2024 - 2025

PREBLE ESC
PREBLE COUNTY EDUCATIONAL SERVICE CENTER

597 Hillcrest Drive, Eaton, OH 45320
Phone: 937-456-1187 Fax: 937-456-3253
www.preblecountyesc.org

The following forms and documentation MUST be completed and returned to assure enrollment in a Preble County Educational Service Center Preschool classroom.

STUDENT NAME: _____ **BIRTH DATE:** _____

Is this a returning student? __ YES __NO Is your child toilet trained? __ YES __NO

If transportation is available, would you be interested? __ YES __NO

If transportation is different from the parent, please complete:

Pick up/Drop off Contact Name: _____ Phone: _____
Address: _____

REQUIRED COMPLETED FORMS

- ☐ Preschool Registration Form
- ☐ Student Information Form
- ☐ Early Childhood Education Eligibility Screening Tool (4 pages)
- ☐ Emergency Contacts Authorizations & Consents
- ☐ Preschool Authorizations & Consents
- ☐ Preschool Tuition & Transportation Agreement

REQUIRED DOCUMENTATION

- ☐ Copy of Birth Certificate
- ☐ Immunization/Shot Record
- ☐ Child Medical Statement (due within **30 days** of school)
- ☐ Dental Form (due within **30 days** of school)
- ☐ Copy of Proof of Income (tuition students only)
- ☐ Copy of Proof of Residence (IEP students only)
- ☐ Copy of Custody documentation of student (if applicable)

PARENT PREFERENCE PLACEMENT (Please rate each session below by number in order of preference):

Eaton-East Preschool Program *506 Aukerman Street, Eaton*		ESC Preschool Program *597 Hillcrest Drive, Eaton*		ECE Grant Program *597 Hillcrest Drive, Eaton*
☐ AM Eaton-East 7:45-10:45 am		☐ AM ESC Office 8:10-11:10 am		☐ AM ESC Office 8:10-11:25 am
☐ PM Eaton-East 11:30-2:30 pm		☐ PM ESC Office 12:00-3:00 pm		☐ PM ESC Office 12:00-3:15 pm

We do not guarantee placement choice, but will take preference into consideration.
The class times above are tentative and subject to change.

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2024-2025 PRESCHOOL REGISTRATION FORM

STUDENT DATA

Last Name: _____

First Name: _____

Gender: (circle one) Female Male

Date of Birth: Month _____ Day _____ Year _____

Birth City: _____

Ethnicity: ___ Black/African American ___ White/Caucasian
___ Hispanic/Latino ___ Asian
___ American Indian or Alaskan Native
___ Native Hawaiian/Pacific Island

STUDENT ADDRESS

Street Address: _____

City: _____ Zip Code: _____

Mailing Address:(if different from above)

_____
Street *City* *Zip*

RESIDENCY -Student lives with (check one)

___ Mother Only ___Father Only
___Mother & Father ___Mother & Step Father
___Father & Step Mother ___Foster Parent
___Grandparent ___Court apt. Guardian

MOTHER

___ Mother ___ Step-Mother ___Guardian/Foster Parent

Last Name: _____ First Name: _____
Email Address: _____
Mailing Address: (if different from student)

_____
Street *City* *Zip*

Phone Number (Home): _____
Phone Number (Cell): _____
Phone Number (Work): _____
Employer: _____ Occupation: _____
Military Status: ___ Active Duty ___Active Reserve

FATHER

___ Father ___ Step-Father ___Guardian/Foster Parent

Last Name: _____ First Name: _____
Email Address: _____
Mailing Address: (if different from student)

_____
Street *City* *Zip*

Phone Number (Home): _____
Phone Number (Cell): _____
Phone Number (Work): _____
Employer: _____ Occupation: _____
Military Status: ___ Active Duty ___Active Reserve

PARENTAL CUSTODIAL HISTORY

___Never Married ___Married ___Separated ___Divorced

Parent Deceased: ___Mother ___Father

___ Removed from parent's custody by court order

COURT ORDERED PLACEMENT

___ Mother Only ___Father Only
___ Joint Custody ___Guardian
___ Foster Parent ___ Grandparent

DAYCARE/BABYSITTER INFORMATION

Name of Caregiver: _____
Relationship: _____
Street Address: _____
City: _____ Zip Code: _____
Phone Number (Home): _____
Phone Number (Cell): _____

SIBLINGS

BROTHERS & SISTERS

Name: _____ Date of Birth: _____
School: _____ Grade: _____

Name: _____ Date of Birth: _____
School: _____ Grade: _____

Name: _____ Date of Birth: _____
School: _____ Grade: _____

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EMERGENCY CONTACTS AUTHORIZATIONS & CONSENTS

The purpose of this form is to enable parents/guardian to authorize the provision of emergency medical treatment for a child who becomes ill or injured while under school authority when parents or guardians cannot be reached.

Student Name: _____ Date of Birth: _____

ADDITIONAL EMERGENCY CONTACT INFORMATION

Primary Parent(s)/Guardian(s) will **always** be contacted first in the event of an illness/emergency. Please list in order how **additional** contacts are to be made when we are unable to reach parent(s)/guardian(s).

ADDITIONAL CONTACT #1
Name: _____ Relationship: _____ Can Pick Up Student: Yes No
Primary Phone: _____ Additional Phone: _____

ADDITIONAL CONTACT #2
Name: _____ Relationship: _____ Can Pick Up Student: Yes No
Primary Phone: _____ Additional Phone: _____

ADDITIONAL CONTACT #3
Name: _____ Relationship: _____ Can Pick Up Student: Yes No
Primary Phone: _____ Additional Phone: _____

ADDITIONAL CONTACT #4
Name: _____ Relationship: _____ Can Pick Up Student: Yes No
Primary Phone: _____ Additional Phone: _____

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

Preferred Hospital/ER: _____ Phone: _____
Doctor: _____ Phone: _____
Dentist: _____ Phone: _____
Medical Specialist: _____ Phone: _____

EMERGENCY MEDICAL AUTHORIZATION – (*ONLY INITIAL ONE LINE PLEASE*)

_____ **INITIAL TO GRANT CONSENT** – I hereby give consent for the medical care providers and local hospital to be called. 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 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. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. This information may be shared with school personnel if it is pertinent to my child's health and safety, educational progress, and/or behavioral management plan.

_____ **INITIAL TO REFUSE CONSENT** – I do not give my consent for emergency medical treatment for my child named above. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____
_____.

Signature of Parent/Guardian: _____ **Date:** _____

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Preschool Student Information Form

Student's Name: _____
First Middle Last

Nickname: _____ Date of Birth: _____

1. List all the food or environmental allergies and any special precautions and treatment indicated for these allergies: _____
_____

2. List any medications, food supplements, modified diets or fluoride supplements currently being administered to the child: _____
_____

3. List any chronic physical problems and any history of hospitalization: _____
_____

4. List any diseases the child has had: _____
_____

5. Does your child have any habits we should be aware of? _____
_____

6. Does your child have any fears we should be aware of? _____
_____

7. Does your child currently receive any outside services such as Speech Therapy, Occupational Therapy, etc? _____
_____

Signature of Parent/Guardian _____ Date _____

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PRESCHOOL AUTHORIZATIONS & CONSENT

Student's Name: _____
First Middle Last

PERMISSION TO DISPLAY PHOTOGRAPHS, AUDIO, VIDEO, ELECTRONIC IMAGES, ARTWORK AND/OR STORIES

I give consent (or do not give consent) for photographs, audio, video or electronic images of my student; original written materials, artwork, or other work created by my child during the course of instruction: as well as quoted statement by my child to be used by the district for exhibition, public display, publication, publicity materials, advertising, news media stories, video, audio, or other electronic media such as the Internet, television, CD-ROM, or DVD, and social media sites. I understand that my student's full name may also be used with such display.

_____Yes I give consent _____No I do not give consent

FIELD TRIP PERMISSION

My child, named above, has my permission (or does not have my permission) to attend all scheduled field trips. Written notice, including all details of each field trip, will be sent home with your child prior to each field trip.

_____has my permission _____does NOT have my permission

DEVELOPMENTAL SCREENING

I understand that my child, named above, will receive a developmental screening as required by the State of Ohio and that any concerns/recommendations will be discussed with me at a conference.

_____Yes I understand

EDUCATION INFORMATION

I authorize the Preble County Preschool to release enrollment information, as well as any information pertinent to my child's education to my local school district. I understand that this information will remain confidential.

_____Yes I authorize

NOTIFICATION OF CHANGE

I agree to notify the Preble County Preschool teaching staff immediately of any changes in the drop off or pick up of my child.

_____I agree _____ I do NOT agree

CLASS ROSTER

I agree that my child's name, my name, address, and telephone number may be included in the Class Roster which will be made available to the parent of each child in the program.

_____has my permission _____does NOT have my permission

GROUP ACTIVITIES

I agree that my child may be involved in small group and large group activities with the speech therapist or intervention specialist in the classroom.

_____has my permission _____does NOT have my permission

VIDEO FOR ANALYZATION

I agree that my child may be videotaped in order to collect data for analyzing teaching practices, student behaviors to develop behavior and other educational plans as needed, their Early Learning Assessment and/or IEP goals if applicable. Videotapes will only be shared with appropriate staff.

_____has my permission _____does NOT have my permission

Signature of Parent/Guardian _____ Date_____

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBLITY 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 (First, Middle, Last)	Relationship to You (spouse, son, friend, etc.)	Race	Hispanic or Latino Y or N	Spoken Language	Date of Birth	Gender M or F	U.S. Citizen Y or N
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					

Child 1	Provider Name and Address	What hours/days do you need services? (i.e. child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Child 2	Provider Name and Address	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Child 3	Provider Name and Address	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

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)*
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____
					☐ Sun ____ ☐ Thurs ____ ☐ Mon ____ ☐ Fri ____ ☐ Tues ____ ☐ Sat ____ ☐ Wed ____

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

How Much?

Signature of Applicant	**Date**

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PRESCHOOL TUITION & TRANSPORTATION AGREEMENT

TUITION

The Preble County preschool program charges an annual tuition amount for each child on a sliding scale. We do not charge by the hour, or by the day. Instead, we charge for the slot for the year. When a family pays their tuition each week, they are actually paying toward the cost for the slot for the school year.

_____ has my permission to attend the Preble County Preschool.
(Student's Name)

I agree to pay the amount of $_____ for each week of enrollment, and I understand that tuition is due in advance of each week and the first payment due is the first day of school. Subsequent payments are due every first day of the school week thereafter. Tuition will be due regardless of any absences or snow days (excluding Thanksgiving, Winter and Spring Breaks). If I am one week late with my tuition payment, a reminder note will be sent home with my child. If I am two weeks late with my tuition a second notice will be sent home. If I am three weeks behind on my tuition payment, a final notice will be sent home. If I am not able to pay my child's tuition in full within the date specified on the final notice, I understand I will lose my child's placement in preschool.

_____ _____
Parent/Guardian Signature Date

TRANSPORTATION

_____ has my permission to be transported to their Preschool
(Student's Name)

Program. I understand that my child has the opportunity to be transported for a fee because their place of pick up and drop off is a current bus stop location. I further understand that if their place of pick up and drop off is discontinued as a bus stop in the future, then my child may no longer be able to be transported.

I agree to pay the transportation fee of **$10 per week**, and I understand that the transportation fee is due along with the preschool tuition fee in advance of each week. The first payment is due the first day of school. Subsequent payments are due every first day of the school week thereafter. Tuition and transportation fees are due regardless of any absences or snow days (excluding winter and spring breaks).

_____ _____
Parent/Guardian Signature Date

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OFFICE USE ONLY
TUITION CALCULATION

Student Name: _____

# of dependents that reside in the home _____

_____ IEP Student – No Charge

_____ Over Income/No Proof

Double check with parent the occurrence of the pay check cycle.

Mother's Gross Income check amount →	$
Weekly Pay Check X 52	
Bi-weekly Pay Check X 26	
W2/Taxes	
A. MOTHER'S GROSS TOTAL FOR THE YEAR	A. $
Father's Gross Income check amount →	$
Weekly Pay Check X 52	
Bi-weekly Pay Check X 26	
W2/Taxes	
B. FATHER'S GROSS TOTAL FOR THE YEAR	B. $
TOTAL HOUSEHOLD INCOME (A+B)	$

TOTAL WEEKLY TUITION AMOUNT: $_____

2024 FEDERAL POVERTY GUIDELINES

Size of Family Unit	100% Poverty Level	125% Poverty Level	150% Poverty Level	175% Poverty Level	185% Poverty Level	200% Poverty Level
1	$0-15,060	$15,061-18,825	$18,826-22,590	$22,591-26,355	$26,356-30,119	$30,120 and above
2	$0-20,440	$20,441-25,550	$25,551-30,660	$30,661-35,770	$35,771-40,879	$40,880 and above
3	$0-25,820	$25,821-32,275	$32,276-38,730	$38,731-45,185	$45,186-51,639	$51,640 and above
4	$0-31,200	$31,201-39,000	$39,001-46,800	$46,801-54,600	$54,601-62,399	$62,400 and above
5	$0-36,580	$36,581-45,725	$45,726-54,870	$54,871-64,015	$64,016-73,159	$73,160 and above
6	$0-41,960	$41,961-52,450	$52,451-62,940	$62,941-73,430	$73,431-83,919	$83,920 and above
7	$0-47,340	$47,341-59,175	$59,176-71,010	$71,011-82,845	$82,846-94,679	$94,680 and above
8	$0-52,720	$52,721-65,900	$65,901-79,080	$79,081-92,260	$92,261-105,439	$105,440 and above
ECE Grant	***$0.00***	***$20.00***	***$30.00***	***$35.00***	***$40.00***	***$55.00***
Preschool	***$0.00***	***$15.00***	***$25.00***	***$30.00***	***$35.00***	***$50.00***
	A	**B**	**C**	**D**	**E**	**F**

Ohio | Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 3/12/2018

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Immunizations:		**Exempt from Immunization:**	
Complete for Age	◯ Yes ◯ No	Religious Conviction	◯ Yes ◯ No
In Process	◯ Yes ◯ No	Health	◯ Yes ◯ No
		Other	_____

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician Assistant
- ☐ Advanced Practice Registered Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

PREBLE COUNTY EDUCATIONAL SERVICE CENTER

Early Childhood Programs
597 Hillcrest Dr., Eaton, OH 45320
PH: 937-456-1187 FAX: 937-456-3253

DENTAL FORM

Child's Name: _____

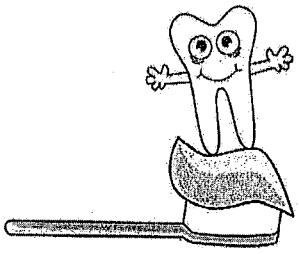
Gender: _____ DOB: _____

Parent/Guardian's Name: _____ Phone: _____

Address: _____ Zip: _____ Teacher: _____

Preventive Services Completed:

Date: _____



_____Exam

_____Prophy

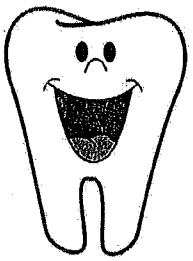
_____Fluoride

_____X-rays

_____OHI

Treatment Completed:

Date: _____



_____Restorative

_____Extractions

_____Pulpotomy

_____Sealants

Comments:

- ☐ Check if treatment is required. How many restorations? _____
- ☐ Check if all services for this child have been completed.
- ☐ Check if treatment is discontinued: Reason _____

6-month check up appt. _____ Next Treatment Date: _____

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

Dentist's Signature: _____

Address: _____ Phone: _____