Preschool Enrollment Documentation Checklist

Complete this checklist for all students enrolled into the CMSD preschool program. All documentation must be present and completed to enroll a student.

**Student Name:**

<table>
<thead>
<tr>
<th>Completed</th>
<th>Document</th>
<th>File</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CMSD Student Enrollment Form</td>
<td>Student Ohio Department of Education Licensing File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td><strong>Birth Certificate</strong></td>
<td>Student Ohio Department of Education Licensing File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td><strong>Physical Examination and Immunization Records</strong></td>
<td>Student Ohio Department of Education Licensing File, School Office File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td>completed within 12 months must be signed and dated by the physician</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Dental Exam</strong> - completed within 12 months</td>
<td>Student Ohio Department of Education Licensing File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td>must be signed and dated by the dentist</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Valid Photo ID / Guardian Documentation</strong></td>
<td>Student Ohio Department of Education Licensing File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td>(if applicable)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Proof of Address</strong> (i.e.: utility bill, paystubs, lease)</td>
<td>Student Ohio Department of Education Licensing File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td><em>Must be a resident of Cleveland - excluding Montessori and Leadership Academies</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Proof of Income &amp; Medical Insurance Card</strong></td>
<td>Student Ohio Department of Education Licensing File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td>(i.e.: 2 Consecutive Paystubs, W2, Tax Statements, SSI, Yearly Child Support Statement)</td>
<td><em>Income collected for all ECE, and Head Start funded classrooms</em></td>
</tr>
<tr>
<td></td>
<td>* dependent upon preschool placement*</td>
<td>For questions regarding acceptable forms of income documentation contact The Office of Early Childhood</td>
</tr>
<tr>
<td></td>
<td>Preschool Emergency Contact Information Form</td>
<td>Student Ohio Department of Education Licensing File, School Office, &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td>Student Emergency Form</td>
<td>Student Ohio Department of Education Licensing File, School Office File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td>Child Release Authorization Form</td>
<td>Student Ohio Department of Education Licensing File, School Office File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td>Media Consent Form</td>
<td>Student Ohio Department of Education Licensing File &amp; Uploaded into E-school</td>
</tr>
<tr>
<td></td>
<td>Walking Field Trip/ Assumption of Risk Form</td>
<td>Student Ohio Department of Education Licensing File, School Office File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td>Preschool and School Age Childcare Medication Form</td>
<td>Student Ohio Department of Education Licensing File, School Office File &amp; Uploaded into E-School</td>
</tr>
<tr>
<td></td>
<td>Preschool Eligibility for Special Education Services Form</td>
<td>Student Ohio Department of Education Licensing File &amp; Uploaded into E-school</td>
</tr>
</tbody>
</table>

**Parent Social Security Card**

**Child Social Security Card**
Student Enrollment Form

☐ Re-enrollment ☐ Pre-registration ☐ Never enrolled at CMSD

Student’s legal name: ___________________________ Last Name ___________________________ First Name ___________________________ Middle Initial ___________________________ Suffix ___________________________

Address: _____________ Number _____________ Street _____________ City _____________ Zip Code _____________ Apt. number: _____________ Up ☐ Down ☐

Grade: _____________ Most recent school district attended/Community school: ___________________________

Birthday: _____________ Month _____________ Date _____________ Year _____________ Birthplace: ___________________________ City _____________ State _____________ Nickname: ___________________________

Gender: ☐ Male ☐ Female

Is student of Hispanic/Latino origin, regardless of race? ☐ Yes ☐ No

Race (select at least one):
☐ White ☐ Black/African-American ☐ Asian ☐ American Indian/Alaska Native ☐ Hawaiian/Other Pacific Islander

Student Lives With: (check all that apply):
☐ Mother ☐ Father ☐ Step-parent ☐ Foster parent ☐ Legal guardian ☐ Host parents (foreign exchange student) ☐ Self – Independent student ☐ Other (explain):

Are you or your child currently homeless, doubled-up for economic reasons (living in someone else’s home), or an unaccompanied youth (student living and in the care of someone who is not the custodial adult) or student in foster care? ☐ Yes ☐ No

Legal Custody:
☐ Mother and Father – Legally married ☐ Mother – Never legally married to biological father ☐ Father – Never legally married to mother/established paternity through courts ☐ Shared parenting through divorce or legal separation ☐ Parents legally married but not living together ☐ Student is 18 years old and lives independently ☐ Legal guardian* ☐ Grandparent Affidavit/Power of Attorney* ☐ CCDFCS*

Court journal entry: ☐ Probate Court ☐ Juvenile Court

*Case Number: ___________________________

School choice(e): ___________________________

1. ___________________________

2. ___________________________

3. ___________________________

School Choices entered in Choice Portal (ChooseCMSD.org)? ☐ Yes ☐ No

Did the child learn to speak a first language other than English? ☐ Yes ☐ No

Is the language most often spoken by the child one other than English? ☐ Yes ☐ No

Is the language most often spoken in the child’s home one other than English regardless of the language spoken by the child? ☐ Yes ☐ No

Native language: ___________________________

Is the child in gifted or advanced placement classes? ☐ Yes ☐ No If yes, describe services:

Does the child have a 504 Plan or medical plan? ☐ Yes ☐ No If yes, describe services:

Does the child have a current IEP (special education)? ☐ Yes ☐ No If yes, list year of most recent evaluation:

If yes, do you have a copy of the IEP and MFE? ☐ Yes ☐ No If yes, indicate program:

Is the child currently suspended? ☐ Yes ☐ No If yes, from what district?

Is the child currently expelled? ☐ Yes ☐ No If yes, from what district?

End date: ___________________________

Revised 1/8/2018
Parent(s)/Guardian Information

Name: ________________________  Last Name: ________________________  First Name: ________________________

☐ Single  ☐ Married  ☐ Remarried  ☐ Lives with  ☐ Relationship to child: ________________________
☐ Divorced  ☐ Separated  ☐ Deceased  ☐ Does not live with

Address: ________________________  Number ________________________  Street ________________________
City ________________________  Zip Code ________________________

Completing this section ensures you will be notified of important information affecting your child(ren)
☐ E-mail ________________________  ☐ Home Phone ________________________  ☐ Text message opt out
☐ Cell Phone ________________________  ☐ Work Phone ________________________

Name: ________________________  Last Name: ________________________  First Name: ________________________

☐ Single  ☐ Married  ☐ Remarried  ☐ Lives with  ☐ Relationship to child: ________________________
☐ Divorced  ☐ Separated  ☐ Deceased  ☐ Does not live with

Address: ________________________  Number ________________________  Street ________________________
City ________________________  Zip Code ________________________

Completing this section ensures you will be notified of important information affecting your child(ren)
☐ E-mail ________________________  ☐ Home Phone ________________________  ☐ Text message opt out
☐ Cell Phone ________________________  ☐ Work Phone ________________________

Emergency Contact Information (in addition to contacts listed above)

Name: ________________________  ☐ Relationship to child: ________________________

Address: ________________________  Number ________________________  Street ________________________
City ________________________  Zip Code ________________________

Telephone: ________________________  E-mail: ________________________

Please list all other children under the age of 22 who live at the home address:

<table>
<thead>
<tr>
<th>NAME</th>
<th>GRADE</th>
<th>DATE OF BIRTH</th>
<th>GENDER</th>
<th>RELATIONSHIP TO CHILD</th>
<th>CURRENT SCHOOL</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

How did you hear about CMSD?
☐ Radio  ☐ Mailer  ☐ Facebook  ☐ E-Newsletter
☐ Newspaper  ☐ Flyer  ☐ Friend/colleague  ☐ Other: ________________________
☐ Website  ☐ Community event  ☐ CMSD employee  ☐ Cleveland resident

Why did you choose your child’s school?
☐ Distance from home/work/childcare  ☐ Word of mouth/Recommendation
☐ Programs offered at building  ☐ Other: ________________________
☐ State rating

The Cleveland Metropolitan School District has the authority to require students to be immunized as a requirement for admission to school, except in situations of good cause such as religious convictions. I am signing that I am aware of the District’s Immunization Policy. I am also signing that I hereby certify, under penalty of perjury, that all of the information that I have given is correct in all respects to the best of my knowledge.

Parent/Legal Guardian/Independent Student: ________________________  Date: ________________________

Revised 1/8/2018
Formulario de Inscripción de Estudiantes

☐ Re-inscripción  ☐ Pre-inscripción  ☐ Nunca inscrito en el Distrito Escolar

Nombre Legal del Estudiante: __________________________ Apellidos __________________________ Nombre __________________________ Inicial del segundo nombre __________________________ Sufijo __________________________

Dirección: __________________________________________
N. __________ Calle __________ Ciudad __________ Código Postal __________
Apartamento: __________ Arriba ☐ Abajo ☐

Grado: __________________________ Último Distrito Escolar asistido: __________________________

Fecha de nacimiento: __________ / __________ / __________ Lugar de Nacimiento: __________________________ Ciudad __________ Estado __________ Apodo: __________________________

Género: ☐ Masculino  ☐ Femenino

¿El estudiante es de descendencia Hispa/na/Latina, sin importar raza?  ☐ Sí ☐ No

Raza (seleccione una): ☐ Blanca  ☐ Negra/Afro-Americana  ☐ Asiática  ☐ India Americana/Nativa de Alaska  ☐ Hawaiana/Otra Isla del Pacífico

El Estudiante Vive Con: (marque la que se aplique):
☐ Madre  ☐ Padre  ☐ Padastro  ☐ Tutor Legal  ☐ Padre/Madre de Crianza  ☐ Solo/a – Independiente  ☐ Padres Anfitriones (estudiante en intercambio)  ☐ Otro (explique):

¿Usted o su hijo se encuentra actualmente sin hogar, viviendo con otra(s) persona(s) debido a una razón económica (viviendo en la casa de otra persona)? Usted es un adolescente no acompañado (estudiante viviendo bajo el cuidado de otra persona que no es el adulto con custodia legal) o es estudiante en el sistema de familias de crianza?
☐ Sí ☐ No

Custodia Legal:
☐ Madre y Padre – Legalmente casados
☐ Madre – No casada legalmente con el padre biológico
☐ Padre – No casado legalmente con la madre/paternidad establecida por la Corte
☐ Custodia compartida por medio de divorcio o separación legal
☐ Padres – legalmente casados pero no viven juntos
☐ El estudiante tiene 18 años de edad y vive fuera del hogar
☐ Tutor Legal *
☐ Declaración jurada del Abuelo/ Poder de un Abogado*
☐ CCDCFS*

Orden de la Corte:
☐ Corte de Probatoria ☐ Corte Juvenil

*Número del Caso: __________________________

Opciones Escolares:

1. __________________________________________
2. __________________________________________
3. __________________________________________

¿Metió sus Opciones Escolares en el portal de Opciones Escolares (ChooseCMSD.org)?
☐ Sí ☐ No

¿El idioma que el estudiante adquirió por primera vez fue otro que no sea inglés?
☐ Sí ☐ No

¿El idioma más hablado por el estudiante es otro que no sea inglés?
☐ Sí ☐ No

¿El idioma principal utilizado en el hogar, independientemente del idioma en que se expresa el estudiante, es otro que no sea inglés?
☐ Sí ☐ No

Idioma Materno: __________________________________________

¿Está el niño en el programa para superdotados?
☐ Sí ☐ No  Si marcó que sí, describa los servicios:

__________________________________________

¿Tiene el niño un Plan 504 o un plan médico?
☐ Sí ☐ No  Si marcó que sí, describa los servicios:

__________________________________________

¿Tiene el niño un Programa Educativo Individualizado (IEP) actualizado (educación especial)?
☐ Sí ☐ No  Si marcó que sí, indique el año de la evaluación más reciente:

__________________________________________

Si marcó que sí, ¿tiene usted una copia del IEP y del MFIE?
☐ Sí ☐ No  Si marcó que sí, indique el programa:

__________________________________________

¿Está el niño suspendido actualmente?
☐ Sí ☐ No  Si marcó que sí, ¿de qué distrito?

¿Está el niño expulsado actualmente?
☐ Sí ☐ No  Si marcó que sí, ¿de qué distrito?

Fecha en que se vence la expulsión: __________________________

Revised 1/8/2018
**Physician Examination Report**

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>DOB</th>
<th>Sex □ M □ F</th>
<th>Age</th>
<th>Date of Exam</th>
</tr>
</thead>
</table>

**Significant Medical History (include chronic illness, injuries, and hospitalizations):**

__________________________________________________________________________

Any medical restrictions? What are they? (Please explain reason why?)

__________________________________________________________________________

**Speech Development:** Normal □ Delayed □ Referred □ (SLP? □): ______________________

**Motor Development:** Normal □ Delayed □ Referred □ (OT/PT? □): ______________________

**Allergies:** (Epi-Pen needed?)

__________________________________________________________________________

Does child wear glasses? □ Y □ N Does child wear hearing aids? □ Y □ N

Does child require special equipment? □ Y □ N Specify:

__________________________________________________________________________

**Tests and Measurements:**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Pulse</th>
<th>BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Screen Date: 20/20</td>
<td>OD OS 20/20</td>
<td>Hearing Test Date:</td>
<td>R / L</td>
</tr>
<tr>
<td>Lead Testing History of elevated lead level? □ Y □ N</td>
<td>Highest lead level Date:</td>
<td>Treatment</td>
<td>Most Recent Lead Test Date:</td>
</tr>
<tr>
<td>Glucose Screening Date:</td>
<td>Result:</td>
<td>Sickle Cell Test Date:</td>
<td>Result</td>
</tr>
</tbody>
</table>

**General Physical Exam:** (Please explain abnormal findings)

<table>
<thead>
<tr>
<th>General appearance</th>
<th>Normal □</th>
<th>Abnormal □</th>
<th>Lungs</th>
<th>Normal □</th>
<th>Abnormal □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>□</td>
<td>□</td>
<td>Abd</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Skin</td>
<td>□</td>
<td>□</td>
<td>GI</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Head</td>
<td>□</td>
<td>□</td>
<td>Genitalia</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Eyes</td>
<td>□</td>
<td>□</td>
<td>GU</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>ENT</td>
<td>□</td>
<td>□</td>
<td>Neu</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Teeth</td>
<td>□</td>
<td>□</td>
<td>NM</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Neck</td>
<td>□</td>
<td>□</td>
<td>Spine/Scoliosis</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Thyroid</td>
<td>□</td>
<td>□</td>
<td>Lymph nodes</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Heart</td>
<td>□</td>
<td>□</td>
<td>Extremities</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Explanation of abnormal findings:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

**Please continue to second page*****
General Neurological Exam:

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gait</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Station</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Muscle Strength</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Muscle Tone</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Reflexes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cranial Nerves</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Gross Motor Coordination: ____________________________________________

Fine Motor Coordination: ____________________________________________

Sensory: ___________________________________________________________

Mental Health/Behavioral Health:

<table>
<thead>
<tr>
<th></th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperactive</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Withdrawn</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Short attention span</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Disturbed sleep pattern</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Aggression</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other (please describe)</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Notes: ______________________________________________________________

____________________________________________________________________

Current Medications/Treatment Regimens (i.e. Tube feed, Suction, Glucose testing): ______________________________________________________________

____________________________________________________________________

Medical Recommendations/Referrals: ____________________________________________

____________________________________________________________________

____________________________________________________________________

I certify that the above-named student has had a complete physical examination:

Physician/Examiner's Name: (Print) ____________________________________________

Physician/Examiner's Signature: __________________________ Date: __________

Address: ____________________________________________

Telephone: __________________________ Fax: __________________________

Office Stamp: ____________________________________________

*****Please attach a current immunization record *****

PLEASE RETURN TO SCHOOL NURSE AT YOUR CHILD'S SCHOOL. THANK YOU!
<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Vaccine</th>
<th>(mo/day/yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B (e.g., HepB, Hib-HepB, DTap-HepB-IPV) Give IM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, Tetanus, Pertussis (e.g., DTap, DTap/Hib, DTap-HepB-IPV, DT, DTap-IPV/Hib, Tdap, Dtap-IPV, Td) Give IM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus Influenzae Type b (e.g., Hib, Hib-HepB, DTap/Hib) Give IM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio (e.g., IPV, DTap-HepB-IPV, DTap-IPV/Hib, DTap-IPV) Give IPV SC or IM. Give all others IM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccine</td>
<td>Type of Vaccine</td>
<td>Date given (mo/day/yr)</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (e.g., MMR, MMRV) Give SC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (e.g. VAR, MMRV) Give SC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (Hep A) Give IM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal (e.g., MCV4, MPSV4) Give MCV4 IM and MPSV4 SC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CLEVELAND METROPOLITAN SCHOOL DISTRICT
CHILD'S HEALTH RECORD
DENTAL EXAM

CHILDS NAME: ______________________  SEX: ______  DOB: ______

1. Is the child now receiving:
   *If yes, include length of time receiving fluoride.

<table>
<thead>
<tr>
<th>Topical Fluoride Application</th>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoride Water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Supplement diet</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
   (Tablets __  Liquid ___)      |     |    |         |

2. Does the child have any trouble with teeth, gums, or mouth than the parent knows about? Yes _ No_

3. Child has previously seen Dentist? Yes _ No_ Dentist Name: ______________________  Last visit date: ______

4. Child is under Physician's Care? Yes _ No_  Physician's Name: ______________________

5. Child is receiving medication? Yes _ No_  Type: ______________________

6. Child is reported to have:
   *Give details/attach Health History if necessary

<table>
<thead>
<tr>
<th>Allergies</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart/Vascular Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, please explain →</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Source of reimbursement or Services
   _ EPSOT/Medicaid
   _ Federal, State, or local Agency
   _ Head Start
   _ In-Kind Provider
   _ Parents/Guardians
   _ Other (3rd Party)

8. Priority Group
   _ Needs Attention immediately
   _ Needs Attention Soon
   _ Needs Routine Care

9. Oral conditions before treatment:
   *Indicate restorations you perform in item 10
   MISSING ☒
   FILLED ☉
   DECAYED ☜

*Turn to the back
Preschool Emergency Contact Information

School: ____________________________  Child's Name: ____________________________

Address: ____________________________  Phone Number: ____________________________

Please list four emergency contacts name and numbers who you authorize to be contacted for an emergency, illness, or accident if needed.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Please provide the name, address and telephone numbers of your physician and dentist who you authorize to be contacted in case of an emergency, illness, or accident.

<table>
<thead>
<tr>
<th>Dentist Name</th>
<th>Phone</th>
<th>Address</th>
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<tr>
<th>Physician Name</th>
<th>Phone</th>
<th>Address</th>
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Parent/Guardian Name: ____________________________

Parent/Guardian Signature: ____________________________
STUDENT EMERGENCY FORM

(Return to School Office)

Student's Name: ____________________________

Birth Date: ___________ Sex: □ Male □ Female Grade ______

Home Address: ____________________________________________________________

Parent/Guardian Name: ____________________________ Relationship ____________

Phone #: Home: ____________________________ Cell: ____________________________

Other: ____________________________ Work: ____________________________

Child lives with: □ Mother □ Father □ Caregiver/Guardian □ Other ________

Language spoken at home: __________________________________________________

EMERGENCY CONTACT NUMBERS: In case of emergency, illness, or accident to the
child named above, the school is authorized to process as indicated.

Contact #1: Name: ____________________________ Address: (If different from home above) ____________________________

Contact #2: Name: ____________________________ Address: (If different from home above) ____________________________

Contact #3: Name: ____________________________ Address: (If different from home above) ____________________________

My child should never be released to the following: ____________________________

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

______________________________ Date ________________

Signature of Parent/Guardian

Cleveland Municipal School District

EMERGENCY DATA FORM

Student's Name: __________________________________________ Phone Number: ______

Address: __________________________________________ Room: ______

School: ____________________________

The following is required by Section 3313.712 of the Ohio Revised Code.

EMERGENCY MEDICAL AUTHORIZATION

Purpose – to enable parents and guardian to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

ALL BLANK SPACES MUST BE FILLED IN

In the event reasonable attempts to contact me at ____________________________ (phone) or ____________________________ (other parent) at ____________________________ (phone) have been unsuccessful school personnel will call 911.

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL IMPAIRMENTS to which a physician should be alerted:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Family Physicians: ____________________________ Address: __________ Phone: ______

Signature of Parent or Guardian ________________ Date ________________
Preschool Child Release Authorization

Child's Name: 

School: 

Address: 

Phone Number: 

Please provide the names and phone numbers of individuals who **are** authorized to pick up your child from school:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
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</table>

Please provide the names of individuals who **are not** authorized to pick up your child from school:

<table>
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<tr>
<th>Name</th>
<th>Relationship</th>
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Parent/Guardian Name: 

Parent/Guardian Signature: 
CLEVELAND METROPOLITAN SCHOOL DISTRICT

Media/IVR Consent Form

(Check the Applicable Box) RETURN THIS FORM TO YOUR CHILD'S SCHOOL

☑ I hereby irrevocably consent to the unrestricted photographing, videotaping or otherwise recording or broadcasting or publishing and other unrestricted use of my child's writing, photographs, video, image or likeness, or quotes without limit, reservation or remuneration by the media and/or the Cleveland Metropolitan School District (CMSD). CMSD shall be the sole and exclusive owner of all rights to the said recordings it has taken. I release all rights in the said recordings on behalf of myself and my ward/child.

☑ I do not consent to the photographing, videotaping or otherwise recording or broadcasting or publishing and other use of my child's writing, photographs, video, image or likeness, or quotes by the media and/or the Cleveland Metropolitan School District.

☑ I do not consent to receiving IVR (Interactive Voice Response) messages to my home or emergency phone numbers at any time including notifications of school-related emergencies.

STUDENT INFORMATION
Student Name ____________________________

School ____________________________ Grade ____________

Parent/Guardian Signature ____________________________

Parent Printed Name: ____________________________

Home Address: ____________________________

Home Phone: ____________________________

Cell Phone: ____________________________

Date

* Disclaimer: As a matter of policy, the Cleveland Metropolitan School District will not publish both a student's name and photograph together.

* Students over the age of 18 do not need to obtain parental consent.

The goal of the Cleveland Metropolitan School District is to become a premier school district in the United States of America.
Cleveland Metropolitan School District
Preschool
Walking Field Trip Permission
Assumption of Risk

Field trips are an important part of classroom instruction as they provide an opportunity for the teacher to enrich and extend the learning experiences for students. There may be times during the school year when your child may take a walking field trip around the grounds of the school, the neighborhood, or to a nearby business. These field trips will be appropriate for the age of the students and supervised by the classroom teacher and volunteers. Please sign below indicating your understanding and agreement.

I recognize and acknowledge that such activity carries a certain risk. I agree to assume all such risk which my child may sustain as a result of participating in any such activity.

I hereby give permission for my child to accompany his/her class on walking field trips that are planned and supervised by school staff with the understanding that school personnel will make every effort to arrange for a safe walking route and provide supervision to and from the school site.

Child’s Name: __________________________________________

Parent/Guardian Name 1: ________________________________

Parent/Guardian 1 Signature: _____________________________

Parent Guardian Name 2: ________________________________

Parent/Guardian 2 Signature: _____________________________

Both parents must sign unless only one has custody.
A Medication Form is a request for the administration of prescription and non-prescription medication.

A separate form must be completed for each medication.

Except in cases of emergency, families provide the first dose of any newly prescribed medication so that they may personally observe the child’s reaction.

Section I - Request for Administration of Medication

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>Child's Age</th>
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<tbody>
<tr>
<td>Medication Name</td>
<td>Dosage</td>
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<tr>
<td>Staff Authorized to</td>
<td>Dosage Time/s</td>
</tr>
<tr>
<td>Administer Medication</td>
<td></td>
</tr>
<tr>
<td>Physician Signature</td>
<td>Date</td>
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</tbody>
</table>

All prescription medicine must be current within the last twelve months, kept in its original container and have a legible label containing the child’s name and written instructions for use from a licensed physician, nurse practitioner, or dentist.

All medicines must be kept in a place inaccessible to children. An inhaler or nonprescription medication may be available to a school child with a special health condition with parental permission in accordance with the program’s policy.

Section II - Authorized Staff Member Medication Log

<table>
<thead>
<tr>
<th>Dosage Date/Time</th>
<th>Dosage Amount</th>
<th>Trained and Authorized Staff Member Signature</th>
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</table>
Eligibility for Preschool Special Education Services

Child’s Name: ____________________________  School: ____________________________

Please answer the following questions for special education services:

1. Is this child currently receiving special education services?
   □ Yes  □ No

2. Does this child have a current Individualized Education Plan (IEP)?
   □ Yes  □ No
   If the IEP is not current, when did it expire? ____________________________

3. Does this child have a current Evaluation Team Report (ETR)?
   □ Yes  □ No

4. Please provide the classroom teacher with a copy of the child’s current IEP and ETR.

Parent/Guardian Name: ____________________________

Parent/Guardian Signature: ____________________________

Date: ____________________________
UPK FILE DOCUMENT CHECKLIST

Use this form to keep track of ALL of the documents that will need to be included in your files for each child in the UPK program. These are the documents that will be reviewed during the monitoring visit(s).

☐ UPK HEALTH SCREENING REQUIREMENT ACKNOWLEDGEMENT FORM

☒ UPK SCHOLARSHIP INCOME AND RESIDENCY VERIFICATION FORM (FOR SCHOLARSHIP ELIGIBILITY)
Not Applicable

☐ COPY OF INCOME DOCUMENT

☐ COPY OF RESIDENCY DOCUMENT

☐ UPK PRIVACY PRACTICES ACKNOWLEDGEMENT

☒ TRANSITION SUMMARY (If Applicable)
Dear Parent(s)/Caregiver,

As part of the Universal Pre-Kindergarten program your child may be asked by the provider to have certain health screenings. These health screenings are not mandatory for UPK admission; however certain screenings may help prevent future problems with your child’s health. Some of these screenings may be offered by your child’s preschool. If not, a list of resources is attached for those screenings that may be provided by your child’s preschool.

Thank you!

Below is a list of recommended screenings that may be asked for by the provider:

- Lead screening
- Hematocrit/Hemoglobin screening
- Dental screening
- Vision screening
- Hearing screening

Your signature below verifies that you are aware of the medical screenings your child needs; confirms that you received the necessary forms for your doctor or dentist to complete; and confirms that you received the list of local resources available to assist you with completing the medical screenings.

______________________________
Child’s Name

______________________________
Parent/Caretaker

______________________________
Date

______________________________
Site Manager/Representative

______________________________
Date

Original to Parent Copy to Child’s File
Starting Point

4600 Euclid Avenue Suite 500
Cleveland, Ohio 44103
(216) 575-0061

ACKNOWLEDGEMENT OF RECEIPT OF THE
NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Privacy Practices: I, the undersigned, acknowledge that I have received and have been given the opportunity to review the Cuyahoga County Universal Pre-Kindergarten program Notice of Privacy Practices. I understand that I will be given additional copies of this Notice of Privacy Practices any time at my request.

Please list children enrolled ages 3 to 5 years (not in kindergarten)  SITE: ____________________________

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
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</table>

Name of Parent/Guardian ____________________________________________

Address ___________________________________________________________

_________________________________________________________________

Telephone ( ) - ( )
Home Work

_________________________________________________________________

Signature

_________________________________________________________________

Print Name

_________________________________________________________________

Date _____________________________________________________________

Original: UPK/PRE4CLE file

Copy: Starting Point
Attn: Julia Garber
4600 Euclid Avenue, Suite 500
Cleveland, OH 44103

Copy: Parent

Revised 2/2018
Universal Pre-Kindergarten COPA Application

Application Date: _______________

Child’s Name: ___________________ Birth Date: _______________

Gender: (Circle One) Male Female Social Security Number: _______________

Language: _______________ Ethnicity: (Circle One) Hispanic Latino Neither

Race: (Circle One) African American Asian Bi-Racial/Multi-racial Caucasian Native American Other Pacific Islander Unspecified

Disability (if applicable): _______________ Circle Any Plan Applicable: IEP/IFSP/NCP

Primary Caregiver:

Parent/Guardian Name: ___________________ Birth Date: _______________

Gender: (Circle One) Male Female Social Security Number: _______________

Address: ___________________________________________________________

City: ___________________ State: _______ Zip Code: _______________

Home Phone Number: _______________ Cell Phone Number: _______________

Education Level: _______________ Employment Status: _______________

Employer/School Name: _______________ Income: _______________

Employer/School Phone Number: _____________________________

# in Family: _____ # in Household: _____ Disability: (Circle One) Yes No

Medical Insurance Carrier: _______________________________________

Current Housing: (Circle One) Homeless Own Rent Other

Current Housing Date: ___________ Caregiver Relationship to Child: ___________

Is there a Secondary Caregiver/Parent/Guardian? (Circle One) Yes No

*If there is a Secondary Caregiver, complete the next section on Page 2 and sign the verification section. If there is no Secondary Caregiver in the home, then skip the next section and proceed to verification section.*
Universal Pre-Kindergarten COPA Application

Secondary Caregiver:

Parent/Guardian Name: ___________________________ Birth Date: ____________

Gender: (Circle One)  Male   Female   Social Security Number: ________________

Address: ______________________________________________________________________

City: ___________________________ State: _______ Zip Code: ________________

Home Phone Number: ________________ Cell Phone Number: ________________

Education Level: ________________ Employment Status: _______________________

Employer/School Name: ________________ Income: ____________________________

Employer/School Phone Number: ______________________________________________________________________

Language: ________________ Disability: (Circle One)  Yes  No

Medical Insurance Carrier: ______________________________________________________________________

Caregiver Relationship to Child: __________________

________________________________________________________________________

Verification Section:

I verify that the information on this application is correct.

Parent/Guardian Name: (Print) ____________________________________________

Signature: ___________________________ Date: ____________

Staff Name: (Print) ______________________________________________________

Staff Signature: ___________________________ Date: ____________
Ohio Department of Job and Family Services
PUBLICLY FUNDED CHILD CARE SUPPLEMENTAL APPLICATION
*This form is valid only for publicly funded child care when attached to a JFS 01121 Early Childhood Education Eligibility Screening Tool

1. Voter registration application attached - Assistance Available
If you are not registered to vote where you live now, would you like to apply to register to vote here today?
☐ YES, I want to register to vote. ☐ NO, I do not want to register to vote.
If you do not check either box, you will be considered to have decided not to register to vote at this time.

2. Tell us about you (the applicant)
First Name | MI | Last Name | Date of Birth
Street Address
Mailing Address (if different from street address)
City | County | State | Zip Code
☐ Check here if you are homeless (We will still need a mailing address)
Home Phone Number ( )
Cell Phone Number ( )
Work Phone Number ( )
E-Mail Address
May we send text messages to your cell phone number?
☐ Yes ☐ No

3. Tell us more about you (the applicant)
Are you:
☐ Visually Impaired ☐ Hearing Impaired
☐ Interpreter ☐ Other: ____________________________
☐ Sign Language
Social Security Number (Optional)
Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Not Married
Have you, or anyone living with you, ever received cash, child care, food, or medical assistance? ☐ Yes ☐ No
If yes, who: __________________________________ Where (City/County/State): ____________________________
What is your preferred language?
Spoken: ______________________________________ Written: ____________________________
Do you and the people in your home have more than one million total dollars in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)? ☐ Yes ☐ No
Are you or anyone in your household in the military? ☐ Yes ( ☐ Active Duty ☐ National Guard/Reserves) ☐ No
Have you ever been found guilty of child care fraud? ☐ Yes ☐ No
Do you currently have an Ohio Works First (OWF) Self-Sufficiency Plan? ☐ Yes ☐ No
If you are a minor, are you currently in LEAP? ☐ Yes ☐ No

4. Emergency Contact
☐ N/A First Name | MI | Last Name
Street Address
City | County | State | Zip Code
Home Phone Number ( )
Cell Phone Number ( )
Work Phone Number ( )
E-Mail Address
May we send text messages to the cell phone number?
☐ Yes ☐ No
5. Tell us about everyone that lives in your home

You must list everyone who lives with you even if they are not applying. Please be sure to list your name first. Please include all household members regardless of the member's need for child care. If you need more space, attach a separate piece of paper.

<table>
<thead>
<tr>
<th>Name (First, Middle, Last)</th>
<th>Social Security Number (optional)</th>
<th>Date of Birth</th>
<th>Highest Level of Education Completed</th>
<th>Current School Attendance (if applicable)</th>
<th>Relation to you (spouse, son, etc)</th>
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<td>□ Some High School</td>
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### 6. Tell us more about the child(ren) who need child care

#### Child 1
- **Child's First Name**
- **MI**
- **Child's Last Name**
- **Child's City of Birth**
- **Relationship to Applicant**
- **Child's preferred spoken language**

**Child's needs**
- Does the child require protective child care? [ ] Yes [ ] No
- If yes, is there a case plan? [ ] Yes [ ] No
- Is the child enrolled in Head Start? [ ] Yes [ ] No
- If yes, what is the child's schedule?

**Is the child a United States citizen or qualified alien?**
- [ ] Yes [ ] No

**You must provide verification in order to receive child care.**

From ________ to ________

#### Child 2
- **Child's First Name**
- **MI**
- **Child's Last Name**
- **Child's City of Birth**
- **Relationship to Applicant**
- **Child's preferred spoken language**

**Child's needs**
- Does the child require protective child care? [ ] Yes [ ] No
- If yes, is there a case plan? [ ] Yes [ ] No
- Is the child enrolled in Head Start? [ ] Yes [ ] No
- If yes, what is the child's schedule?

**Is the child a United States citizen or qualified alien?**
- [ ] Yes [ ] No

**You must provide verification in order to receive child care.**

From ________ to ________

#### Child 3
- **Child's First Name**
- **MI**
- **Child's Last Name**
- **Child's City of Birth**
- **Relationship to Applicant**
- **Child's preferred spoken language**

**Child's needs**
- Does the child require protective child care? [ ] Yes [ ] No
- If yes, is there a case plan? [ ] Yes [ ] No
- Is the child enrolled in Head Start? [ ] Yes [ ] No
- If yes, what is the child's schedule?

**Is the child a United States citizen or qualified alien?**
- [ ] Yes [ ] No

**You must provide verification in order to receive child care.**

From ________ to ________

#### Child 4
- **Child's First Name**
- **MI**
- **Child's Last Name**
- **Child's City of Birth**
- **Relationship to Applicant**
- **Child's preferred spoken language**

**Child's needs**
- Does the child require protective child care? [ ] Yes [ ] No
- If yes, is there a case plan? [ ] Yes [ ] No
- Is the child enrolled in Head Start? [ ] Yes [ ] No
- If yes, what is the child's schedule?

**Is the child a United States citizen or qualified alien?**
- [ ] Yes [ ] No

**You must provide verification in order to receive child care.**

From ________ to ________