



Northwest Local School District

# Houston Early Learning Center PRESCHOOL REGISTRATION PACKET

2022-2023





## Northwest Local School District Preschool Program 2022-2023

The Northwest Local School District is pleased to offer preschool classes at the Houston Early Learning Center.

Preschool students attend five (5) days per week either in the morning or afternoon at the Houston Early Learning Center. Children must reside within the Northwest Local District and must be three or four years of age on or before September 30, 2022 to be eligible to attend this program. *A child must be toilet trained by August 1, 2022 for final acceptance into the Early Childhood Program.*

The Northwest Local School District serves preschool students with disabilities in blended preschool classrooms. This means students with disabilities and typical students are in one classroom. If you feel your child may require services for a disability, please contact the Special Education Services Department at 513-522-6700 extension 4917 for additional information.

The tuition requirement for the Northwest Local District Early Childhood Preschool Program is based on income and is supported by the Northwest Local School District. Support is received through state and federal funds. These funds are based on criteria which must be adhered to including stringent income eligibility components in order for the funds to be retained. One such requirement is the Early Childhood Education Eligibility Screening Tool which you will find in this packet.

Tuition for the 2022-2023 school year will remain at \$200 per month. Reduced tuition rates are available for those who qualify.

Class size in preschool classrooms is limited in order to comply with state regulations. Completed registration packets must be submitted to the Houston Early Learning Center at 3308 Compton Rd. Cincinnati, OH 45251. Packets will be accepted until class capacity is met. After that a waiting list is established on a first come, first served basis.

In June, parents will be notified via email of the assigned screening date and time for their child. Teacher assignment and parent-teacher-child conference times and dates will be mailed after the screenings take place. Mandatory screenings will take place in July.



**NORTHWEST LOCAL SCHOOL DISTRICT  
EARLY CHILDHOOD PRESCHOOL PROGRAM**

**Document Verification List**

Houston Early Learning Center Office  
3308 Compton Rd, Cinti, Ohio 45251  
Phone (513) 385-8000 ext.: 4901  
Fax (513) 385-8090

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(As it appears on Birth Certificate)

**Documents & Forms Required for PRESCHOOL Enrollment**

**Please Complete and Sign the Following FORMS:**

- \_\_\_\_\_ Student Enrollment Form
- \_\_\_\_\_ Physical Examination Form *(completed and signed by physician)* **Due By 6/1/22**
- \_\_\_\_\_ Immunization Record *(completed and signed by physician)* **Due By 6/1/22**
- \_\_\_\_\_ Dental Form *(completed and signed by dentist)* **Due By 6/1/22**
- \_\_\_\_\_ Student Health Form **Due at Registration**
- \_\_\_\_\_ Emergency Medical Authorization Form **Due at Registration**
- \_\_\_\_\_ Student Dismissal Information **Due at Registration**
- \_\_\_\_\_ Early Childhood Education Eligibility Screen Tool **Due at Registration**
- \_\_\_\_\_ Parent Financial Agreement **Due at Registration**

**The following documents MUST be provided:**

- \_\_\_\_\_ Child's Birth Certificate or Passport **Due at Registration**
- \_\_\_\_\_ Court-Stamped Custody Papers *(if applicable)* **Due at Registration**
- \_\_\_\_\_ Parent/Guardian's Driver's License or State ID **Due at Registration**
- \_\_\_\_\_ Proof of Residency (2 required) **Due at Registration**
- \_\_\_\_\_ Current Mortgage, Tax Bill, Commercial Lease OR Residency Affidavit  
with Owner's Proof and Business Mail addressed to the Name of the Parent/Guardian
- \_\_\_\_\_ 2 current pay stubs or Employer Letter for Wage Verification **Due at Registration**
- \_\_\_\_\_ 2021 1040 or 1040 EZ tax form for Dependent Verification\*  
**Due No Later Than 4/25/22**

***Registration forms must be completed and documents must be provided at the time of registration.\****

***\*2021 Tax forms are due no later than April 25, 2022***

***\*Physical and Dental forms are due no later than June 1, 2022***

***Failure to turn in the required paperwork will result in removal from the preschool class list.***

Northwest Local School District

Please Circle Session Choice:

AM

PM

7:55 am-10:45am

12:10pm-3:00pm

Early Childhood Student Enrollment Form (due at registration)

Student Name \_\_\_\_\_
First Middle Last

Grade \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Circle One: White Black Hispanic\*\* Asian Multiracial\* American Indian/Alaskan Native Native Hawaiian/Other Pacific Islander

\*\*If Hispanic, Select Racial Group: Cuban Mexican Puerto Rican South or Central American Other Spanish Culture

\*If Multi-Racial, Select Racial Groups: White Black/African American Asian American Indian/Alaskan Native Native Hawaiian/Other Pacific Islander

Circle One: Male Female Last School Attended \_\_\_\_\_ Age \_\_\_\_\_

Last District Attended \_\_\_\_\_

If born outside of US, give date of entry \_\_\_\_\_

Parent Information:

Status of Parents (circle one): Married Divorced Widowed Separated Single/Never Married

Are you the natural/adoptive parent(s) of the child (circle one): Yes No If no, your relationship: \_\_\_\_\_

Father/Guardian:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell/Pager: \_\_\_\_\_

Email: \_\_\_\_\_

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

Business Phone: \_\_\_\_\_

Step-Mother (if applicable): \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mother/Guardian:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell/Pager: \_\_\_\_\_

Email: \_\_\_\_\_

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

Business Phone: \_\_\_\_\_

Step-Father (if applicable): \_\_\_\_\_

Work Phone: \_\_\_\_\_

Home Language Survey:

- 1. What language did your son/daughter speak when he/she first learned to talk? (Native Language)
2. What language does your son/daughter use most frequently at home? (Home Language)
3. What language do you use most frequently with your son/daughter?
4. What language do the adults at home most often speak?
5. How long has your son/daughter attended school in the United States?

Special Services: Has your child received any of the following services? (Please check all that apply)

- Multifactor/Psychological Evaluation Individual Education Plan (IEP) ESOL Services

Annual Class Roster: Each year we prepare a roster for each classroom in our program. This roster will not be furnished to any person (s) other than parents of children enrolled in our program. I authorize the following information to be listed on the parent roster:

My Child's Name, Parent/Guardian name, Address and Phone Number: Yes No Signature of Parent/Guardian Date:

Other Siblings In The District:

Name: Grade: Name: Grade: Name: Grade:

Name: Grade: Name: Grade: Name: Grade:

I, the undersigned, do hereby state and declare under penalty of falsification (\*), that I am the parent or legal guardian of the above named student and that this registration information is true and correct. Consent is hereby granted to Law Enforcement Officers to look at my child's records and make copies, thereof, if the matter of a missing child develops.

Parent/Guardian Signature

Date

(\* Falsification under Ohio Revised Code Section 2921.13 is a misdemeanor of the first degree punishable by a maximum of six (6) months imprisonment or a fine of \$1,000 or both.

## Immunizations for Child Care, Head Start and Pre-School Attendance:

Please follow the following link to the ACIP Easy-to-read Immunization Schedule for Infants and Children<sup>1,2</sup>

<http://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf>

### Ohio Revised Code 5104.014, Division B:

Each child's<sup>3</sup> caretaker parent shall provide to the center, home, or in-home aide a medical statement, as described in division (D) of this section, indicating that the child has been immunized against or is in the process<sup>4</sup> of being immunized against all of the following diseases:

- |                                   |                           |                    |
|-----------------------------------|---------------------------|--------------------|
| 1. Chicken pox;                   | 6. Influenza;             | 11. Poliomyelitis; |
| 2. Diphtheria;                    | 7. Measles;               | 12. Rotavirus;     |
| 3. Haemophilus influenzae type b; | 8. Mumps;                 | 13. Rubella;       |
| 4. Hepatitis A;                   | 9. Pertussis;             | 14. Tetanus.       |
| 5. Hepatitis B;                   | 10. Pneumococcal disease; |                    |

### Ohio Revised Code 5104.014, Division C:

A child is not required to be immunized against a disease specified in Division (B) of this section if any of the following is the case:

1. Immunization against the disease is medically contraindicated for the child;
2. The child's parent or guardian has declined to have the child immunized against the disease for reasons of conscience, including religious convictions;
3. Immunization against the disease is not medically appropriate for the child's age.

*In the case of influenza, a child is not required to be immunized against the disease if the seasonal vaccine is not available.*

### Ohio Revised Code 5104.014, Division D:

The medical statement shall include all of the following information:

1. The dates that a child received immunizations against each of the diseases specified in division (B) of this section;
2. Whether a child is subject to any of the exceptions specified in division (C) of this section.
3. The medical statement shall include a component where a parent or guardian may indicate that the parent or guardian has declined to have the child immunized.

Follow the link below to the Ohio Department of Jobs and Family Services' Child Medical Statement:

<http://www.odifs.state.oh.us/forms/findform.asp?formnum=01305>

<sup>1</sup> Vaccine doses are only considered valid if administered according to the most recent version of the *Recommended Immunization Schedules for Persons Aged 0 Through 18 Years* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices.

<sup>2</sup> Vaccine doses administered  $\leq 4$  days before the minimum interval or age are valid (grace period). Doses administered  $\geq 5$  days earlier than the minimum interval or age are not valid doses and should be repeated as age-appropriate. If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.

<sup>3</sup> "Child" includes both of the following: 1) An infant, toddler, or preschool age child; and 2) A school-age child who is not enrolled in a public or nonpublic school but is enrolled in a child day-care center, type A family day-care home, or licensed type B family day-care home or receives child care from a certified in-home aide.

<sup>4</sup> "In the process of being immunized" means having received at least the first dose of an immunization sequence and complying with the immunization intervals or catch-up schedule prescribed by the director of health (in accordance with the ACIP catch-up schedule).



Early Childhood Preschool
PHYSICAL EXAMINATION FORM

\*Due by 6/1/22

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_

School \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

General Exam:

Table with 6 columns: Evaluation, Normal, Abnormal, Evaluation, Normal, Abnormal. Rows include Skin, Posture/Gait, Speech/Communication, Head, Eyes, Ears, Nose, Mouth/Teeth etc., Heart & Circulatory, Chest & Lungs, Weight, Abdomen & Groin, Genitalia & Urinary, Bones/Joints, Neurological, Gross & Fine Motor, Muscles, Cognitive, Self Help, Social Skills, Glands Thyroid/Lymph, Other.

Vision Screening Results: RIGHT 20/ \_\_\_\_\_ LEFT 20/ \_\_\_\_\_

Hearing Screening Results: P / F

Lead \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Hct/Hgb \_\_\_\_\_

Allergies: \_\_\_\_\_

Chronic Condition(s): \_\_\_\_\_ Immunizations on Schedule? YES NO (A copy of immunizations must be attached)

Table with 3 columns: ABNORMAL FINDINGS/DIAGNOSIS, PLAN OF ACTION (If needed, attach physician order for school use), RECOMMENDED FOLLOW-UP AND TIME FRAME

DATE OF EXAM: \_\_\_\_\_ \*Physical Exam Forms are Valid for 1 year from Exam Date

This child has been examined and is in suitable condition for participation in group care. The child has had the age appropriate immunizations required by Section 3313.671 of the Ohio Revised Code for admission to school or is to be exempted from immunizations for the following reason(s):

\_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician Name \_\_\_\_\_

(Please Print)

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_



**EARLY CHILDHOOD PRESCHOOL  
DENTAL FORM**

**\*Due by 6/1/22**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

School \_\_\_\_\_ Age \_\_\_\_\_

**REPORT OF DENTAL EXAMINATION**

This is to certify that I have examined the teeth of the above-named student and I find:

- Oral hygiene is:            Good            Fair            Poor
- Number of teeth filled \_\_\_\_\_
- Number of teeth extracted \_\_\_\_\_
- All necessary dental work has been completed \_\_\_\_\_ Yes \_\_\_\_\_ No
- Treatment is in progress \_\_\_\_\_ Yes \_\_\_\_\_ No
- No dental work is necessary \_\_\_\_\_ Yes \_\_\_\_\_ No
- Is child under regular dental supervision? \_\_\_\_\_ Yes \_\_\_\_\_ No

**REMARKS**

Please elaborate on any of the above or make any recommendations that would assist the school in helping this child.

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

**DATE OF EXAM**

*\*Dental Forms are Valid for 1 year from Date of Exam*

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

Office Address \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

**PLEASE RETURN THIS COPY TO SCHOOL**

**Northwest Local School District  
Student Health History  
2022-2023**

**(To be completed by parent/guardian)  
(Due at registration)**

STUDENT'S LAST NAME	FIRST	MIDDLE	DATE OF BIRTH
Parent/Guardian Contact Information			
	Home Phone #	Work Phone #	Cell Phone #

**FAMILY HEALTH HISTORY** - Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father: \_\_\_\_\_  
 Mother: \_\_\_\_\_  
 Brothers and Sisters: \_\_\_\_\_

**I. HEALTH CONDITIONS** - please check any that apply to your child

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Abdominal Spinal Curvature (scoliosis etc.) | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Meningitis or Encephalitis  |
| <input type="checkbox"/> ADHD/ADD                                    | <input type="checkbox"/> Diarrhea/Constipation (chronic) | <input type="checkbox"/> Neuromuscular Disorder      |
| <input type="checkbox"/> Allergies - Food***                         | <input type="checkbox"/> Eating Problems                 | <input type="checkbox"/> Seizures/Epilepsy           |
| <input type="checkbox"/> Allergies - Medication                      | <input type="checkbox"/> Ear Problems/Hearing Difficulty | <input type="checkbox"/> Sickle Cell Anemia          |
| <input type="checkbox"/> Allergies - Other _____                     | <input type="checkbox"/> Eczema                          | <input type="checkbox"/> Skin Rashes (frequent)      |
| <input type="checkbox"/> Anemia                                      | <input type="checkbox"/> Emotional Problems              | <input type="checkbox"/> Stool Soiling               |
| <input type="checkbox"/> Asthma                                      | <input type="checkbox"/> Hearing Aids                    | <input type="checkbox"/> Speech Problems             |
| <input type="checkbox"/> Behavior Problems                           | <input type="checkbox"/> Headaches (frequent)            | <input type="checkbox"/> Throat Infection (frequent) |
| <input type="checkbox"/> Birth or Congenital Malformation            | <input type="checkbox"/> Hearing Aids                    | <input type="checkbox"/> Tics/Nervous Twitches       |
| <input type="checkbox"/> Bone/Muscle/Joint Problems                  | <input type="checkbox"/> Heart Problems                  | <input type="checkbox"/> Traumatic Brain Injury      |
| <input type="checkbox"/> Bowel/Bladder Problems                      | <input type="checkbox"/> Hemophilia                      | <input type="checkbox"/> Vision Problems             |
| <input type="checkbox"/> Cancer - Type _____                         | <input type="checkbox"/> Juvenile Arthritis              | <input type="checkbox"/> Urinary Tract Infections    |
| <input type="checkbox"/> Chicken Pox                                 | <input type="checkbox"/> Lead Poisoning                  | <input type="checkbox"/> Wetting (day/night)         |

**II. VISION AND HEARING**

Frequent ear infections? \_\_\_\_\_ Left \_\_\_\_\_ Right \_\_\_\_\_ Both \_\_\_\_\_ How Often? \_\_\_\_\_  
 Hearing problems? \_\_\_\_\_ When? \_\_\_\_\_ Ear Tubes? \_\_\_\_\_  
 Wears glasses? \_\_\_\_\_ Reason \_\_\_\_\_ Date of Last Eye Exam \_\_\_\_\_

**III. INJURIES AND ILLNESS** - Please list any severe injuries or illnesses:

Injuries/Illness	Child's Age	Hospitalization
_____	_____	_____
_____	_____	_____

Comments: \_\_\_\_\_

What medications are given daily or frequently? \_\_\_\_\_

This child is usually: \_\_\_\_\_ Very Active \_\_\_\_\_ Normally Active \_\_\_\_\_ Inactive

Do you have any concern about how your child gets along with others? \_\_\_\_\_

Do you have other comments/concerns about this child's health, development, behavior, family or home life that you would like to share with the school?

Please explain/comments \_\_\_\_\_

**V. PAST OR PRESENT SERVICES RECEIVED**

- |   |  |
|---|--|
| <input type="checkbox"/> Previous Psychological Evaluation _____ Year | <input type="checkbox"/> Counseling or Mental Health Services _____ Year |
| <input type="checkbox"/> Special Education Support _____ Year         | <input type="checkbox"/> Speech Therapy _____ Year                       |

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_

DATE OF LAST DENTAL EXAM: \_\_\_\_\_

FORM COMPLETE BY: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_

I hereby authorize the school nurse and/or school health service specialist to share necessary health information about my child with the appropriate school staff.  
 This information will be shared in a confidential manner. This authorization is valid for the current calendar school year only.  
 I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

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

I do not give permission to share information

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



2022-2023

(Due At Registration)

**EMERGENCY MEDICAL AUTHORIZATION AND AUTHORIZATION TO PICK UP FROM SCHOOL**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority and/or are permitted to pick up the child if he/she becomes ill or injured, when parents or guardians cannot be reached.

**PART I OR II MUST BE COMPLETED**

**PART I - TO GRANT CONSENT:**

Parent/Guardian (Custodial Guardian)

Mother's Name \_\_\_\_\_

Telephone # during School Hrs \_\_\_\_\_

e-mail \_\_\_\_\_

cell phone # \_\_\_\_\_

Father's Name \_\_\_\_\_

Telephone # during School Hrs \_\_\_\_\_

e-mail \_\_\_\_\_

cell phone # \_\_\_\_\_

Do mother & father live in the same house? **Y** **N** If not, who has legal custody? **Mother** **Father** **Shared**

**Name of Two Relatives or Friends (Required)**

(1) Who may be notified \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship to Student \_\_\_\_\_

(2) Who may be notified \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Doctor to be called \_\_\_\_\_ Phone \_\_\_\_\_

Dentist to be called \_\_\_\_\_ 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-name doctor, 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. Preferred local hospital \_\_\_\_\_

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

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

Date \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_

Address \_\_\_\_\_

**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: \_\_\_\_\_

Date \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_

Address \_\_\_\_\_

2022-2023

EARLY CHILDHOOD  
STUDENT DISMISSAL INFORMATION (Due At Registration)  
(Please complete this form in blue or black ink.)

Session: \_\_\_\_\_

Teacher: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_ (Unlisted?)

E-mail address: \_\_\_\_\_

Do mother and father live in the same house? Yes No

If not, who has legal custody? (Court documentation must be provided.)

Mother Father

Shared (If custody is shared, please provide address of both parents.) Other: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Hours from \_\_\_\_\_ to \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell #/Pager #: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Hours from \_\_\_\_\_ to \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell #/Pager #: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Step-Parent's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Hours from \_\_\_\_\_ to \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell #/Pager #: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Guardian's Name: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Hours from \_\_\_\_\_ to \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell #/Pager #: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Babysitter's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #/Pager #: \_\_\_\_\_

Please list all other children in your household who attend Northwest Local Schools: \_\_\_\_\_

MANDATORY EMERGENCY CONTACTS: Please list at least two people who are permitted to pick up your child if he/she were ill and you could not be reached. Please list in the order you prefer called, making sure we have the **DAYTIME PHONE NUMBER**; we must be able to reach someone during the day!

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_

IS THERE ANYONE WHO IS NOT TO PICK UP YOUR CHILD?

\_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: **X** \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Date: \_\_\_\_\_

Ohio Department of Job and Family Services  
Ohio Department of Education  
**EARLY CHILDHOOD EDUCATION ELIGIBILITY SCREENING TOOL**

Tell us about you (the applicant)			
First Name	MI	Last Name	
Address			Today's Date
City	State	County	Zip Code
Phone Number (    )	Additional Phone Number (    )	E-mail Address	

Tell us about the people in your home							
Name <i>(First, Middle, Last)</i>	Relationship to You <i>(spouse, son, friend, etc.)</i>	Race	Hispanic or Latino <i>Y or N</i>	Spoken Language	Date of Birth	Gender <i>M or F</i>	U.S. Citizen <i>Y or N</i>
	Self	<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 Islander					
		<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 Islander					
		<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 Islander					
		<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 Islander					
		<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 Islander					

**Tell us about your needs for your child(ren)**

<b>Tell us about your needs for your child(ren)</b>			
<b>Child 1</b>	<b>Provider Name and Address</b>	<b>Child's Needs</b>	<b>What hours/days do you need services? (i.e. child care or preschool) Check all that apply</b>
<b>Name</b>		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"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat  <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings  <input type="checkbox"/> Weekends
<b>Child's Mother's Maiden Name</b>			<b>What is the child's home school district?</b>
<b>Child's City of Birth</b>			
<b>Child 2</b>	<b>Provider Name and Address</b>	<b>Child's Needs</b>	<b>What hours/days do you need services? (child care or preschool) Check all that apply</b>
<b>Name</b>		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"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat  <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings  <input type="checkbox"/> Weekends
<b>Child's Mother's Maiden Name</b>			<b>What is the child's home school district?</b>
<b>Child's City of Birth</b>			
<b>Child 3</b>	<b>Provider Name and Address</b>	<b>Child's Needs</b>	<b>What hours/days do you need services? (child care or preschool) Check all that apply</b>
<b>Name</b>		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"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat  <input type="checkbox"/> Mornings <input type="checkbox"/> Afternoons <input type="checkbox"/> Evenings  <input type="checkbox"/> Weekends
<b>Child's Mother's Maiden Name</b>			<b>What is the child's home school district?</b>
<b>Child's City of Birth</b>			

**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.

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"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____
					<input type="checkbox"/> Sun _____ <input type="checkbox"/> Thurs _____ <input type="checkbox"/> Mon _____ <input type="checkbox"/> Fri _____ <input type="checkbox"/> Tues _____ <input type="checkbox"/> Sat _____ <input type="checkbox"/> Wed _____

Do you or anyone in your household pay Child or Spousal Support?  Yes  No

How Much?

Signature of Applicant

Date



**Northwest Local School District  
Early Childhood Preschool Program**

Please complete this form and submit at the time of registration. Every effort will be made to honor parents' session preferences. However, the principal reserves the right to assign students to classes based on the needs of the school and district.

**Due at Registration  
\*\*\*PARENT FINANCIAL AGREEMENT\*\*\*  
2022-2023**

***\* A COMPLETED TUITION SUBSIDY FORM WILL DETERMINE ELIGIBILITY FOR TUITION ASSISTANCE\****

1. I agree to pay the tuition fee in advance with no deduction for absences, holidays, or vacations. The monthly tuition fee is due by the 25<sup>th</sup> of the prior month for that month of enrollment. For example, the bill for September is due August 25<sup>th</sup>. I understand that legal action will be taken to collect unpaid obligations.  
 I agree that if my child is enrolled in preschool and the fee is not paid by the final notice from the treasurer's office, my child will be withdrawn from the Houston Early Learning Center preschool. The Northwest Local School District does not have payment plans available for families who are unable to pay the tuition.
2. I also agree to pay the first month's tuition fee prior to the first day of my child's attendance.
3. I agree to pay a \$30.00 fee for a returned check and will submit a money order for future payments.
4. I agree to submit any program changes for my child in writing. I understand that changes will become effective the first day of the following month.
5. I understand that my child will not be able to enroll in any future tuition programs within the Northwest Local School District if there are past due balances on my account.

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

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Parent(s) Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Parent Signature \_\_\_\_\_