PRESCHOOL REGISTRATION FORM

Student ID#__________________________ (office use only)

Student's Name ____

First Middle Last

Gender (M or F) Student's Date of Birth Last 4 digits of Social Security Number

Street Address Student's City & State of Birth

Mailing Address (PO Box # if applicable) Student's Mother's Maiden Name

City State Zip code Home/Cell Phone #

FAMILY INFORMATION

Mother's name Occupation Work or Contact #

Father's name Occupation Work or Contact #

Name & ages of siblings: ____

STATEMENT OF CUSTODY

I state that I have _____ full custody rights or ____ shared custody rights of said child for the following reason:

( ) Married ( ) Separated ( ) Divorced ( ) Father Deceased ( ) Mother deceased
( )Never Married ( ) Foster ( )Court Placed ( ) Grandparent – Power of Attorney required

Note: If the student does not reside with parents, legal documentation must be provided to the school at time of enrollment. Ex: official court papers, legal guardianship papers, power of attorney, etc.

Custody/Court documents on file at school ___ Yes ___ No

Student lives with: (check one)

____ Both natural parents ____ Mother only ____ Father only
____ Shared parenting ____ Mother/Stepfather ____ Father/Stepmother
____ Grandparents ____ Other – please specify ______________________________

(CONTINUE ON BACK)

Non-custodial or shared parent: Information

____
Name Relationship

____
Address

____
Phone #

ETHNIC/RACE INFORMATION

The United States Department of Education mandates that school districts collect and report racial and ethnic data. The purpose for collecting this information is to "ensure equal access" to education for all students.

Is the student Hispanic/Latino: _____ **Yes** _____ **No**

Which of the following five racial groups applies to the student? Check all that apply:

_____ **American Indian or Alaska native** Person having origins in any of the original people of North and South American (including Central America) and who maintain tribal affiliation or community attachment.

_____ **Asian** Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, Cambodia, China, India, japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____ **Black or African American** Person having origins in any of the black racial groups in Africa.

_____ **Native Hawaiian or Other Pacific Islander**

_____ **White** People who have origins in any of the original peoples of Europe, North Africa, or the Middle East

Citizenship Status (check one) _____**U.S.A.** _____**Other** **Country** ______________________

Is the student's primary/home language English? _____ **Yes** _____ **No** __________________**Language**

If no, Home Language Survey is required

SPECIAL SERVICE (IF APPLICABLE)

Please check if your child is currently receiving any of the following services:

_____ **Speech** _____ **Occupational Therapy** _____**Physical Therapy**

_____ **Behavior Therapy** **Other** ______________________________

Any Medical Concerns:

____

____

____ ______________

Parent/Guardian Signature **Relationship** **Date**

UNION LOCAL SCHOOLS
EMERGENCY MEDICAL RELEASE FORM

Child's Full Name______________________________**Birth Date**__________________**M or F**

Address ____________________________________**Telephone #** ____________________

City ______________________________**County** ______________**Last 4 digits SS#** ________

Guardian's Name	**Guardian's Name**
Relationship to child	**Relationship to child**
Place of Employment	**Place of Employment**
Work #	**Work #**
Physician's Name	**Dentist's Name**
Address	**Address**
Phone #	**Phone #**
Hospital Preferred	

PART 1: TO GRANT CONSENT

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 name doctors, or in the event the designated preferred practitioner is not available by another licensed physician or dentist, and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and physical impairments to which a physician should be alerted: ______________________________

____

____

Date ________________Signature of Parent/Guardian______________________________

DO NOT COMPLETE PART II IF YOU COMPLETED PART 1

I Do Not give my consent for emergency medical treatment of my child. In the even of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: ____________

____

____

Parent/Guardian Signature ______________________________**Date** ______________

Please list 3 people that can be contacted at 3 different addresses & phone numbers in the event that reasonable attempts to contact parent/guardian have been unsuccessful. **It is a state requirement to have three (3) sets of contact information for all children**

1. **Name** ____

   Address ____ **Phone** ______________

   Relationship to child ______________________________
2. **Name** ____

   Address ____ **Phone** ______________

   Relationship to child ______________________________
3. **Name** ____

   Address ____ **Phone** ______________

   Relationship to child ______________________________

Please list ALL other persons who have permission to pick up your child. Persons already listed above do not need to be listed again. Anyone picking up or dropping off your child must be 18 years of age.

A picture identification is required. Anyone not listed will not be permitted to pick up your child without prior permission. Please feel free to contact us at any time to change and/or update this listing.

Name ____________________________________ **Relationship to Child** ____________________

Name ____________________________________ **Relationship to Child** ____________________

Name ____________________________________ **Relationship to Child** ____________________

Name ____________________________________ **Relationship to Child** ____________________

Name ____________________________________ **Relationship to Child** ____________________

Name ____________________________________ **Relationship to Child** ____________________

TRANSPORTATION TO AND FROM SCHOOL

_____ **I grant permission for my child to be transported by my local public school to and from school.**

_____ **I will be responsible for transporting my child to and from school.**

I have completed and agree with the information on this form.

Parent/Guardian Signature ____________________________________ **Date** ________________

OHIO SCHOOL HEALTH HISTORY
To be completed by parent or guardian

Child's full name ______________________________
Last First Middle

Male ________ Female _____ Birth date ______________________________
Month Day Year

Child's address ______________________________

Father's name ______________________________

Address (if different from child) ______________________________

Work Phone ______________________________ Home Phone ______________________________

Mother's name ______________________________

Mother's address (if different from child) ______________________________

Work Phone ______________________________ Home Phone ______________________________

Who is this child's legal guardian? ______________________________
Name Relationship

Please list this child's brothers and sisters:

FAMILY HISTORY

	Birth year	Sex		Birth year	Sex
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

PRENATAL HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy? Yes _______ No _________

If yes, explain briefly ______________________________

How old was the mother when this child was born? ______________________________

Was this infant born: full term ________ early __________ late _______ What was the birth weight? ______________

Did the infant have any sickness or problems while in the nursery? Yes _________ No___________

If yes, explain briefly ______________________________

DEVELOPMENTAL HISTORY

Please give the approximate age at which this child:

walked alone __________ was toilet trained _____________ spoke in sentences _________dressed self ___________

How does child's development compare to other children, such as his or her siblings or playmates?

about the same _______ slower _______ faster ________

IMMUNIZATION RECORD

PLEASE ATTACH A COPY OF CURRENT IMMUNIZATION RECORD FROM THE CHILD'S PHYSICIAN.

REQUIRED COMPULSORY IMMUNIZATION LAW: 5 DTaP, 4 Polio, 4 Hib, 2 Hepatitis A, 3 Hepatitis B, 2 MMR ,
2 Varicella
(Preschool)

___Abnormal spinal curvature ___Allergies ___Anemia ___Arthritis ___Asthma or wheezing ___Attention Deficit Disorder or Hyperactivity ___Bedwetting at night ___Behavior Problems ___Birth or congenital malformation ___Cancer, type ___________ ___Chicken pox ___Chronic diarrhea or constipation ___Concern about relationship with siblings or friends ___Cystic fibrosis ___Diabetes ___Eczema ___Emotional problems ___Frequent headaches ___Frequent skin infections ___Frequent sore throat infections ___Heart disease, type ___Hemophilia	___Hepatitis ___Kidney disease, type ___________ ___Measles ___Meningitis or encephalitis ___Multiple ear infections (3 or more) ___Mumps ___Near-drowning or near-suffocation ___Nervous twitches or tics ___Poisoning ___Rheumatic Fever ___Seizures or epilepsy ___Sickle cell disease ___Stool soiling ___Toothaches or dental infections ___Urinary tract infections ___Wetting during day ___Vision problems ___Wears glasses ___Hearing problems ___Wears hearing aid ___Other ___________

ALLERGIES – Please list and describe allergies or reactions to:

Medicine / drugs ___________

Foods / plants / animals / other ___________

Recommended treatment if allergy is severe ___________

ILLNESS AND INJURIES – Please list any severe illnesses or injuries

Illness / Injury	Age of child	Check if hospitalized

Does this child always wear seat belts in cars? Yes _____ No_____

ADDITIONAL INFORMATION:

What medications are given daily? ___________

What medications are given frequently but not daily? ___________

This child is usually: very active ____ normally active ____ rather inactive ____

Do you have any concern about how your child gets along with other children? ___________

____

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly: ___________

____

COMPLETED BY: ___________ RELATIONSHIP TO CHILD ___________

Union Local Elementary School
Emergency Dismissal

TORNADO The school will be informed by the local weather station in the event of possible tornadoes for the area. The Superintendent's office will determine dismissal when conditions warrant.

ALL OTHER EMERGENCIES (Weather, Fire, Plant Failure, etc.) The Superintendent's office will determine dismissal when conditions warrant.

PARENTS SHOULD BE SURE THEIR CHILDREN ***CLEARLY*** UNDERSTAND WHERE THEY SHOULD GO IN CASE OF AN ***EARLY DISMISSAL*** ESPECIALLY PARENTS WHO WORK OR KNOW THAT THEY WILL NOT BE HOME DURING THE DAY.

Please fill in the bottom half of this form and return it to school immediately so it can be filed in your child's permanent record.

****

Student's Name ________________________________ Grade ________

Teacher ________________________________

I received the school emergency dismissal sheet and my child clearly understands that he/she is to go to the address listed below. Please list the complete name, address, and phone number of the person's home that your child will be going to in case of early dismissal. Include the bus number if this will be a different bus.

Name ________________________

Address ________________________

Phone ________________________

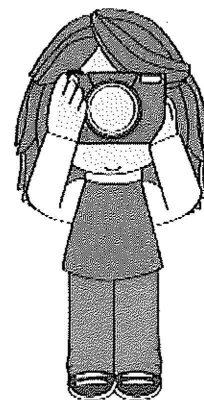
Bus Number ____________________

____
Signature of Parent/Guardian

____
Telephone Number

____
Emergency Telephone Number

LITTLE JETS PRESCHOOL
PUBLICATION/RELEASE INFORMATION



Child's Name________________________________

Permission for picture publication:

_____ **Yes!** My child has my permission to have his/her picture taken for possible publication (newspaper, brochure, UL website)

_____ **No!** My child does not have my permission to have his/her picture taken for possible publication.

_____ **Yes!** My child has permission to have his/her picture taken or video recorder **for the purpose of documenting for State required assessments**.

Permission for release of roster information:

_____ I give my permission to release my child's name, telephone number, and my name to parents in the preschool classroom.

_____ I do NOT give my permission to release my child's name, telephone number, and my name to parents in the preschool classroom.

Parent/Guardian Signature ____________________________
Date__________________

PLEASE COMPLETE THIS QUESTIONAIRE FOR ADDITIONAL INFORMATION ON YOUR CHILD

Do you have any concerns regarding your child's development, specifically in the areas of speaking and understanding language, motor skills, social skills and behavior?

____

____

Has your child ever received any therapies or services in the areas of Speech and Language, Occupational Therapy, Physical Therapy, Counseling/behavioral Therapy, or Psychiatric Services.

____

____

Has your doctor or anyone else ever raised concerns regarding your child's development in the areas of: speech/language, motor skills, behavior, and social skills?

____

____

Does your child have any health concerns? Does your child have any medical conditions or diagnosis? Is your child taking any medications?

____

____

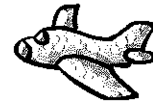
Is there anything else we might need to know to best service your child?

____

____

UNION LOCAL ELEMENTARY SCHOOL

66699 Belmont-Morristown Rd.
Belmont, Ohio 43718
740-782-1384



Little Jets Preschool

Parent/Guardian:

Thank you for choosing to apply to the Little Jets Preschool. Please find attached a Pre-School Fee Application for the 2024-25 school year. Please complete the Fee Application and return with the registration packet. Enrolled public pre-school children who do not meet the federal income levels as prescribed in our pre-school project are subject to a Sliding Fee Schedule, payable at the Elementary School as follows:

A. A $125.00* payment for half day classes or a $200 payment for the full day class is due prior to the first day of school, or on Orientation Day with payments of $125.00* for half day classes or $200 for the full day class are made monthly thereafter, or

B. Total payment of $1125.00*for half day classes or $1800.00 for the full day class prior to the first day of school.

According to your enrollment application, the following fee scale applies relative to family income. You will receive the total fee due prior to your child's Orientation Day (you will receive a letter regarding the Orientation Day.) Please note you will need to submit verification of income. **The following information can be submitted for verification: W-2 form, check stub (2 pay stubs), tax form, OWF case number, food stamp number, or medical card**. The above information is to be submitted to the Elementary Office. The payment, if required, can be a personal check made payable to the **Union Local Elementary School**.

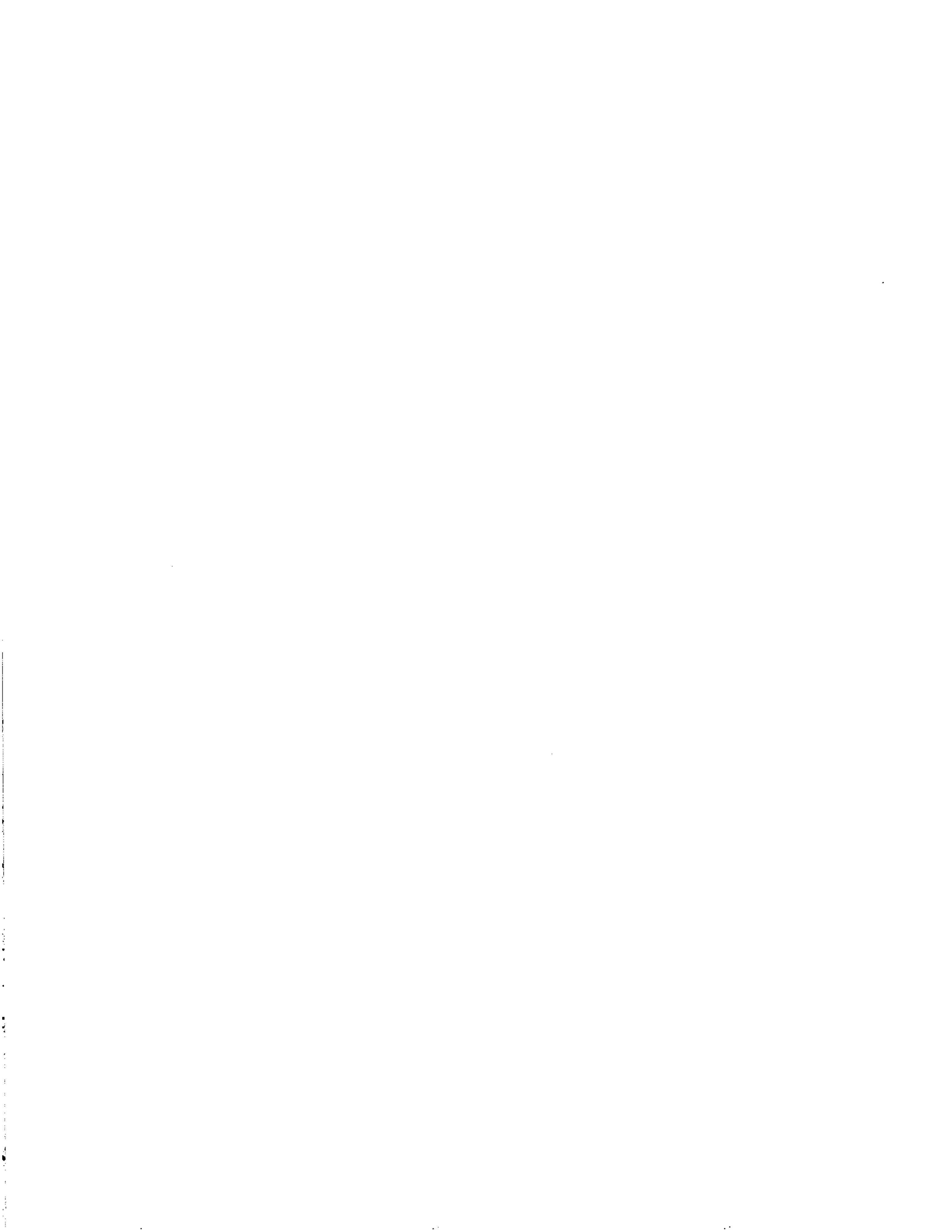
Again, after initial $125.00* for half day class or $200 for the full day class payment is made prior to the first day of school, a monthly payment of $125.00* or $200 will be required. If a payment is not received monthly, you will be sent a written notification as a warning of overdue payment. **Payment not received for two months will result in your child being removed from the Little Jets Preschool Program.**

The base tuition is currently $125.00* per month for half day classes and $200 for the full day class. ***This rate may be subject to change contingent upon future projected budgets.** If you have any questions, please call my office, 740-782-1384.

Sincerely,

Mrs. Dana Kendziorski

Dana Kendziorski
Preschool Director



UNION LOCAL SCHOOL DISTRICT
PUBLIC PRE-SCHOOL APPLICATION
SCHOOL YEAR 2024/25

NAME OF CHILD______________________________**TELEPHONE**____________________________

BIRTHDATE________________________________**AGE BY (8/1/24)**________________________

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER____

FATHER'S NAME_______________________**MOTHER'S NAME**_____________________________

CHILD RESIDES WITH:____

ADDRESS____

All applicants are **required to supply Proof of Income (what is acceptable in box below)** for the following income information as part of the state funding continuation process for our preschool program. Please check below the category that accurately describes your family size and income situation.

FEDERAL POVERTY INCOME PROGRAM 2024-2025
TOTAL NUMBER OF PEOPLE LIVING IN THE HOUSEHOLD

(PLEASE CIRCLE CORRECT NUMBER/SIZE OF FAMILY & INCOME)

Circle size of family – then follow across that line and circle income

TOTAL COMBINED ANNUAL INCOME OF ALL HOUSEHOLD MEMBERS

Size of family	100% poverty level	125% poverty level	150% poverty level	175% poverty level	185% poverty level	200% poverty level or over
1	$15,060	$18,825	$22,590	$26,355	$27,861	$30,120
2	$20,440	$25,550	$30,660	$35,770	$37,814	$40,880
3	$25,820	$32,275	$38,730	$45,185	$47,767	$51,640
4	$31,200	$39,000	$46,800	$54,600	$57,720	$62,400
5	$36,580	$45,725	$54,870	$64,015	$67,673	$73,160
6	$41,960	$52,450	$62,940	$73,430	$77,626	$83,920
7	$47,340	$59,175	$71,010	$82,845	$87,579	$94,680
8	$52,720	$65,900	$79,080	$92,260	$97,532	$105,440
EACH ADDITIONAL	+ $5,380	+ $6,725	+ $8,070	+ 9,415	+ 9,953	+ $10,760

If there are more than eight (8) people living in your household, please indicate the total number of members in your family and total combined annual income of all members.

 # in Household__________**Income**____________________

Parent Signature: ____

To be completed by Preschool Office:

VERIFICATION OF ABOVE INCOME (REQUIRED):

______**W-2 FORM** ______**OWF CASE NUMBER** ______**TAX FORM**
______**CHECK STUB (2)** ______**FOOD STAMP NUMBER** ______**MEDICAL CARD**
______**OTHER**____

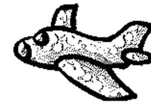
VERIFIED BY______________________________DATE___________________

. . . .

______100% _____125% _____150%____175%_______185%_______200%______201%

UNION LOCAL BOARD OF EDUCATION

Union Local Elementary
66699 Belmont-Morristown Rd.
Belmont, Ohio 43718
740-782-1384 FAX 740-782-0181



Little Jets Preschool

PHYSICIAN FORM

Name: ______________________ Birth Date: ______________________

Address: ____

Parent/Guardian: ________________ Phone: ______________________

Disease History

Rubeola ________
Rubella ________
Mumps ________
Chicken Pox ________
Asthma ________
Diabetes ________
Hepatitis A ________
Heart Disease ________
Meningitis ________

Tuberculosis________
Epilepsy ________
Polio ________
Rheumatic Fever ______
Scarlet Fever ______
Whooping Cough ______
Pneumonia ______
Hepatitis B ______
Other ________

Surgical History

Type Date

____
____
____

Other Pertinent History Information

____
____
____
____

Immunization: List dates (month, day, year)

DTP (1) ________ (2) ________ (3) ________ (4) ________ (5) ________

Oral Polio (1) ________ (2) ________ (3) ________ (4) ________

MMR (1) ________(2) ________ OR Mumps ________ Rubella ________ Rubeola ________

Hepatitis B (1) ________ (2) ________ (3) ________

HIB (1) ________ (2) ________ (3) ________ (4) ________

Varicella (1) ________ (2) ________ Influenza ________

Hepatitis A (1) ________ (2) ________

Pneumococcal (1) ________ (2) ________ (3) ________ (4) ________

Physical Examination

Sex: Male _____ Female ______

Height: _______Weight ________

Milk Sensitivity: ________________

Allergies: ______________________________________

Lead ______________________

Hematacrit ______________________

Blood Pressure: ________________

Pulse: ________________

Respiration: ________________

Teeth: ____________________ Head and Neck: ____________________

Chest: ____________________ Heart: ____________________

Eyes: Right __________ Left __________ Abdomen: ____________________

Ears: Right __________ Left __________ Extremities ____________________

Tubes: Yes __________ No __________ Lungs: ____________________

Hernia: ____________________

Neurological (i.e. seizures, EEG's, muscle weakness etc). If seizures, indicate the type and frequency

____

Orthopedic (non-ambulatory, scoliosis, braces etc.) Please specify.

____

____

Other pertinent medical information ____________________________________

____

Other test results (laboratory or developmental screening) ______________________

____

Indicate any physical limitations ______________________________________

____

Diagnosis ____

Medications

Name	Hours Given	Purpose

I am concerned that this child may be developmentally delayed in the following areas: (circle appropriate areas)

Cognitive **Communication** **Fine Motor** **Gross Motor**

Social/Emotional **Self Help** **Hearing** **Vision**

______________________ ______________________

Physician's Signature **Physician's Name Printed**

__________ __________ ______________________

Date **Phone** **Address**

____

City **State** **Zip**

UNION LOCAL SCHOOL DISTRICT

Little Jets Preschool

OHIO SCHOOL HEALTH RECORD
Dental Report

Child's Name ____________________________ Birth Date __________________

The following services have been performed:

_____examination

_____diagnosis ____________________________

_____ radiographs

_____ oral prophylaxis

_____ prescription for fluoride supplements

_____ topical application of fluoride

_____ other ______________________________

The following oral hygiene instruction was provided:

_____ tooth brushing

_____ flossing

_____ diet counseling reflecting relation of diet to dental health

The following statements are applicable:

_____ all necessary services have been performed

_____ no restorative services are required at this time

_____ further treatment is indicated

_____ further appointments have been arranged for _________________________

Comments: ____

____

____

Please print or stamp:

Dentist ___________________________

Address ____

Phone ____________________________ **Date** ________________________

Dentist Signature ____