NOTRE DAME
PRESCHOOL + PRE-K

Enrollment Packet

Notre Dame Preschool + Pre K

1401 Gallia St

Portsmouth, OH

45662

740-353-2354 EXT 25100

www.notredameschools.com

Enrollment Checklist

NOTRE DAME
PRESCHOOL + PRE-K

To be completed prior to admission:

_____ Completed Preschool Application

_____ $30 Registration Fee

_____ Copy of Birth Certificate

_____ Completed Child Medical Statement (by 1st day of school)

_____ Shot Records (by 1st day of school)

_____ Step up to Quality Family Information Form

To be completed only if applying for ECE Scholarship (income based):

_____ Complete application on Ohio Benefits Self Service Portal (SSP) https://ssp.benefits.ohio.gov/apspssp/ssp.portal (please see ECE guidance document)

To be completed after admission:

_____ Register for FACTS Management Tuition Payment System

_____ DIAL-4 Developmental Screen (scheduled by staff)

_____ DIAL-4 Parent Questionnaire

_____ ASQ-SE-2 Form

_____ ASQ3 Form

_____ Handbook/Discipline Policy Signature

Dear potential Preschool + PreK family,

Thank you for your interest in our program! Please answer the following questions to help us get to know you better. Please note that submitting an application does not guarantee admittance to our program. We will be in contact after the enrollment period to schedule screening and to collect any missing paperwork. If you have any questions in the meantime, please feel free to reach out.

Please list two references for enrollment:

NAME   NUMBER

1. _____   _____

2. _____   _____

Has your child attended a previous preschool or childcare setting? If so, please list name of program and length of enrollment.

_____

_____

Why did you choose Notre Dame Preschool + PreK?

_____

_____

Do you have any developmental concerns for your child and/or does your child's pediatrician or previous school have developmental concerns? If so, please explain:

_____

_____

_____

Is your child currently receiving or has previously received intervention services? (developmental intervention, speech language therapy, occupational therapy, physical therapy, or social behavior therapies) If so, where are they receiving services?

_____

_____

Are you interested in a scholarship? Yes___ No____

If you marked yes, please complete the online application for Ohio Benefits. **Please note this is the ECE Scholarship for 3 and 4 year olds, NOT Ed Choice which only applies to elementary students K-12)**

Office of Early Learning and School Readiness
Preschool
Enrollment Form
Revised 11/30/18

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

Section I - Student & Family Information

Child's Name _____   Date of Birth _____

Family/Guardian Name _____

| Please select 1, 2 or 3 to set call order of phone number used to reach you: |

Home Address _____   Cell Phone _____ Call Order _____

City _____ State _____ Zip _____   Home Phone _____ Call Order _____

Employer Name _____   Work Phone _____ Call Order _____

Employer Street Address _____   City _____ State _____ Zip _____

Alternate Family Information:

| Please select 1, 2 or 3 to set call order of phone number used to reach you: |

Family/Guardian Name _____   Cell Phone _____ Call Order _____

Family Street Address _____   Home Phone _____ Call Order _____

City _____ State _____ Zip _____   Work Phone _____ Call Order _____

Employer Name _____

Employer Street Address _____   City _____ State _____ Zip _____

Section II - Authorization for Emergencies

List 2 Emergency Contacts for use ONLY if the parents cannot be contacted:

Name _____   Name _____

Street Address _____   Street Address _____

City _____ State _____ Zip _____   City _____ State _____ Zip _____

| Please select 1, 2 or 3 to set call order of phone number used to reach emergency contact: |

Home _____ Call Order _____   Home _____ Call Order _____

Cell _____ Call Order _____   Cell _____ Call Order _____

Work _____ Call Order _____   Work _____ Call Order _____

List Medical Contacts, In Case Of Emergency:

Physician _____   Dentist _____

Street Address _____   Street Address _____

City _____ State _____ Zip _____   City _____ State _____ Zip _____

Phone _____   Phone _____

Section III - Child's Health Information

Child's Chronic Medical/Health Needs

_____

Please complete both pages of form

Child's History of Hospitalization:

Child's Disease History:

Child's Allergies/Treatment:

Child's Dietary Needs/Restrictions:

NOTE: A MEDICATION FORM MUST BE COMPLETED FOR EACH MEDICATION ADMINISTERED WHILE IN PROGRAM ATTENDANCE

Child's Medication/s:

Section V - Registration Authorizations

I authorize the following to be listed on the parent roster:

My child's name ☐ Yes ☐ No

Family name ☐ Yes ☐ No

Phone numbers ☐ Yes ☐ No

Annual Class Roster: Each year the program prepares a roster for each group of children. This roster will <u>not</u> be furnished to any persons other than parents of children enrolled in our program.

☐ Cell ☐ Home ☐ Work

Exempt from immunizations because of religious conviction: ☐ Yes ☐ No

Child immunization records attached: ☐ Yes ☐ No

Date

Signature of Authorized
Family Member/Guardian

The Notre Dame Schools Preschool Registration Form

Diocese of Columbus Office of Catholic Schools
Please fill out 1 form per child attending to The Notre Dame Schools

NOTRE DAME PRESCHOOL + PRE-K

DATE_____

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH

HOME ADDRESS	CITY	STATE	ZIP

BIRTHPLACE CITY/STATE	LAST 4 OF SSN	(CIRLCE ONE) MALE FEMALE
		(CIRLCE ONE) CATHOLIC NON-CATHOLIC

RACE (*OPTIONAL*)

WHITE, NON HISPANIC   BLACK, NON HISPANIC   HISPANIC   AMERICAN INDIAN/ALASKAN   MULTI-RACIAL

Name	Address	Phone/Cell Phone
Mother/ Guardian		
Employer		
Father/ Guardian		
Employer		

PARENT/GUARDIAN HOME STATUS: MARRIED   SINGLE   SEPARATED   DIVORCED

STUDENT LIVES WITH: BOTH PARENTS   MOTHER   FATHER   OTHER_____

NUMBER OF CHILDREN IN FAMILY: OLDER BOYS____   OLDER GIRLS____   YOUNGER BOYS____   YOUNGER GIRLS___

SACRAMENT OF BAPTISM:

DATE	CHURCH	CITY	STATE

WERE YOU REFERRED BY A NOTRE DAME FAMILY?   Y/N   IF SO, PLEASE LIST THE NAME BELOW:

_____

The Notre Dame Schools Preschool Days Attending Form

Diocese of Columbus Office of Catholic Schools

NOTRE DAME *Please fill out 1 form per child attending to The Notre Dame Schools*
PRESCHOOL + PRE-K

Name of Child	Date of Birth

Name	Address	Phone/Cell Phone	Email
Mother (Guardian)			
Father (Guardian)			

Attendance Preference (Please check one)

Three Day Option

HALF DAY T/W/TH 8:00-12:00	
FULL DAY T/W/TH 8:00- 2:00	

Five Day Option

HALF DAY M-F 8:00-12:00	
FULL DAY M-F 8:00-2:00	

The Notre Dame Schools Preschool Emergency Authorization Form

Diocese of Columbus Office of Catholic Schools
Please fill out 1 form per child attending to The Notre Dame Schools

NOTRE DAME
PRESCHOOL + PRE-K

Name of Child	Date of Birth

Name	Address	Phone/Cell Phone
Mother/ Guardian		
Employer		
Father/ Guardian		
Employer		

If parent/guardian cannot be reached in the event of an emergency, the following may be contacted:

Name	Address	Phone/Cell Phone	Relation to Child

Please choose one of the following options for emergency care:

_____I **GIVE** Notre Dame Preschool permission to transport my child to:

_____   _____
Hospital/clinic   Dentist/clinic

_____I **DO NOT** give my permission for Notre Dame Preschool to transport my child for emergency medical or dental care. In the event of an illness or injury, which requires emergency medical or dental treatment, I wish the following action be taken:

_____

_____

_____   _____
Parent/Guardian Signature   **Date**

The Notre Dame Schools Preschool Pick Up Authorization Form

Diocese of Columbus Office of Catholic Schools
Please fill out 1 form per child attending to The Notre Dame Schools

NOTRE DAME
PRESCHOOL + PRE-K

Child's Name _____

The following adults are authorized to pick up the above names child from school:

Name	Relationship to child	Phone Number
Parent/guardian		
Parent/guardian		

The following adults are _NOT_ authorized to pick up the above names child from school:

Name	Relationship to child	Phone Number

The adults named above are authorized to pick up my child in the event I am unable to do so. I will inform them to bring a driver's license to show preschool staff upon pick up. I understand that my child will NOT be released to anyone not on the authorized list. I understand it is my responsibility to inform the school by written note or phone call, when there is an unforeseen event that would require an unlisted individual to transport my child from school. I will make every effort to keep this list updated.

Parent/Guardian Signature_____ Date:_____

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name *(Last)*	*(First)*	Nickname *(If any)*

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)* How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful

☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily

☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing

☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative

☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. *(Check the one that applies.)*

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature	Date

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 _____ Blood Lead _____ Hemoglobin _____

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.