

Ethnic/Race Information

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

Is the student Hispanic/Latino: _____ Yes _____ No

(a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

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

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

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

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

_____ **Native Hawaiian or Other Pacific Islander**

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

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

Is student’s primary/home language English? _____ Yes _____ No: _____ Language
If no, Home Language Survey is required.

Special Services (if applicable)

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

_____ Speech _____ Occupational Therapy _____ Physical Therapy

Other _____

Any Medical Concerns: _____

Parent/Guardian Signature and Relationship to Student

Date

OHIO SCHOOL HEALTH HISTORY

To be completed by parent or guardian

Child's full name _____
Last First Middle

Male _____ Female _____ Birth date _____
Month Day Year

Child's address _____

Father's name _____

Address (if different from child) _____

Work Phone _____ Home Phone _____

Mother's name _____

Mother's address (if different from child) _____

Work Phone _____ Home Phone _____

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

Please list this child's brothers and sisters:

FAMILY HISTORY

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

PRENATAL HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy?
yes ___ no ___ If yes, explain briefly _____

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

Was this infant born: full term ___ early ___ late ___ What was the birth weight? _____

Did the infant have any sickness or problems while in the nursery? yes ___ no ___
If yes, explain briefly _____

DEVELOPMENTAL HISTORY

Please give the approximate age at which this child:
walked alone _____ was toilet trained _____ spoke in sentences _____ dressed self _____

How does child's development compare to other children, such as his or her siblings or playmates?
about the same _____ slower _____ faster _____

IMMUNIZATION RECORD

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

REQUIRED COMPULSORY IMMUNIZATION LAW: 4 DTaP, 3 Polio, 3/4 Hib, 3 Hepatitis B, 1 MMR, 1 Varicella (Preschool)

<input type="checkbox"/> Abnormal spinal curvature <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma or wheezing <input type="checkbox"/> Attention Deficit Disorder or Hyperactivity <input type="checkbox"/> Bedwetting at night <input type="checkbox"/> Behavior Problems <input type="checkbox"/> Birth or congenital malformation <input type="checkbox"/> Cancer, type _____ <input type="checkbox"/> Chicken pox <input type="checkbox"/> Chronic diarrhea or constipation <input type="checkbox"/> Concern about relationship with siblings or friends <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Diabetes <input type="checkbox"/> Eczema <input type="checkbox"/> Emotional problems <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Frequent skin infections <input type="checkbox"/> Frequent sore throat infections <input type="checkbox"/> Heart disease, type _____ <input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney disease, type _____ <input type="checkbox"/> Measles <input type="checkbox"/> Meningitis or encephalitis <input type="checkbox"/> Multiple ear infections (3 or more) <input type="checkbox"/> Mumps <input type="checkbox"/> Near-drowning or near-suffocation <input type="checkbox"/> Nervous twitches or tics <input type="checkbox"/> Poisoning <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Seizures or epilepsy <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Stool soiling <input type="checkbox"/> Toothaches or dental infections <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Wetting during day <input type="checkbox"/> Vision problems <input type="checkbox"/> Wears glasses <input type="checkbox"/> Hearing problems <input type="checkbox"/> Wears hearing aid <input type="checkbox"/> Other _____
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ALLERGIES – Please list and describe allergies or reactions to:

Medicine / drugs _____

Foods / plants / animals / other _____

Recommended treatment if allergy is severe _____

ILLNESS AND INJURIES – Please list any severe illnesses or injuries

Illness / Injury	Age of child	Check if hospitalized

Does this child always wear seat belts in cars? Yes _____ No _____

ADDITIONAL INFORMATION:

What medications are given daily? _____

What medications are given frequently but not daily? _____

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

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

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

COMPLETED BY: _____ RELATIONSHIP TO CHILD _____

UNION LOCAL SCHOOLS
EMERGENCY MEDICAL RELEASE FORM

Child's Full Name _____ Birth Date _____ M F
Address _____ Telephone # _____
City _____ County _____ Last 4 digits SS# _____

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

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available by another licensed physician or dentist, and (2) the transfer of the child to any hospital reasonably accessible.

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

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

Date _____ Signature of Parent/Guardian _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II: REFUSAL TO CONSENT

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Parent/Guardian Signature _____ Date _____

PLEASE TURN OVER TO CONTINUE

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

1. Name _____
Address _____ Phone _____
Relationship to Child _____
2. Name _____
Address _____ Phone _____
Relationship to Child _____
3. Name _____
Address _____ Phone _____
Relationship to Child _____

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

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

- Name _____ Relationship to Child _____
- Name _____ Relationship to Child _____
- Name _____ Relationship to Child _____
- Name _____ Relationship to Child _____
- Name _____ Relationship to Child _____
- Name _____ Relationship to Child _____

TRANSPORTATION TO AND FROM SCHOOL

_____ I Grant permission for my child to be transported by my local public school to and from school

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

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

Parent/Guardian Signature _____ Date _____

Union Local Elementary School Emergency Dismissal

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

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

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

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

Student's Name _____ Grade _____

Teacher _____

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

Name _____

Address _____

Phone _____

Bus Number _____

Signature of Parent/Guardian

Telephone Number

Emergency Telephone Number

Little Jets Preschool
Publication/Release Information

Child's Name _____

Permission for picture publication:

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

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

Permission for release of roster information:

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

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

UNION LOCAL BOARD OF EDUCATION



Administrative Offices
66779 Belmont-Morristown Rd.
Belmont, Ohio 43718
740-782-1978



Little Jets Preschool

PHYSICIAN FORM

Name: _____ Birth Date: _____

Address: _____

Parent/Guardian: _____ Phone: _____

Disease History

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

Tuberculosis _____
Epilepsy _____
Polio _____
Rheumatic Fever _____
Scarlet Fever _____
Whooping Cough _____
Pneumonia _____
Hepatitis B _____
Other _____

Surgical History

Type	Date
_____	_____
_____	_____
Other Pertinent History Information	
_____	_____
_____	_____
_____	_____

Immunization: List dates (month, day, year)

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

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

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

Hepatitis B (1) _____ (2) _____ (3) _____

HIB (1) _____ (2) _____ (3) _____ (4) _____

Varicella (1) _____ (2) _____ Influenza _____

Hepatitis A (1) _____ (2) _____

Pneumococcal (1) _____ (2) _____ (3) _____ (4) _____

Physical Examination

Sex: Male _____ Female _____

Blood Pressure: _____

Height: _____ Weight _____

Pulse: _____

Milk Sensitivity: _____

Respiration: _____

Allergies: _____

Lead _____

Hematocrit _____

Teeth: _____

Head and Neck: _____

Chest: _____

Heart: _____

Eyes: Right _____ Left _____

Abdomen: _____

Ears: Right _____ Left _____

Extremities _____

Tubes: Yes _____ No _____

Lungs: _____

Hernia: _____

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

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

Other pertinent medical information _____

Other test results (laboratory or developmental screening) _____

Indicate any physical limitations _____

Diagnosis _____

Medications

Name	Hours Given	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Cognitive	Communication	Fine Motor	Gross Motor
Social/Emotional	Self Help	Hearing	Vision

Physician's Signature

Physician's Name Printed

Date

Phone

Address

City

State

Zip

UNION LOCAL SCHOOL DISTRICT

Little Jets Preschool

OHIO SCHOOL HEALTH RECORD

Dental Report

Child's Name _____ Birth Date _____

The following services have been performed:

- ___ examination
- ___ diagnosis _____
- ___ radiographs
- ___ oral prophylaxis
- ___ prescription for fluoride supplements
- ___ topical application of fluoride
- ___ other _____

The following oral hygiene instruction was provided:

- ___ tooth brushing
- ___ flossing
- ___ diet counseling reflecting relation of diet to dental health

The following statements are applicable:

- ___ all necessary services have been performed
- ___ no restorative services are required at this time
- ___ further treatment is indicated
- ___ further appointments have been arranged for _____

Comments: _____

Please print or stamp:

Dentist _____

Address _____

Phone _____ **Date** _____

Dentist Signature _____

**UNION LOCAL SCHOOL DISTRICT
PUBLIC PRE-SCHOOL APPLICATION
SCHOOL YEAR 2017-2018**

NAME OF CHILD _____ **TELEPHONE** _____

BIRTHDATE _____ **AGE BY (8/1/17)** _____

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER _____

FATHER'S NAME _____ **MOTHER'S NAME** _____

CHILD RESIDES WITH: _____

ADDRESS _____

All applicants are required to supply the following income information as part of the state funding continuation process for our preschool program. Please check below the category that accurately describes your family size and income situation.

FEDERAL POVERTY INCOME PROGRAM
2017-2018

TOTAL NUMBER OF PEOPLE LIVING IN THE HOUSEHOLD
(PLEASE CIRCLE CORRECT NUMBER/SIZE OF FAMILY & INCOME)

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

TOTAL COMBINED ANNUAL INCOME OF ALL HOUSEHOLD MEMBERS

Size of family	100% poverty level	125% poverty level	150% poverty level	175% poverty level	200% poverty level	201% poverty level or over
1	\$11,880	\$14,850	\$17,820	\$20,790	\$23,760	\$23,879
2	\$16,020	\$20,025	\$24,030	\$28,035	\$32,040	\$32,220
3	\$20,160	\$25,200	\$30,240	\$35,280	\$40,320	\$40,522
4	\$24,300	\$30,375	\$36,450	\$42,525	\$48,600	\$48,843
5	\$28,440	\$35,550	\$42,660	\$49,770	\$56,880	\$57,164
6	\$32,580	\$40,725	\$48,870	\$57,015	\$65,160	\$65,486
7	\$36,730	\$45,913	\$55,095	\$64,278	\$73,460	\$73,827
8	\$40,890	\$51,113	\$61,335	\$71,558	\$81,780	\$82,189

FOR FAMILY UNITS WITH MORE THAN 8 MEMBERS, ADD \$4,160.00 FOR EACH ADDITIONAL MEMBER

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

Check here if your income is more than \$82,189.00

Parent Signature: _____

To be completed by Preschool Office:

VERIFICATION OF ABOVE INCOME:

_____ W-2 FORM _____ OWF CASE NUMBER _____ TAX FORM

_____ CHECK STUB _____ FOOD STAMP NUMBER _____ MEDICAL CARD

_____ OTHER _____

VERIFIED BY _____ DATE _____

.....

_____ 100% _____ 125% _____ 150% _____ 175% _____ 200% _____ 201% _____ N/A _____

UNION LOCAL ELEMENTARY SCHOOL



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



Little Jets Preschool

Parent/Guardian:

Thank you for choosing to apply to the Little Jets Preschool. Please find attached a Pre-School Fee Application for the 2017-18 school year. Please complete the Fee Application and return with the registration packet. Enrolled public pre-school children who do not meet the federal income levels as prescribed in our pre-school project are subject to a Sliding Fee Schedule, payable at the Elementary School as follows:

- A. A \$125.00* payment for half day classes or \$200.00* for all day class are due prior to the first day of school, or on Orientation Day with payments of \$125.00* for half day classes and \$200 for all day class made monthly there after, or
- B. Total payment of \$1,125.00* for half day classes or \$1,800.00 for all day class made prior to the first day of school.

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

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

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

Sincerely,

Dana Kendziorski
Preschool Director