

Preschool Information Documents

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Clark Early Learning Center Enrollment Form

☐ **New Enrollment** to our Preschool **OR** ☐ **Returning** from last school year

Student Name ______________________ ☐ Male ☐ Female

Date of Birth ______________________ Age as of 9/30: ☐ 3 years-old ☐ 4 years-old

Parent/Guardian ______________________

Address ______________________

Email Address ______________________ Home Phone ______________________

Cell Phone ______________________ Work Phone ______________________

Teacher Preference ______________________

Toilet Trained: ☐ Yes ☐ No

Do you have any areas of concern about your child? ______________________

____

Parent(s)/Guardian(s) are you an employee of Springfield City School District? ☐ Yes ☐ No

If yes, please state position and location: ______________________

FOR OFFICE USE ONLY

Classroom Assignment ______________________

Session Assignment: ☐ AM ☐ PM ☐ Ext. Day ☐ Full Day

Elementary/Middle School Area: ______________________

ITEMS TO FILL OUT IN THIS PACKET

☐ Child Enrollment Form

☐ Health History Form

☐ Grant Screening Tool

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Child Enrollment Information

Child's Name ______________________________ Date of Birth ____ /____ /______

Parent/Guardian ______________________________ Cell Phone ______________

Home Address ______________________________ Home Phone ______________

Employer Name & Address ______________________________ Work Phone ______________

Please check which phone number should be first, second or third to reach you while your child is in the program.

Cell ☐ 1 ☐ 2 ☐ 3 Home ☐ 1 ☐ 2 ☐ 3 Work ☐ 1 ☐ 2 ☐ 3

Parent/Guardian ______________________________ Cell Phone ______________

Home Address ______________________________ Home Phone ______________

Employer Name & Address ______________________________ Work Phone ______________

Please check which phone number should be first, second or third to reach you while your child is in the program.

Cell ☐ 1 ☐ 2 ☐ 3 Home ☐ 1 ☐ 2 ☐ 3 Work ☐ 1 ☐ 2 ☐ 3

Please list two people not in the household to be contacted in the event of an emergency if the parent cannot be contacted.

Contact 1:

Name	
Street Address	
City	
State	Zip Code
Relationship to Child	
Home Phone	
Cell Phone	
Work Phone	

Contact 2:

Name	
Street Address	
City	
State	Zip Code
Relationship to Child	
Home Phone	
Cell Phone	
Work Phone	

Physician:

Name
Street Address
City, State, Zip Code
Phone

Dentist

Name
Street Address
City, State, Zip Code
Phone

PSR-3

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Annual Class Roster

Each year we prepare a roster for each group of children in our program.
This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize the following to be listed on the parent roster: (Please check "Yes" or "No" in each column.)

My child's name	Parents'/Guardian's Name	Phone Number
☐ Yes ☐ No	☐ Yes ☐ No	☐ Work ☐ Mobile ☐ Home ☐ No

Signature of parent or guardian ____________________ Date ____________

Chronic Physical Problem(s):
History of Hospitalization:
Diseases this child has had:
Allergies and Treatment:
Medications, Food Supplements, Modified Diet or Fluoride Supplements:

List of person(s) to whom child can be released (Please print)

List of person(s) NOT permitted to pick up this child (Please print)

	Restraint papers or divorce decree attached: ☐ Yes ☐ No
	Restraint papers or divorce decree attached: ☐ Yes ☐ No
	Restraint papers or divorce decree attached: ☐ Yes ☐ No

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Clark Early Learning Center Health History

Child's Name ____________________ Date of Birth ____ /____ /______

School ____________________

Medical insurance: Primary ______________ Secondary ______________ ☐ None

Prenatal History

Birth Weight ______ lbs. ______ oz.
☐ Full Term ☐ Premature ☐ Late

Did you receive prenatal care during the
☐ 1st ☐ 2nd ☐ 3rd trimester

Mother's age at birth ______

Were drugs/alcohol used during pregnancy ☐ Yes ☐ No
Did baby require oxygen ☐ Yes ☐ No
Any feeding problems ☐ Yes ☐ No
Was infant breast-fed ☐ Yes ☐ No
Have jaundice ☐ Yes ☐ No
Birth defects/problems ☐ Yes ☐ No
If yes, please list ______

Does your child have any unusual birthmarks or blue spots? ☐ Yes ☐ No

Growth Development

What age did your child?
Crawl ______ Sit alone ______
Walk ______ Dress self ______
Speak with meaning ______
Stop using a bottle ______

Is your child toilet trained?
☐ Yes ☐ No If yes, at what age ______

Does child wear diapers or pull-ups?
☐ Yes ☐ No

How often does your child have toilet accidents? ______

Physician/Dentist

Physician/Clinic ______
Address ______
Phone ______
Dentist/Clinic Name ______
Address ______
Phone ______

Does child have any of the following?
Missing Teeth ☐ Yes ☐ No
Dental Caps ☐ Yes ☐ No
Loose Teeth ☐ Yes ☐ No
Cavities ☐ Yes ☐ No
Difficulty Eating ☐ Yes ☐ No
Other Dental Problems ☐ Yes ☐ No
Describe ______
How often does your child brush teeth? ______

Health History

Has your child ever been seen by a dentist?

Has your child had any of the following?
Allergies Yes ☐ No
Anemia ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Bleeding Tendencies ☐ Yes ☐ No
Bone/Joint Disorders ☐ Yes ☐ No
Broken Bones ☐ Yes ☐ No
Chicken Pox ☐ Yes ☐ No
Developmental Delays ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Ear Infections, 3 or more ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Hearing Difficulties ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Meningitis ☐ Yes ☐ No
MRSA ☐ Yes ☐ No
Nervous Habits ☐ Yes ☐ No
Over Weight ☐ Yes ☐ No
Phobias (Fears) ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Sickle Cell Trait ☐ Yes ☐ No
Skin Rashes/Infections ☐ Yes ☐ No
Speech Language Impairment ☐ Yes ☐ No
Tonsil Surgery ☐ Yes ☐ No
Trouble Sleeping Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Urinary Infections ☐ Yes ☐ No
Whooping Cough ☐ Yes ☐ No
Emotional Problems ☐ Yes ☐ No
If yes, explain ______

Exhibit destructive behavior ☐ Yes ☐ No
If yes, explain ______

Surgery/Hospital Stay ☐ Yes ☐ No
If yes, explain ______

Has your child ever had a serious accident - broken bones, head injuries falls and/or burns? ☐ Yes ☐ No
If yes, explain ______

List any diseases or conditions not listed: ______

Allergies (Identify)

Does your child have any allergies to the following?
Drugs ______
Plants/Animals ______

Does your child take medication for allergies? ______

Name of medications ______

Taken how often ______

Nutrition History

Is your child on a special diet? ☐ Yes ☐ No
If yes, explain ______

Does your child have any food allergies?
☐ Yes ☐ No If yes, explain ______

Does your child eat any non-food items?
☐ Yes ☐ No If yes, explain ______

Does your child take vitamins? ☐ Yes ☐ No
If yes, were they prescribed? ☐ Yes ☐ No
Does your child receive WIC? ☐ Yes ☐ No

Medication/Treatment

List medications taken daily or frequently ______

Taken how often ______
If your child received therapy, what type and where? ______

Does your child use an EpiPen? ☐ Yes ☐ No

Other Information

Does your child have any of the following?
Glasses ☐ Yes ☐ No
Tubes in ear(s) ☐ Yes ☐ No
☐ Right ☐ Left ☐ Both

I understand that if my child has a medical or religious need for a special diet, I must submit the required form before my child may start.

Parent/Guardian ______________ Date ______

Staff ______________ Date ______

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Child Medical Statement

Required by Office of Early Learning and School Readiness

Child's Name ______________________________ Date of Birth ____ /____ /________

Height ________________ Weight ________________

Limitations or health condition (including allergies, medications, dietary restrictions)

Immunizations	Please check one
Complete for age	☐ Yes ☐ No
Immunizations	☐ Yes ☐ No

Exempt from Immunizations	Please check one
Religious conviction	☐ Yes ☐ No
Health concern	☐ Yes ☐ No
Other:	

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

Signature of examining Physician/Physicians Assistant or Advanced Practice Nurse Address: Phone:	Date of Exam

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program

Assessments/ Screenings	Type of Instrument Used	Date Completed	Pass or Fail	Referral Completed Yes or No
Vision			☐ Pass ☐ Fail	☐ Yes ☐ No
Hearing			☐ Pass ☐ Fail	☐ Yes ☐ No
Lead	☐ Yes ☐ No			
Hemoglobin	☐ Yes ☐ No			

PLEASE INCLUDE IMMUNIZATIONS

Student File Copy **Teacher File Copy**

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Clark Early Learning Center
Dental Form

Exam Date ____ /____ /________

Child's Name ______________________________ Birth Date ____ /____ /________

Exam Completed by: ☐ DMD ☐ RDH ☐ Other: Specify ______________________

Provider Setting: ☐ Doctor/Dentist/Clinic ☐ School/Center ☐ Other: Specify ______________

Evaluation Type: ☐ Screening ☐ Exam

Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times per Day Child Brushes Teeth: ____________

Uses Fluoride Toothpaste: ☐ Yes ☐ No Takes Fluoride Supplement: ☐ Yes ☐ No

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

General Comments on Oral Health: ______________________________

Today's Visit:

☐ Visual Screening
☐ Full Exam
☐ X-Rays
☐ Cleaning
☐ Fluoride Treatment
☐ Oral Hygiene Instruction
☐ Treatment (specify)

____
____
____
____
____
____

Treatment:

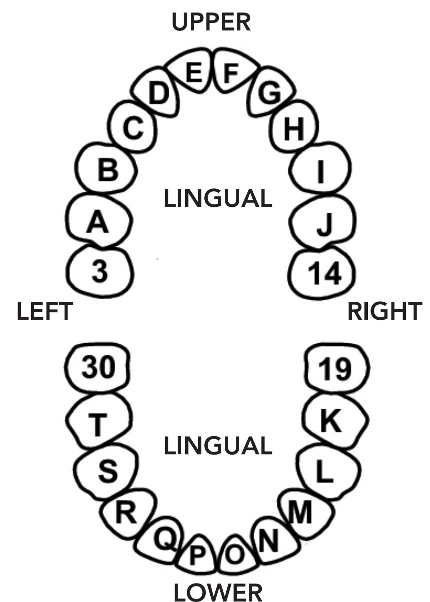
☐ No Needs
☐ Treatment Needed

Next Appointment Date:

____ /____ /________

Treatment Plan:

____
____
____
____
____
____



Provider Signature ______________________ **Exam Completion Date** ____ /____ /________

Printed/Stamped Name/Address of Provider: ______________________

Address ______________________ **Phone** ______________________

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Local Early Childhood Education Grant Eligibility Screening Tool Supplement

Child's Name ______________________________

Section 1: Family Size: Check all that apply

- ☐ All parents/guardians of the child live in the home (including other siblings/children)
- ☐ A stepparent lives in the home including minor children
- ☐ Grandparents of the child live in the home; ONLY if parent of child is a minor
- ☐ Unmarried parents of any common child who lives in the home including minor children
- ☐ Child lives with foster or kinship family (must have custody papers)

Section 2: Income of the Family

- ☐ All adults are working outside of the home
- ☐ One of the adults is working outside of the home and another adult is not
- ☐ No one in the home is working - skip to Section 4
- ☐ Social Security Retirement

Section 3: Proof of Income: Check all that apply *(Documents must be attached)*

- ☐ I/we can provide 2 pay stubs (most recent)
- ☐ I/we can provide a W2 form
- ☐ I/we are self-employed AND can provide pay stubs or W2 (or can sign a release)
- ☐ I/we are self-employed and CANNOT provide pay stubs or W2
  - ☐ I can provide proof of estimated gross income based on current business records
- ☐ I/we PAY child support to someone else

Section 4: Parent/Guardian Proof of Unearned (other) income:

(even if there are workers in the home)

- ☐ O.W.F. Cash Assistance
- ☐ SSI
- ☐ Unemployment benefits
- ☐ Child Support
- ☐ SNAP Assistance (food stamps)
- ☐ Housing Assistance
- ☐ Utility Assistance (PIPP)
- ☐ I live rent free with someone who is not the biological parent of any of my children
- ☐ Shelter Living
- ☐ Food Pantry / Free Markets
- ☐ Soup Kitchen / Free Meals
- ☐ Clothing Closets
- ☐ Rides from Friends/Family Members
- ☐ Local Transit / Cab Vouchers
- ☐ Cash Gifts
- ☐ Gifts of groceries and personal items
- ☐ Other: ______________________

☐ I live with someone who is not the biological parent to my child/children but they provide for my living expenses.

Please have this person fill the bottom portion of this form out.

I, ______________________________, cover the following expenses (circle those that apply):

housing, utilities, food, transportation for ______________________________ and his/her family.

______________________________ Signature

______________________ Date

Ohio Department of Job and Family Services Ohio Department of Education

Local Early Childhood Education Grant Eligibility Screening Tool Supplement

Child's Name ______________________________

Tell us about you (the applicant)

First Name	MI	Last Name	
City			Today's Date
City	State	County	Zip Code
Phone Number	Additional Phone Number	Email 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					

Tell us about your needs for your child(ren)

Child 1	Provider Name and Address	Child's Needs	What hours/days do you need services? (i.e. child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe:	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ 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			

Child 2	Provider Name and Address	Child's Needs	What hours/days do you need services? (i.e. child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe:	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ 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			

Child 3	Provider Name and Address	Child's Needs	What hours/days do you need services? (i.e. child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? ☐ Yes ☐ No Describe:	☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ 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			

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.

Child's Name ______________________________

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 ____ ☐ Thu ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thu ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thu ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thu ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thu ____ ☐ 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 ______________

Certification of Zero Income

Name ____

Address ____

Phone ____________________ Child's Name ____________________

I hereby certify that I do not receive income from any of the following sources

1. Wages from employment
2. Income from operation of a business
3. Rental Income
4. Interest or dividends from assets
5. Social Security payments, annuities, insurance policies, retirement funds, pensions or death benefits.
6. Unemployment or disability payments
7. Public assistance
8. Alimony, child support
9. Sales from self employment resources (Avon, Tupperware etc)
10. Any other source not named above

How do you pay for rent, utilities, food?

____

____

____

____

____

Signature ______________________________ Date ____________