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:

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

parent social security card
child social security card

Student Enrollment Form

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

CLEVELAND METROPOLITAN SCHOOL DISTRICT
1111 Superior Ave. E, Suite 1800, Cleveland, OH 44114 • 216.838.0000

Student's legal name: _____
Last Name First Name Middle Initial Suffix

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

Grade: _____ Most recent school district attended/Community school: _____

Birthday: _____ Birthplace: _____ Nickname: _____
Month Date Year City State

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*
☐ CCDCFS*

Court journal entry: _____
☐ Probate Court ☐ Juvenile Court

*Case Number: _____

School choice(s):

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: _____

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:

NAME	GRADE	DATE OF BIRTH	GENDER	RELATIONSHIP TO CHILD	CURRENT SCHOOL

How did you hear about CMSD?

☐ Mailer ☐ Facebook ☐ E-Newsletter
☐ Radio ☐ Flyer ☐ Friend/colleague ☐ Other: _____
☐ Newspaper ☐ Community event ☐ CMSD employee _____
☐ Website ☐ School visit ☐ 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: _____

Formulario de Inscripción de Estudiantes

CLEVELAND METROPOLITAN SCHOOL DISTRICT

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

Distrito Escolar Metropolitano de Cleveland
1111 Superior Avenue E, Suite 1800, Cleveland, OH 44114 • 216.838.0000

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

Dirección: _____ Apartamento: _____ Arriba ☐ Abajo ☐
Número Calle Ciudad Código Postal

Grado: _____ Último Distrito Escolar asistido: _____

Fecha de nacimiento: ____ / ____ / ____ Lugar de Nacimiento: _____ Apodo: _____
Mes Día Año Ciudad Estado

Género:
☐ Masculino ☐ Femenino

¿El estudiante es de descendencia Hispana/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 ☐ Padrastro ☐ 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 adolecente 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 MFE?
☐ 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

CLEVELAND METROPOLITAN SCHOOL DISTRICT

PHYSICAL EXAMINATION REPORT

Child's Name	DOB	Sex ☐ M ☐ F	Age	Date of Exam

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:

Height	**Weight**	**Pulse**	**BP** _____/_____
Vision Screen Date:	OD 20/ OS 20/	**Hearing Test** Date:	R L
Lead Testing History of elevated lead level? ☐ **Y** ☐ **N**	**Highest lead level** Date: Result: _____mcg/dL	**Treatment**	**Most Recent Lead Test** Date: Result: _____mcg/dL
Glucose Screening Date: Result:	**HCT/HGB - Date:** Result:	**Sickle Cell Test** Date:	**Result**

General Physical Exam: (Please explain abnormal findings)

	Normal	Abnormal		Normal	Abnormal
General appearance	☐	☐	Lungs	☐	☐
Nutrition	☐	☐	Abd	☐	☐
Skin	☐	☐	GI	☐	☐
Head	☐	☐	Genitalia	☐	☐
Eyes	☐	☐	GU	☐	☐
ENT	☐	☐	Neu	☐	☐
Teeth	☐	☐	NM	☐	☐
Neck	☐	☐	Spine/Scoliosis	☐	☐
Thyroid	☐	☐	Lymph nodes	☐	☐
Heart	☐	☐	Extremities	☐	☐

Explanation of abnormal findings:

_____ _____

_____ _____

_____ _____

_____ _____

******Please continue to second page******

CLEVELAND METROPOLITAN SCHOOL DISTRICT

PHYSICAL EXAMINATION REPORT

General Neurological Exam:

	Normal	Abnormal		Normal	Abnormal
Gait	☐	☐	Muscle Tone	☐	☐
Station	☐	☐	Reflexes	☐	☐
Muscle Strength	☐	☐	Cranial Nerves	☐	☐

Gross Motor Coordination: _____

Fine Motor Coordination: _____

Sensory: _____

Mental Health/Behavioral Health:

Hyperactive	☐	Disturbed sleep pattern	☐
Withdrawn	☐	Aggression	☐
Short attention span	☐	Other (please describe)	☐

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!

Immunization Record for _____(child's name)

	Vaccine	(mo/day/yr)
Hepatitis B (e.g., HepB, Hib-HepB, DTap-HepB-IBV) Give IM		
Diphtheria, Tetanus, Pertussis (e.g., DTap, DTap/Hib, DTap-HepB-IPV, DT, DTap-IPV/Hib, Tdap, Dtap-IPV, Td) Give IM		
Haemophilus Influenzae Type b (e.g., Hib, Hib-HepB, DTap,/Hib) Give IM		
Polio (e.g., IPV, DTap-HepB-IPV, DTap-IPV/Hib, DTap-IPV) Give IPV SC or IM. Give all others IM		
Vaccine	**Type of Vaccine**	**Date given (mo/day/yr)**
Measles, Mumps, Rubella (e.g., MMR, MMRV) Give SC		
Varicella (e.g. VAR, MMRV) Give SC		
Hepatitis A (Hep A) Give IM		
Meningcoccal (e.g., MCV4, MPSV4) Give MCV4 IM and MPSV4 SC		

CLEVELAND METROPOLITIAN 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.*

Topical Fluoride Application	YES	NO	UNKNOWN
Fluoride Water			
Fluoride Supplement diet (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*

	YES	NO
Allergies		
Asthma		
Bleeding		
Diabetes		
Epilepsy		
Heart/Vascular Disease		
Liver Disease		
Rheumatic Fever		
Sickle Cell Disease		
Other, please explain →		

7. Source of reimbursement or Services

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

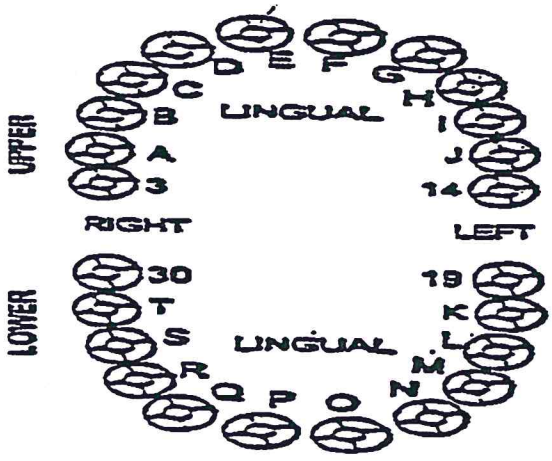
8. Priority Group

_ 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.

Name	Relationship	Phone	Address

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.

Dentist Name	Phone	Address

Physician Name	Phone	Address

Parent/Guardian Name:

_____

Parent/Guardian Signature:

_____

Cleveland Municipal School District

STUDENT EMERGENCY FORM

(Return to School Office)

Date _____ Room _____ Teacher _____

Student's Name: _____

Birth Date: ☐☐ ☐☐ ☐☐☐☐ *month day year* Sex: ☐ Male ☐ Female Grade _____

Home Address: _____

Parent/Guardian Name: _____ Relationship _____

Phone #s: Home: _____ Cell : _____ Work: _____

Child lives with: ☐ Mother ☐ Father ☐ Caregiver/Guardian ☐ Other _____

Language spoken at home: _____

HEALTH CONDITIONS: *(check box)*

☐ Asthma ☐ Bee Sting Allergy

☐ Diabetes ☐ Seizures

☐ Food/Medication Allergy *(please list)* _____

☐ Other *(please explain)* _____

Other children/siblings at this school: *(list name and grade)*

1. _____
2. _____
3. _____

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: _____ Relationship to student: _____

Address: *(If different from home above)* _____ Phone: *(home, work, cell)* _____

Contact #2: Name: _____ Relationship to student: _____

Address: *(If different from home above)* _____ Phone: *(home, work, cell)* _____

Contact #3: Name: _____ Relationship to student: _____

Address: *(If different from home above)* _____ Phone: *(home, work, cell)* _____

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.

_____ _____

Signature of Parent/Guardian Date

Cleveland Municipal School District

EMERGENCY DATA FORM

Cleveland Municipal School District

Student's Name: _____

Address: _____ Phone Number: _____

School: _____ Room: _____

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:

Name	Relationship	Phone Number

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

Name	Relationship

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: _____

Date: _____

Parent/Guardian Name 1: _____

Parent Guardian Name 2: _____

Parent/Guardian 1 Signature: _____

Parent/Guardian 2 Signature: _____

Both parents must sign unless only one has custody.

Office of Early Learning and School Readiness

Preschool and School Age Child Care Medication Form

Revised 7/11/2016

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

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

Name of Child		Child's Age	
Medication Name		Dosage	
Staff Authorized to Administer Medication		Dosage Time/s	
Physician Signature		Date	

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

Dosage Date/Time	Dosage Amount	Trained and Authorized Staff Member Signature

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)

CUYAHOGA COUNTY
Invest in Children

Universal Pre-Kindergarten Health Screening Resources

Universal Pre-Kindergarten Health Screening Requirement Acknowledgement Form

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: _____

First Name	Middle Name	Last Name	Date of Birth

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

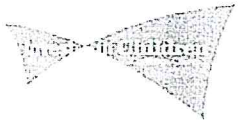
Medical Insurance Carrier: _____

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	☐ Check here if you are homeless (We will still need a mailing address)
Mailing Address *(if different from street address)*	

City	County	State	Zip Code

Home Phone Number ( )	Cell Phone Number ( )	May we send text messages to your cell phone number?
Work Phone Number ( )	E-Mail Address	☐ Yes ☐ No

3. Tell us more about you (the applicant)

Are you:
☐ Visually Impaired
☐ Hearing Impaired

Do you need any of the following services?
☐ 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 ( )	May we send text messages to the cell phone number?
Work Phone Number ( )	E-Mail Address	☐ 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.**

Name *(First, Middle, Last)*	**Social Security Number** *(optional)*	**Date of Birth**	**Highest Level of Education Completed**	**Current School Attendance** *(if applicable)*	**Relation to you** *(spouse, son, etc)*
			☐ Some High School ☐ HS Diploma/GED ☐ 2 Year Degree ☐ 4 Year Degree ☐ Masters or Above **Graduation Date:** ________ **Number of College Credit Hours:** _____	☐ Elementary Grade level ___ ☐ JR High/HS Grade level ___ ☐ Vocational ☐ College Name of School ________ Hours in School: From _____ To _____	**SELF**
			☐ Some High School ☐ HS Diploma/GED ☐ 2 Year Degree ☐ 4 Year Degree ☐ Masters or Above **Graduation Date:** ________ **Number of College Credit Hours:** _____	☐ Elementary Grade level ___ ☐ JR High/HS Grade level ___ ☐ Vocational ☐ College Name of School ________ Hours in School: From _____ To _____	
			☐ Some High School ☐ HS Diploma/GED ☐ 2 Year Degree ☐ 4 Year Degree ☐ Masters or Above **Graduation Date:** ________ **Number of College Credit Hours:** _____	☐ Elementary Grade level ___ ☐ JR High/HS Grade level ___ ☐ Vocational ☐ College Name of School ________ Hours in School: From _____ To _____	
			☐ Some High School ☐ HS Diploma/GED ☐ 2 Year Degree ☐ 4 Year Degree ☐ Masters or Above **Graduation Date:** ________ **Number of College Credit Hours:** _____	☐ Elementary Grade level ___ ☐ JR High/HS Grade level ___ ☐ Vocational ☐ College Name of School ________ Hours in School: From _____ To _____	
			☐ Some High School ☐ HS Diploma/GED ☐ 2 Year Degree ☐ 4 Year Degree ☐ Masters or Above **Graduation Date:** ________ **Number of College Credit Hours:** _____	☐ Elementary Grade level ___ ☐ JR High/HS Grade level ___ ☐ Vocational ☐ College Name of School ________ Hours in School: From _____ To _____	

6. Tell us more about the child(ren) who need child care

Child 1

Child's Fist 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?

From _____ to _____

Is the child a United States citizen or qualified alien?
☐ Yes ☐ No

You must provide verification in order to receive child care.

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?

From _____ to _____

Is the child a United States citizen or qualified alien?
☐ Yes ☐ No

You must provide verification in order to receive child care.

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?

From _____ to _____

Is the child a United States citizen or qualified alien?
☐ Yes ☐ No

You must provide verification in order to receive child care.

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?

From _____ to _____

Is the child a United States citizen or qualified alien?
☐ Yes ☐ No

You must provide verification in order to receive child care.