Montgomery County ESC
Early Childhood Program
2528 Wilmington Pike
Dayton, OH 45419
(937) 424-3838

Registration Form 2020-2021
Program:
_______ Deaf/Hard of Hearing
_______ NME
_______ Kindergarten

Section I – Student & Family Information

Child's Name ______________________________ Date of Birth ____________ Gender _______

Parent/Guardian 1 Name ______________________ Cell Phone (___)__________ Call Order _______

Home Address ____________________ Apt. ______ Home Phone (___)__________ Call Order _______

City___________________________Zip_______ Work Phone (___)__________ Call Order _______

Employer Name_____________________________ Email_______________________________

Parent/Guardian 2 Name ______________________ Cell Phone (___)__________ Call Order _______

Home Address ____________________ Apt. ______ Home Phone (___)__________ Call Order _______

City___________________________Zip_______ Work Phone (___)__________ Call Order _______

Employer Name_____________________________ Email_______________________________

Child Lives With: (please check only ONE of the following descriptions that applies to your child)

___Both natural/adoptive parents ___Mother & Stepfather ___Father & Stepmother

___Mother only ___Father only ___Grandparents

Foster Parent(s) Caseworker Name:______________________ Phone:____________________

Other: describe____

____

Housing Arrangement ___House ___Apartment ___Sharing a residence w/________________(name)

LIST BROTHERS AND SISTERS OF STUDENT LIVING IN THE SAME HOUSEHOLD			
LAST NAME, FIRST NAME	GENDER	DATE OF BIRTH	SCHOOL ATTENDING, IF ANY

Section II – Student & Family Information

List TWO (2) Emergency Contacts for use ONLY if the parents cannot be contacted:

Name ____ Cell Phone (___)____________ Call Order __________

Home Address ______________________ Apt. ________ Home Phone (___)__________ Call Order __________

City______________________________Zip__________ Work Phone (___)__________ Call Order __________

Relationship to child______________________________

Parent/Guardian 2 Name ________________________ Cell Phone (___)____________ Call Order __________

Home Address ______________________ Apt. ________ Home Phone (___)__________ Call Order __________

City______________________________Zip__________ Work Phone (___)__________ Call Order __________

Relationship to child______________________________

Section III – Child's Health Information

Child's chronic medical/health needs:	
History of hospitalizations	Medications (note: a medication form must be completed for each medication administered while in program attendance. Forms are available in the school office).
Allergies/Treatments	Dietary Needs or Restrictions

Child's immunizations records are attached: ________ yes ________no

Exempt from immunizations because of religious conviction: ________ yes ________no

(Exemption form is available in the school office)

Purpose of this form: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority *<u>when parents or guardians cannot be reached.</u>*

Emergency Medical Authorization

Section 3313.712, Ohio Revised Code
Early Childhood Education Programs

Child's name:________________________ Date of Birth: ____________ School Attending: ____________

Address:________________________________ City: ________________ Zip: ____________

Parent/Guardian name:________________________________ Daytime phone: ____________________

Relationship to child: ________________________________ Cell phone: ____________________

Parent/Guardian name:________________________________ Daytime phone: ____________________

Relationship to child: ________________________________ Cell phone: ____________________

MUST HAVE THREE CONTACTS OTHER THAN PARENTS:

Emergency Contact name:________________________________ Daytime phone: ____________________

Relationship to child: ________________________________ Cell phone: ____________________

Emergency Contact name:________________________________ Daytime phone: ____________________

Relationship to child: ________________________________ Cell phone: ____________________

Emergency Contact name:________________________________ Daytime phone: ____________________

Relationship to child: ________________________________ Cell phone: ____________________

Complete EITHER Part I or Part II Below

PART I – TO GRANT CONSENT

I hereby *<u>give consent</u>* for the following medical care providers and local hospital to be called:

Doctor:________________________ Phone: ________________

Dentist: ________________________ Phone: ________________

Medical Specialist: ________________________ Phone: ________________

Local Hospital: ________________________ 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 doctor, or, in the even the designated preferred practitioner is not available by another licensed physician or dentist; and 2) transfer of the child to any hospital reasonable accessible

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians concur 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:

Date: ________________ Signature of Parent or Guardian:________________________________

Date Updated: ____________ *Signature of Parent or Guardian:* ________________________________

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:________________________________

____

____

Date: ________________ Signature of Parent or Guardian: ________________________________

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Status of Custody Form

This form is to be completed before a student is registered in the Montgomery County ESC Learning Center, and any applicable custody documents must be provided.

Student Name: ____ Date of Birth:

Building Enrolled/Preschool Site:

Name of Adult Completing Paperwork:

Relationship to Student:

Child lives with:

_______ Both Natural/Adoptive Parents – *married at time of birth*________ Yes _______No

_______ Father Only _______ Grandparent(s)

_______ Mother Only _______ Aunt and/or Uncle

_______ Foster Family _______ Other: explain _______________________________________

____

____

If the child does not reside with both natural/adoptive parents, please check the parental status:

_______ Divorced; current custody document is on file with this school

_______ Legally separated; current document is on file with this school

_______ Separated – custody not on file (both parents have equal rights regarding custody)

_______ Not married at time of birth

_______ Intent to gain custody paperwork is currently on file with this school

_______ Guardianship

_______ Temporary Protection Order (restraining order or TPO) is currently on file with this school

_______ Other parent deceased

I understand the right of my child's other parent. If a legal separation divorce or other custody change is initiated, I will furnish a copy of the custody document to the school.

Parent/Guardian Signature: ____ Date: _____________________

Address, City, Zip: ____

Daytime Phone: _______________________________ Cell Phone: ___________________________________

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Ethnicity/Race Data Collection Form

The United State Department of Education has issued guidelines regarding the collection of data on race and ethnicity for public school students. The federal government, which requires all states to collect this information, has developed a new way to report ethnicity and race that includes new categories..

Child's Name: ______________________________ Date of Birth: ____________________

Address: ______________________________ Gender: ____________________

____

PART 1 – Is this student of Hispanic/Latino heritage? (**Choose only one answer**)

______ No, not Hispanic/Latino

______ Yes, Hispanic/Latino (a person of Cuban Mexican, Puerto Rican, South or Central American or other Spanish Culture or origin, regardless of race.

PART 2 – RACE – Choose **only one** category below that best describes your child's racial identity.

______ American Indian or Alaskan Native

______ Asian

______ Black/African American

______ Hispanic/Latino

______ Native Hawaiian or Pacific Islander

______ White

______ Multi-racial/Other (please indicate which races best reflect your child's identity)

____.

Child's place of birth: ____________________ Country: ____________________

1. What language did your child speak when he/she was first learning to talk? ____________
2. What language does your child usually speak at home now? ____________________
3. What language do you usually use with your child? ____________________
4. What language do the adults usually speak at home? ____________________
5. Does someone in your home read English? ______Yes ______No
6. Do you need help with translation? ______Yes ______No
7. Are you a refugee? ______Yes ______No

   If yes, from which country? ______________________________
8. Are you currently homeless? ______Yes ______No

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Special Education/504 Plan

Child's name: ______________________________ Date of Birth: ____________________

__________ My child does NOT currently receive special education services.

If checked you do not have to complete the reset of this form. Please sign at the bottom.

_________ My child is currently on an _________IEP __________504 Plan

_______ I have provided a current copy of the IEP (Individualized Education Plan)

_______ I do not have a current copy of the IEP

_______ I have provided a current copy of the MFE (Multi-factored Evaluation)

_______ I do not have a current copy of MFE

_______ I have provided a 504 Plan Statement

Date: __________________ Signature of Parent or Guardian:____

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Authorizations & Releases

2020-2021 Program Year

Child's Name ______________________________ Birth Date: ______________________

Class Roster & Directory Authorizations

*(**Annual Class Roster:** Each year the program prepares a roster for each group of children. This roster will not be furnished to any persons other than parents of children enrolled in your child's classroom.)*

I authorize the following to be listed on the class roster:

My child's name: _______ yes _______ no

Family name: _______ yes _______ no

Phone numbers: _______ yes _______ no _________ cell _____________ home ___________ work

Date: _______________ Signature of Parent or Guardian: ______________________________

ASSESSMENT RELEASE	Please circle your response to each statement below.	
I give my permission to have my child participate in all learning and developmental screenings and assessments which are required by the Ohio Department of Education	YES	NO
PHOTOGRAPHY RELEASE		
1) I give my permission for my child to be photographed for portfolio projects, classroom activities	YES	NO
2) I give my permission for my child to be photographed/video recorded that may be included in articles, publication (i.e. yearbook, class picture) videos, etc. and placed on school websites.	YES	NO
VISION, HEARING & SPEECH SCREEING RELEASE		
I give my permission for the preschool staff and its contractors to administer vision, hearing and speech screenings for my child.	YES	NO

I have read and have specified in each section, the type of permission I am granting.

Date: _______________ Signature of Parent or Guardian: ______________________________

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Transportation List

Child's Name ______________________________ School: ______________________________

The following adults are authorized to pick up the above named child from school

Name	Relationship to Child	Phone/Cell Number(s)

The following adults are **NOT** permitted to pick up my child

Name	Relationship to Child	Description

The adults named above are authorized to pick up my child in the event I am unable to do so. I will inform them to bring a driver's license to show the teachers and aides until school staff are familiar with them I understand that my child will NOT be released to anyone not on this list. I understand it is my responsibility to inform the school by written note or phone call, when there is an unforeseen event that would require an unlisted individual to transport my child from school. I will make every effort to keep this list updated.

Date: ______________________ Signature of Parent or Guardian:

Date Updated: ____________ *Signature of Parent or Guardian:*

Date Updated: ____________ *Signature of Parent or Guardian:*

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Child Medical Statement

To be completed by a Medical Professional Only

This form meets Ohio Administrative Code

Section I – Child Medical Information

Child's Name ______________________________ Date of Birth ______________ Gender M F

Height: _______ (_____%) Weight: _________ (_____%) BP: ______ Pulse: _______ Respiration: ________

General Physical Exam Findings:

Heart _______ Head _______ Eyes ________ Ears ________ Nose ________ Neck _______ Chest ________

Lymphatics _________ Back ________ Abdomen __________ Genitalia ___________

_______ No significant findings were noted during the general physical exam.

_______ Limitations or health conditions were noted during exam.

Please Specify ____

____

____

ALLERGIES: ____

Medication	Dosage	Prescribed For

Blood Lead Screening Date: _____ Results: _______ Hematocrit Test Date: __ Results: _______________%

Vision (Check all that apply)

Within normal limits? Yes/No (if not, specify: ____)

Wears corrective lenses? Yes/No

Had Eye Surgery? Yes/No (if not, specify: ____)

Hearing (Check all that apply)

Within normal limits Yes/No (if not, specify: ____)

________ History of frequent ear infections Yes/No

________ PE Tubes Inserted Yes/No (Date: ______________________) Other: ______________________________

Diagnosed Disorders/Syndromes (Check all that apply)

_________ Seizure Disorder (specify type and frequency) ____________________

_________ Cerebral Palsy (Specify Impact) ____________________

_________ Down Syndrome Atlantoaxial Instability X-Ray: __________ completed (positive/negative) __________ not completed

_________ Pervasive Developmental Disorder (Specify) ____________________

_________ Diabetes ______ Metal Health Disorder Explain ____________________

Behavioral Concerns: Circle all that apply

Hyperactivity Distracted Short attention span Withdrawn Aggression Anxiety

Other (Explain) ____________________

Immunization Record	Dates (Must include month/day/year)				
Vaccine	**Dose 1**	**Dose 2**	**Dose 3**	**Dose 4**	**Dose 5**
DPT, DTap, or DT/pediatric (Diphtheria, Tetanus, Pertussis)					
Polio Vaccine					
Hepatitis B					
HIB (Haemophilus Influenza Type B)					
Varicella Zoster (Chicken Pox)					
MMR (Measles, Mumps, Rubella)					
Hepatitis A					
Influenza					
Pneumococcal					
TB Test required for all students born outside the US	____________ Negative	____________ Positive			

Immunizations: _______ complete for age _______ in progress

Exempt from Immunizations for: _______ religious conviction _______ medical reason

- Doctor's exemption statement form is available in the school office

I certify that no communicable disease is evident at the time of this examination and the child may attend a preschool program.

Examination Date: __________ ____________________

Physician's Signature (Indicate: MD, DO, or NP) Date

Phone Number: ____________ Address: ____________________

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Child Dental Exam Record

To be completed by your Dentist

Exam Date: ________________ Child's Name: ____

_______ Male _______ Female Birth Date: ____

Address: ____ City/Zip _______________________________

Exam Completed By: _______ DMD _______ RDH _______ Other: Specify ___________________________

Evaluation Type: _______ Exam _______ Screening

Mouth and Structures:

Normal appearance and function? _______ Yes _______ No

Abnormalities Noted: ____

Today's Visit Included:

_____ Visual Screening
_____ Full Exam
_____ X-rays
_____ Cleaning
_____ Fluoride Treatment
_____ Oral Hygiene Instruction
_____ Treatment (describe)

Future Treatment:

_____ Visual Screening
_____ Visual Screening

Next Appointment
Date:
Treatment Plan:

KEY:	Missing	Decayed	Filled

Dental Professional's Signature: ________________________________ Exam Completion Date: __________________

Printed or Stamped Name: ____ Phone: ___________________________

Address of Provider: ____