



# Ohio Valley ESC

## Bright Beginnings Preschool

Prepare your  
student for success!



Welcome to Bright Beginnings!

Please read through this packet and ensure every item is complete and SIGNED when returning your child's application.

**As a NEW student, you will need to submit**

- \*Enrollment Application (all attached pages completed)
- \*Proof of Income (only if requesting tuition assistance)
- \*Birth certificate
- \*Custody Papers/Agreement (if applicable)
- \* Proof of Residency
- \*Immunization Record

*\*We also ask for a Valid EMAIL ADDRESS*

Students will be placed in their home district first, by the date of the returned, COMPLETED application, then by age of the child (older children are placed first).



## Enrollment Application

2021-2022 School Year



**We are excited to learn with you!**

**This packet must be completed and all documentation submitted by March 1, 2021.**

- When all items are complete and submitted, your child will be considered for classroom placement.
- No spaces will be held for returning students unless we have the completed application packet and all required documentation by the March 1, 2021 deadline.
- *\*If you are NOT planning to return to Bright Beginnings Preschool for the 2021-2022 school year :*

*email: [diane.sullivan@ovesc.org](mailto:diane.sullivan@ovesc.org) - for SOLSD and Washington County*

*email :[cathy.williams@ovesc.org](mailto:cathy.williams@ovesc.org) - for Noble Local School District*

Thank you for letting us serve your family!

★ **Application will require extra postage - please use 3 stamps when mailing.**



revised:1/2021

### **Information:**

Thank you for your interest in the Ohio Valley Educational Service Center's Bright Beginnings Preschool for students ages 3 through 5 years old. Children are placed in classes **once ALL required paperwork and documents are submitted.** We place students by date of application, then age of the child (older children are placed first) . We look forward to working with your family!

### **COST:**

Bright Beginnings Preschool offers payment options based upon income and the number of days your child attends class per week/month. **The tuition is a flat rate and refunds are NOT given for absences, holidays and/or calamity days.** The maximum tuition rate possible is \$140 for full time enrollment per month. Tuition assistance may be available upon completion of the enrollment application and submission of required proof of income documents. Tuition is due prior to starting preschool and is due on the first day of each month. May's tuition is due April 15.

### **REQUIRED DOCUMENTS FOR ADMISSION:**

- Enrollment Application (all attached pages completed)
- Proof of Income (only if requesting tuition assistance) \*please see 3 items needed on page 10
- Birth certificate
- Custody Papers (if applicable)
- Proof of Residency
- Immunization Record

*We also require a Valid EMAIL ADDRESS*

*→ Please make sure to sign every signature line with an arrow beside it*

**\*\*ALL REQUIRED INFORMATION IS MANDATORY to secure your child's spot in a preschool classroom. Once our Marietta office receives your completed packet, we will notify you if there is an opening for your child.**

### **Medical and Dental Forms(to be completed by a medical professional):**

- New students have 30 days from classroom start date to submit both documents
- New forms must be submitted yearly (within 13 months of last visit due to insurance reasons)

MAIL TO:

**BRIGHT BEGINNINGS PRESCHOOL**  
**1338 Colegate Drive, Marietta, OH 45750**  
**740-373-6669**



Ohio Valley ESC  
Bright Beginnings Preschool

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### Enrollment Application

**CHILD'S NAME: (Please print entire application)**

<b>First:</b>	<b>Middle:</b>	<b>Last:</b>
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**Child's Information:**

Date of Birth:	Gender (please circle): Male Female
Foster Child: <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Language Spoken at Home:
Birthplace City:	Citizenship:
Mother's Maiden Name:	Country of Origin:

Racial Group/Local Ethnic Category: (check all that apply)

- Asian  Black/African American  Hispanic  
 American Indian/Alaska Native  Multi-Racial  
 White  Native Hawaiian or Other Pacific Islander

Hispanic/Latino:  Yes  No

Did your child attend Bright Beginnings Preschool previous school year? :  Yes  No

Who Child Lives with/Residential Parent is: (circle all that apply):

Mother      Father      Other

Father's Name:	Mother's Name:
Father's Address:	Mother's Address:
Father's Home #:	Mother's Home #:
Father's Cell #:	Mother's Cell #:
Father's Work #:	Mother's Work #:
Father's Email Address:	Mother's Email Address:
District of Residence:	District of Residence:

Is the parent an OVESC employee?  Yes  No

**Preferred School – Please mark - 1<sup>st</sup> choice, 2<sup>nd</sup> choice, 3<sup>rd</sup> choice (Listed by District/School):**

- |  |  |
|--|--|
| <input type="checkbox"/> Belpre - Belpre                   | <input type="checkbox"/> Switzerland of Ohio - Powhatan  |
| <input type="checkbox"/> Fort Frye - Lowell                | <input type="checkbox"/> Switzerland of Ohio - River     |
| <input type="checkbox"/> Frontier - Newport                | <input type="checkbox"/> Switzerland of Ohio - Skyvue    |
| <input type="checkbox"/> Marietta - Marietta               | <input type="checkbox"/> Switzerland of Ohio - Woodfield |
| <input type="checkbox"/> Noble - Shenandoah                | <input type="checkbox"/> Warren - Warren                 |
| <input type="checkbox"/> Switzerland of Ohio - Beallsville | <input type="checkbox"/> Wolf Creek - Waterford          |

<b>Office Use Only</b>	<b>Start Date:</b>	<b>SSID #:</b>
<b>Dis. Condition:</b>	<b>Services:</b>	<b>Preschool:</b>
<b>Teacher:</b>	<b>Poverty Level:</b>	<b>Typical      Itinerant</b>
<b>Entered EMIS √:</b>	<b>By:</b>	

## ENROLLMENT PACKET

Child History:		
Did mother have any unusual physical/emotional illness during pregnancy? ___ Yes ___ No If Yes, Please explain:		
Age of mother when child was born:	Child's Birth Weight:	
Child was: (please check) ___ Full Term ___ Early ___ Late If applicable how early/late?		
Did the child have any sickness/problems? ___ Yes ___ No If Yes, Please explain:		
Please indicate at what age the child began the following activities: Walked alone _____ Was Toilet Trained _____ Spoke in Sentences _____ Dressed Self _____		
How does this child's development compare to other children (siblings or playmates)? (please check) ___ About the same as others ___ Slower than others ___ Faster than others		
Please list/describe allergies (to medications, foods, plants, animals) and reactions to these items:  Please list/describe recommended treatment to these reactions:		
Please list any severe injuries, illnesses, surgeries you child has had:		
Injury/Illness/Surgery	Was the child hospitalized?	Age at time of event?
1.		
2.		
3.		
Please describe any medications, food supplements, modified diet or fluoride supplements, the child takes daily and/or frequently:		
Medication/Supplements	Reason taken?	How often?
1.		
Please check <input checked="" type="checkbox"/> any health conditions the child has/had:		
<input type="checkbox"/> Abnormal spinal curvature <input type="checkbox"/> Allergies/hay fever <input type="checkbox"/> Anemia <input type="checkbox"/> Anaphylactic reaction <input type="checkbox"/> Asthma or wheezing <input type="checkbox"/> Attention Deficit Disorder <input type="checkbox"/> Behavior problems <input type="checkbox"/> Birth/Congenital malformation <input type="checkbox"/> Cancer – Type _____ <input type="checkbox"/> Chicken pox – date _____ <input type="checkbox"/> Chronic diarrhea/constipation <input type="checkbox"/> Chronic ear infections <input type="checkbox"/> Concern about relationships <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes <input type="checkbox"/> Eczema/Chronic skin condition <input type="checkbox"/> Emotional problems <input type="checkbox"/> Eye problems or poor vision <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Frequent sore throats	<input type="checkbox"/> Heart disease – type _____ <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Kidney disease – type _____ <input type="checkbox"/> Measles <input type="checkbox"/> Meningitis or Encephalitis <input type="checkbox"/> Mumps <input type="checkbox"/> Near-drowning/near suffocation <input type="checkbox"/> Nervous twitches or tics <input type="checkbox"/> Poisoning <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Seizure disorder/epilepsy <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Speech difficulties <input type="checkbox"/> Stool soiling <input type="checkbox"/> Toothaches/dental problems <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Wetting during day or night <input type="checkbox"/> Other _____	

## ENROLLMENT PACKET

**Emergency Contacts: Please list 3 people to be contacted in the event of an emergency IF the parent cannot be contacted.**

Contact #1:	Contact #2:	Contact #3:
Street Address	Street Address	Street Address
City State Zip	City State Zip	City State Zip
Relationship to Child:	Relationship to Child:	Relationship to Child:
Phone #	Phone #	Phone #
Cell #	Cell #	Cell #
Work #	Work #	Work #

Child's Name: First	Middle	Last
<b>Authorization to Release Child:</b> My child may be released to his/her parent/guardian AND the following people only (without prior written authorization).		
Name	Relationship to Child	Phone #
My child may <b>NOT</b> be released to the following individuals: Please attach a copy of divorce decree and/or restraining order if applicable.		
Name	Relationship to Child	Please note any special circumstances of which the staff should be aware:

Please indicate if the family is involved with any of the following community services:	
Speech Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?	Head Start/Early Head Start: <input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?	Help Me Grow/Early Intervention: <input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?	Job & Family Services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, caseworker?
Hearing Services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?	Child/Protective Services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, caseworker?
Vision Services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?	Preschool/Day Care: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?
Mental Health/Individual/Family Counseling Services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where?	
Physician's Name:	Dentist's Name:
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Phone #	Phone #
Fax #	Fax #

## ENROLLMENT PACKET

Things I would like my child's preschool teacher to know:	
My child is: <input type="checkbox"/> very active <input type="checkbox"/> normally active <input type="checkbox"/> not very active	
My child prefers playing: <input type="checkbox"/> alone <input type="checkbox"/> with other children	
My child has become violent or acted out in the following manner towards other children or adults. (please check all that apply) <input type="checkbox"/> Hitting <input type="checkbox"/> Kicking <input type="checkbox"/> Biting <input type="checkbox"/> Fighting <input type="checkbox"/> Scratching <input type="checkbox"/> My child has never become violent or acted out toward others.	
If my child becomes upset, they calm themselves by: _____	
I have concerns about how my child gets along with other children. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	
My child's favorite color is: _____	My child's favorite book is: _____
My child's favorite food is: _____	My child's favorite toy is: _____
My child likes to: <input type="checkbox"/> Listen to stories <input type="checkbox"/> Play inside <input type="checkbox"/> Play outside <input type="checkbox"/> Draw/Color <input type="checkbox"/> Play quite games <input type="checkbox"/> Play pretend/make believe <input type="checkbox"/> Other _____	
I would like for my child to be able to:	
Please add any comments or concerns that you have about your child's health, development, behavior, family or home life that you would like the school to be aware of.	

<b>Authorization for School District Transportation:</b> Please initial on the appropriate line below.
<input type="checkbox"/> Yes, I grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate. Furthermore, I grant permission for my child to participate in walking field trips that are close to my child's school.
<input type="checkbox"/> No, I DO NOT grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate. Furthermore, I DO NOT grant permission for my child to participate in walking field trips that are close to my child's school.

<b>Authorization for Annual Class Roster:</b> Each year we prepare a roster for each group of children in our program. This roster will not be shared with any person other than the parents of children enrolled in our program. I authorize the following information to be listed on the Class Roster (please check):	
My Child's Name: <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Home Phone Number <input type="checkbox"/> Yes <input type="checkbox"/> No
Parent/Guardian Name: <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Cell Phone Number <input type="checkbox"/> Yes <input type="checkbox"/> No

**ENROLLMENT PACKET**

**Authorization for Picture Publication:** Please initial on the appropriate line below.

Yes, I grant permission for my child to have his/her picture taken for possible publication (newspaper, brochure, website, or other social media etc.) Furthermore, I grant permission for my child to be videotaped and understand that it may be used for professional development and/or advertising purposes.

No, I DO NOT grant permission for my child to have his/her picture taken for possible publication (newspaper, brochure, website, etc.) Furthermore, I DO NOT grant permission for my child to be videotaped and understand that it may be used for professional development and/or advertising purposes.

As the parent/guardian of \_\_\_\_\_, I authorize the information as listed above  
(*Authorization to Release Child, Authorization for School District Transportation, Authorization for Annual Class Roster, and Authorization for Picture Publication*).

→ \_\_\_\_\_  
Parent/Guardian Printed Name

→ \_\_\_\_\_  
Parent/Guardian Signature Date

**Authorization for Participation and Release of Information:**

My child has permission to participate in any health/developmental/academic screenings and assessments (which may include, but are not limited to physical, dental, vision, hearing, speech, mental health, lead, iron, height, weight, developmental, etc.) that are conducted through the Ohio Valley Educational Service Center, Bright Beginnings Preschool and other community agencies.

The Ohio Valley Educational Service Center has my permission to conduct assessments as required by the Ohio Department of Education (which may include, but are not limited to the Early Learning Assessment, Child Outcomes Summary Process, etc.) I understand that my child's teacher/specialist will provide feedback regarding the assessment to myself and other staff members working with my child. Additionally, I grant permission for the preschool administration to report the results of these assessments electronically, as required by law, to the Ohio Department of Education.

I understand that there may be some screenings/assessments that are not able to be conducted at my child's preschool setting and that I may need to obtain these screenings/assessments through my child's physician, dentist, local health department or other community agencies. I also understand that it may be necessary to obtain follow-up care for my child based on the results of the health/developmental assessments performed and that it will be my responsibility to do so.

As the parent/guardian of \_\_\_\_\_, by signing, I am verifying that I have read, understand and agree with the above information.

→ \_\_\_\_\_  
Parent/Guardian Printed Name

→ \_\_\_\_\_  
Parent/Guardian Signature Date



**OHIO DEPARTMENT OF JOB & FAMILY SERVICES  
OHIO DEPARTMENT OF EDUCATION  
EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL**

<b>Tell us about you (Parent or Guardian)</b>			
First Name	MI	Last Name	
Address			Today's Date
City	State	County	Zip Code
Phone Number	Additional Phone Number	Email Address	

<b>Tell us about the people in your home</b>							
Name (First, Middle, Last)	Relationship to You (Spouse, Son, daughter, friend, etc.)	Race	Hispanic or Latino Y or N	Spoken Language	Date of Birth	Gender M or F	U.S. Citizen Y or N
<b>Name:</b>		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/ American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Island					
<b>Date of Birth:</b>							
<b>Name:</b>		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/ American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Island					
<b>Date of Birth:</b>							
<b>Name:</b>		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/ American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Island					
<b>Date of Birth:</b>							
<b>Name:</b>		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/ American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Island					
<b>Date of Birth:</b>							
<b>Name:</b>		<input type="checkbox"/> African American <input type="checkbox"/> Alaska Native/ American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Island					
<b>Date of Birth:</b>							

↳ **Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Tell us about your needs for your child(ren) – If this information is not applicable, please sign and date bottom of form. Bright Beginnings does not provide before or after school day care.**

<b>Child 1</b>	<b>Provider Name and Address</b>	<b>Child's Needs</b>	<b>What hours do you need services (i.e. child care of preschool) Check all that apply</b>
Name		Do you have concerns about your child's growth and/or development? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat  <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
Child's Mother's Maiden Name			
Child's City of Birth			What is the child's home school district?
<b>Child 2</b>	<b>Provider Name and Address</b>	<b>Child's Needs</b>	<b>What hours do you need services (i.e. child care of preschool) Check all that apply</b>
Name		Do you have concerns about your child's growth and/or development? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat  <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
Child's Mother's Maiden Name			
Child's City of Birth			What is the child's home school district?
<b>Child 3</b>	<b>Provider Name and Address</b>	<b>Child's Needs</b>	<b>What hours do you need services (i.e. child care of preschool) Check all that apply</b>
Name		Do you have concerns about your child's growth and/or development? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe:	<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat  <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings <input type="checkbox"/> Weekends
Child's Mother's Maiden Name			
Child's City of Birth			What is the child's home school district?

→Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**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 all 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.

**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)
		\$			<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat
		\$			<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat
		\$			<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat
		\$			<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat
		\$			<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat

**Do you or anyone in your household pay Child or Spousal Support?** \_\_\_ Yes \_\_\_ No  
**How Much?**

→Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**2020 FEDERAL POVERTY GUIDELINES**  
 OHIO VALLEY EDUCATIONAL SERVICE CENTER  
 1338 Colegate Drive, Marietta, OH 45750 / 740-373-6669

**OFFICE USE ONLY**

Size of Family Unit	100% Poverty Level	115% Poverty Level	125% Poverty Level	187.5% Poverty Level	200% Poverty Level
1	\$12,490	\$14,364	\$15,613	\$23,419	\$24,980
2	\$16,910	\$19,447	\$21,138	\$31,706	\$33,820
3	\$21,330	\$24,530	\$26,663	\$39,994	\$42,660
4	\$25,750	\$29,613	\$32,118	\$48,281	\$51,500
5	\$30,170	\$34,696	\$37,713	\$56,569	\$60,340
6	\$34,590	\$39,779	\$43,238	\$64,856	\$69,180
7	\$39,010	\$44,862	\$48,763	\$73,144	\$78,020
8	\$43,430	\$49,945	\$54,288	\$81,431	\$86,860
Family units with more than 8 members	Add \$4,420 for each additional member	Add \$5,083 for each additional member	Add \$5,525 for each additional member	Add \$8,288 for each additional member	Add \$8,840 for each additional member

Name of Student (Please Print) \_\_\_\_\_ DOB: \_\_\_\_\_

Parents: Due to state reporting requirements, we are required to gather income information for your family. This information in no way will be used to determine if your child qualifies for services and/or what services your child will receive. Simply find the number of family members that are in your household, and determine the dollar amount that is closest to your family's gross income. Please circle the dollar amount in that particular row that most closely reflects the gross income for your family.

**Request for Tuition Assistance: Please Provide ONE proof of income.**

- \* 3 most recent pay stubs **OR**
- \* A statement from Ohio Department of Job & Family Services caseworker stating your poverty level **OR**
- \* A copy of your most recent tax return

→ \_\_\_\_\_ Parent/Guardian Signature

If you would like, you may refuse to provide this information. Simply sign at the bottom of this page that you would not like to release this information. If you have any questions, please contact the OVESC office at 740-373-6669. I \_\_\_\_\_ (printed name of parent), am choosing NOT to provide my family's gross income to the OVESC Preschool. I understand that if I were to provide this information, it would not in any way determine the type or amount of services that my child would receive.

**Waiver of Tuition Assistance:**

I hereby waive my right to be considered for free and reduced tuition. I agree to pay full tuition if accepted in the preschool program. I understand this waiver neither hampers nor enhances the chances of my application being accepted. I understand that if my financial situation changes, I may request a review of my income determination and verification and if my income is eligible, qualify for tuition assistance.

→ \_\_\_\_\_ Parent/Guardian Signature



**McKinney-Vento**

**Student Residency Questionnaire**

The answers to this residency questionnaire help in determining eligibility of services for families in transition that may be received through the federal McKinney-Vento Assistance Act U.S.C. 11435.

Child's Name: \_\_\_\_\_

Do you rent or own your home? (Lease or Mortgage is in your name)  Yes  No

Do you live with another person or persons by choice in housing that is fixed (does not move), regular (always), and adequate (safe, working utilities etc.)  Yes  No

*If you answered No to either of the ABOVE, please complete the remainder of the form.*

*If you answered YES to both questions you may stop here and return this form to the registrar.*

If your answer was **NO** to either question above **PLEASE COMPLETE** the remainder of this form:

1. Please check the mark the appropriate answer that indicates your current living arrangement:

(A) Sheltered:

In an emergency/transitional shelter due to loss of housing, economic hardship, or similar reason

(B) Unsheltered:

In a vehicle of any kind, campground, park, abandoned building or public place not meant for sleeping

Substandard housing (no electricity, running water, health code violation, lack of bathroom or cooking capabilities, etc.)

(C) Doubled Up:

Temporarily with another family due to loss of housing, economic hardship, or similar reason

(I) Doubled Up:

In a hotel/motel due to loss of housing, economic hardship or similar reason

(Y)  Unaccompanied youth not with an adult/legal guardian (couch surfing)

Other (please explain: \_\_\_\_\_)

2. Current nighttime residence: \_\_\_\_\_

3. How long have you lived in this arrangement? \_\_\_\_\_

List ALL adult caregivers responsible for the above child(ren)	Relationship to Child(ren)	Main Phone Number	Other Contact Number

List ALL children in the family (Including children birth to 18). If more than 4 children in the home, please use reverse side of form.	Sex	Age	Grade	School where student is currently enrolled or is enrolling into:	Last school where student was enrolled:
	<input type="checkbox"/> M <input type="checkbox"/> F				
	<input type="checkbox"/> M <input type="checkbox"/> F				

*I have answered all questions to the best of my ability and certify the information presented is true and accurate.*

→ \_\_\_\_\_  
Parent/Guardian Signature Date

**The medical and dental forms that need completed by your CHILD'S PHYSICIAN are attached.**

**These forms need to be completed and returned within 30 days of your child beginning preschool.**

**Please detach these two forms and return to the address below WHEN COMPLETE:**

**Ohio Valley Educational Service Center  
1338 Colegate Drive  
Marietta, Ohio 45750**

**Fax: 1-740-376-5809**

**Thank you!**



**Ohio Valley ESC**  
Bright Beginnings Preschool

1338 Colegate Drive, Marietta, Ohio 45750  
PH: 740-373-6669, FAX: 740-376-5809

**Child Medical Statement**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Child's School \_\_\_\_\_  
I authorize my physician \_\_\_\_\_ to release the completed medical statement to Bright Beginnings Preschool. Please fax to: 740-376-5809.

→ \_\_\_\_\_  
Parent/Guardian Signature Date

Required for ALL children enrolled in Preschool Special Education and Early Childhood Education Grant Programs.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Allergies: \_\_\_\_\_ History: \_\_\_\_\_

	Normal	Abnormal		Normal	Abnormal
General Appearance			Glands (Lymphatic/Thyroid)		
Posture, Gait			Nose, Mouth Pharynx		
Speech			Teeth, Gums		
Head			Heart		
Skin			Lungs		
Eyes			Abdomen		
*symmetrical light reflex			Genitalia		
*external aspects			Bones, Joints, Muscles		
Development			Extremities		
Ears			Muscular Coordination		
Social/Emotional			Neurological (gross, fine, sensory motor)		

Assessments/Screening	Completed		Date	Assessments/Screening	Completed		Date
	(please circle one)				(please circle one)		
Lead	Yes	No		Vision screen	Yes	No	
Hemoglobin/Hematocrit	Yes	No		Hearing screen	Yes	No	

Medications: \_\_\_\_\_

Limitations or health conditions (including food supplements/ modified diets, activity restrictions, health services needed at school): \_\_\_\_\_

**IMMUNIZATION RECORD** (Required by Section 3313.671 of Revised Code and for attendance in preschool program) **Please attach a copy**

\*Exempt from immunizations: \_\_\_\_\_ Religious conviction \_\_\_\_\_ Health concern \_\_\_\_\_ Other \_\_\_\_\_

I have examined this child and found that he/she is in suitable condition for participation in group care.

\* \_\_\_\_\_

Signature Physician/Physician's Assistant/Advanced Practice Nurse

Printed Name

Date of example



# Ohio Valley ESC Bright Beginnings Preschool

1338 Colegate Drive, Marietta, Ohio 45750  
PH: 740-373-6669, FAX: 740-376-5809

## Dental Exam

**Parent/Guardian:** To ensure good dental health, every child needs to have a dental exam. This checkup may be done by your own dentist. If you/your child do not have a primary dentist, please call 740-373-6669 for the names/phone numbers of local dentists taking new patients.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Child's School \_\_\_\_\_

I authorize my dental clinic to release this completed form to Bright Beginnings Preschool. Please fax to 740-376-5809.

→ \_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### To be completed by the dentist:

This child received the following treatment in my office:

- |   |  |
|---|--|
| <input type="checkbox"/> Dental Exam                  | <input type="checkbox"/> Fillings                      |
| <input type="checkbox"/> X-Rays Taken                 | <input type="checkbox"/> Emergency Treatment           |
| <input type="checkbox"/> X-Rays Read                  | <input type="checkbox"/> Extractions                   |
| <input type="checkbox"/> Cleaning                     | <input type="checkbox"/> Steel Crowns                  |
| <input type="checkbox"/> Topical Fluoride Application | <input type="checkbox"/> Space Maintainers             |
| <input type="checkbox"/> Sealants                     | <input type="checkbox"/> Other – Please explain: _____ |

ALL TREATMENTS ARE COMPLETE.

ALL TREATMENTS ARE NOT COMPLETE. THE FOLLOWING IS STILL NEEDED:

- |   |  |
|---|--|
| <input type="checkbox"/> Take X-rays                  | <input type="checkbox"/> Extractions                   |
| <input type="checkbox"/> Read X-rays                  | <input type="checkbox"/> Steel Crowns                  |
| <input type="checkbox"/> Topical Fluoride Application | <input type="checkbox"/> Space Maintainers             |
| <input type="checkbox"/> Sealants                     | <input type="checkbox"/> Other – Please explain: _____ |
| <input type="checkbox"/> Fillings                     |  |

\_\_\_\_\_  
Dentist's Printed Name                      Dentist's Signature                      Telephone #                      Date of Exam



Circle One  
Bus No. AM/PM  
Bus No. AM/PM  
Other

### EMERGENCY MEDICAL AUTHORIZATION FORM

ORC 3313712

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.

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

Home Address \_\_\_\_\_ PO Box # \_\_\_\_\_

City, State/Zip \_\_\_\_\_ Teacher \_\_\_\_\_

Student resides with (circle all that apply) mother father step-parent guardian other \_\_\_\_\_  
If custody is involved with whom is the student living? \_\_\_\_\_

List the names (first and last names) of those who have authority to make decisions in an emergency situation involving the student.  
Indicate on the line to the left of the name the order in which you would like contacts to be made (1<sup>st</sup>, 2<sup>nd</sup>, etc)

Mother: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment \_\_\_\_\_

Father: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment \_\_\_\_\_

Step-parent: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment \_\_\_\_\_

Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment \_\_\_\_\_

Other Contact: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment \_\_\_\_\_

Siblings: Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Permission for picture publication (Newspaper, school articles, etc.): Yes \_\_\_\_\_ No \_\_\_\_\_

COMPLETE ONLY ONE OF THE FOLLOWING: 1. Consent for Treatment **or** 2. Refusal to Consent

#### I. CONSENT FOR TREATMENT:

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

Preferred Physician: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Preferred Dentist: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Medical Specialist: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

#### 2. 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:

\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

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 the preferred doctor indicated, 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 dentists concurring in the necessity for such surgery are obtained prior to the performance of surgery.

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medication being taken, and any physical impairment of which a physician and/or school personnel should be alerted:

\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(consent for treatment)

School staff may be notified of above medical conditions unless otherwise notified.

# TRANSPORTATION INFORMATION

## NOBLE LOCAL SCHOOLS

DATE: \_\_\_\_\_

SCHOOL YEAR: 20 - 20

Please help us to establish our fall bus routes by giving the following information:

a) Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Building of Attendance \_\_\_\_\_ S. E. S. \_\_\_\_\_ S. H. S.

b) Parent's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

c) If you have children who presently ride a Noble Local Bus, please list below:

\_\_\_\_\_

d) If you know the name of the driver of route that passes your home, please list:

Driver's Name \_\_\_\_\_ Bus Number \_\_\_\_\_

e) Give a brief description of the location of your home (for example: name of township, name or number of county, township or state road, name of nearest neighbor with children attending school, former owners or residents of the property you now own or rent): any other identifying remarks.

\_\_\_\_\_  
\_\_\_\_\_