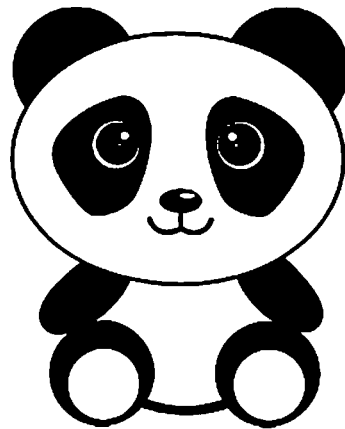




Northwest Local School District

Houston Early Learning Center PRESCHOOL REGISTRATION PACKET

2021-2022





Northwest Local School District Preschool Program 2021-2022

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, 2021 to be eligible to attend this program. *A child must be toilet trained by August 1, 2021 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 2021-2022 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 US Mail 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 6/1/21**
- _____ Immunization Record *(completed and signed by physician)* **Due By 6/1/21**
- _____ Dental Form *(completed and signed by dentist)* **Due By 6/1/21**
- _____ 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**
- _____ 2020 1040 or 1040 EZ tax form for Dependent Verification*
Due No Later Than 4/30/21

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

***2020 Tax forms are due no later than April 30, 2021**

***Physical and Dental forms are due no later than June 1, 2021**

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^{1,2}

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

Ohio Revised Code 5104.014, Division B:

Each child's³ 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 process⁴ 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.odjfs.state.oh.us/forms/findform.asp?formnum=01305>

¹ 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.

² Vaccine doses administered ≤ 4 days before the minimum interval or age are valid (grace period). Doses administered ≥ 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.

³ "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.

⁴ "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 6/1/21

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 6/1/21**

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
2021-2022**

**(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

Previous Psychological Evaluation _____ Year Counseling or Mental Health Services _____ Year

Special Education Support _____ Year 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 _____

2021-2022

(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 _____

2021-2022

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: _____



**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**

**** 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 25th of the prior month for that month of enrollment. For example, the bill for September is due August 25th. 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 _____

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)

Tell us about your needs for your child(ren)			
Child 1	Provider Name and Address	Child's Needs	What hours/days do you need services? (i.e. child care or preschool) Check all that apply
Name		Do you have concerns about your child's growth and/or development? <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
Child's Mother's Maiden Name			What is the child's home school district?
Child's City of Birth			
Child 2	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) Check all that apply
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"/> 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
Child's Mother's Maiden Name			What is the child's home school district?
Child's City of Birth			
Child 3	Provider Name and Address	Child's Needs	What hours/days do you need services? (child care or preschool) Check all that apply
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"/> 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
Child's Mother's Maiden Name			What is the child's home school district?
Child's City of Birth			

Tell us about your finances

Will you or the people in your home receive income this month? Yes No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

Name	Type of Income	Amount of Income <i>(before taxes)</i>	How Often Received <i>(weekly, bi-weekly, etc)</i>	Date Last Received	Work or School Schedule <i>(please list times)</i>
					<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**

**** 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 25th of the prior month for that month of enrollment. For example, the bill for September is due August 25th. 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 _____