



HILLSBORO CHRISTIAN ACADEMY
CRUSADERS

Pre-School Information Sheet

Hillsboro Christian Academy's Pre-school Program is a state licensed program and provides learning opportunities for children three (3) and four (4) years of age. School hours are from 8:30 - 3:00 with early arrivals beginning at 8:15 AM. All students go immediately to their classroom upon arrival.

Tuition rates are reasonable and consistent with those of other pre-schools in the area.

The Pre-School Director and HCA Administrator have worked to ensure that the curriculum used is aligned with Ohio's Early Learning and Developmental Standards.

The teachers in HCA's pre-school are caring, patient, and knowledgeable in the field of early childhood education; providing the children with a developmentally appropriate program in which they can grow spiritually, socially, academically, and physically. The written and practiced philosophy of the pre-school is as follows:

Hillsboro Christian Academy is committed to offering students a source of truth, strength, and vision for living in today's world. We seek to create a rare and special place where students can thrive in a Christ-centered environment designed to help them learn to possess the heart and spirit of Jesus. As a Christian educational institution, we believe that the certain Biblical truths are foundational to academic instruction.

- God is the Creator of everything. - Genesis 1:1
- God's written revelation about Himself is found in the Bible. - II Tim 3:16-17
 - It is divinely inspired.
 - It is the complete and final revelation of God.
 - It is the sole authority for faith and practice.
 - It is the only absolute in developing a Christian worldview.
- God created man in His own image (he did not evolve), and, as a result, has dignity and worth which bring purpose and meaning to his life. Because of personal sin, however, man breaks his relationship with God and is in need of a means of restoration. - Genesis 1:27, Romans 3:23
- God has ordained that a child's parents are responsible for the spiritual and academic education of their child. As an extension of the family unity, the church and schoolwork together to provide an opportunity for the education of the hearts, souls, and minds of children enrolled by providing a Christ-centered, Bible-based, academic environment such that they will be well-equipped for the ministries for which God calls them. - Eph 6:4; Deut 6:7

MORE INFORMATION:

For more detailed information, please contact:

Mr. Tim Baggs, School Administrator

Mrs. Kristy Rhodes, Early Learning Director | Rachel Karnes, Assistant Director of Early Learning

Mrs. Jackie Hopkins, Office Manager/Financial Secretary | Mrs. Buffy Wyckoff, Office Secretary/Admissions
(937-393-8422 / email hca.office@hcaoh.org / www.hillsborochristianacademy.org)

APPLICATION POLICY

Students who wish to enroll in HCA's pre-school program should obtain an application from the school's website or from the school office. The application should be completed and returned to the school office along with a copy of the student's birth certificate and medical/immunization records. Any special needs a child might have need to be disclosed during the application interview.

APPLICATION CHECKLIST:

Physical *Date: _____
 Birth Certification
 Shot Record

MEALS / SNACKS:

Hot lunches are available. Students may buy 5 days a week or any portion of the week. Lunches which are purchased can be paid in the school office on the day they are purchased. Parents can also pay ahead.

Pre-school students have one snack every day. Students should bring their own snacks. A well-timed snack can even out spikes in hunger and provide a much needed energy boost between meals. *Below are some suggested nutritious snacks.

Fruits

Apple slices
Cutie oranges
Blueberries
Strawberries

Dairy

Frozen Gogurt
String Cheese
Cubes of cheese
Yogurt

Grains

Pretzels
Whole grain crackers
Whole grain goldfish
Granola Bars

90-DAY ACADEMIC AND BEHAVIOR PROBATION AGREEMENT

I have read and agree with the policies and procedures for the "90-Day Academic and Behavior Probation Period" as outlined in the *HCA Student/Parent Handbook*.

Parent/Guardian signature

Date

STATEMENT OF COOPERATION

We agree to pay the tuition according to arrangements that shall be made and to conclude all required payments on or before the last day of school. We understand that in the event of financial hardship, we should contact school officials and arrange a means of settlement. We understand that final report cards or transfer of records cannot be completed without financial clearance.

If both parents are a viable part of the child's life, both parents must sign below.

Signature of Commitment

Date



HILLSBORO CHRISTIAN ACADEMY

849 S. High St.

Hillsboro, OH 45133

Phone: 937-393-8422 / Fax: 937-393-4963

www.hillsborochristianacademy.org / email: hca.office@hcaoh.org

Pre-School Enrollment Application

Student Information

Last Name		First Name		Middle Name	Grade Entering
Date of Birth	Age	Gender	Social Security Number		School District

<p><u>Check One:</u></p> <p>Student lives with:</p> <p><input type="checkbox"/> Both natural parents</p> <p><input type="checkbox"/> Mother & Step-father</p> <p><input type="checkbox"/> Father & Step-mother</p> <p><input type="checkbox"/> Father only</p> <p><input type="checkbox"/> Mother only</p> <p><input type="checkbox"/> Grandparent(s) _____</p> <p><input type="checkbox"/> Foster parents</p> <p>If custody is defined by the court in any way, proof must be provided.</p>	<p><u>Check One:</u></p> <p>Race/Ethnicity:</p> <p><input type="checkbox"/> White/Caucasian</p> <p><input type="checkbox"/> Black/African-American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> American Indian/Alaskan Native</p> <p><input type="checkbox"/> Native Hawaiian/Other Pacific Islander</p> <p>Previous Pre-school: _____</p>	<p>Does this child receive any special services?</p> <p><u>Current Special Services:</u></p> <p>Check all that apply:</p> <p><input type="checkbox"/> IEP (Service Plan)</p> <p><input type="checkbox"/> 504</p> <p><input type="checkbox"/> Speech Therapy</p> <p><input type="checkbox"/> Occupational Therapy</p> <p><input type="checkbox"/> Physical Therapy</p> <p><input type="checkbox"/> Gifted</p> <p><input type="checkbox"/> Other</p>
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	Natural / Foster Father	Natural / Foster Mother	Guardian
Name			
Address			
City, State, Zip			
Home Phone			
Cell Phone			
Place of Employment			
Work Phone			
Email Addresses			

I hereby affirm that I have legal rights to enroll this student and the student is eligible for enrollment in Hillsboro Christian Academy free of existing suspension or expulsion at a previous school.

Legal Guardian Signature: _____ Date: _____

TRANSPORTATION - We are required to report your local public school information to the Ohio Department of Education. We also provide this information to the school districts that provide bus services to our school. This information is used to make important transportation decisions by our local school districts.

Will your child need to ride a public school bus? _____

PHOTO CONSENT

Yes, you have my permission to use my child's name/likeness on any or all brochures, videos, website, newspaper articles or advertising materials for HCA promotional purposes.

No, do not use my child's name or likeness on any materials.

_____ Signature of Parent / Step-parent / Guardian

COMMUNICATION

What is your preferred method of communication?

- Phone call or text? (Mother____, Father____, Other_____)
- Email address _____

List all of the phone numbers which you would like to have included in our OneCall communication system (be sure to include a cell phone number if you want to receive texts)

We desire to enroll our child at Hillsboro Christian Academy because:

Are there any unusual factors in your child's life? (Absence of father or mother, invalidism of either, in-laws or grandparents in a home, unusual accidents or serious illness, adoption, etc.) Please comment.

If your child has an IEP or a 504 Plan, what sort of academic difficulties have been assessed? _____

CHURCH ATTENDANCE

Name of church:_____ Senior Pastor:_____

How long have you and your family attended this church? _____

What services do you and your family regularly attend?

- Sunday School
- Sunday AM Worship
- Sunday PM Worship
- Mid-Week

Are your children involved in any youth activities? Yes No

PARENT ROSTER PERMISSION

Your signature gives parental permission to share students' names and phone numbers with other parents upon request. This is a great way to get information for invitations for parties, etc.

- Yes, I give permission to include my student's name and number on the pre-school Roster.
- No, I do not want to have my information listed on the roster.

_____ Signature

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS01217 "Request for Administration of Medication" must be completed and kept on file at the center or family child care home.

Does your child have any food, medication, or environmental allergies? (*check all that apply*)

- No
 Yes - check all that apply Food Medication Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

- No
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed

Does your child have a special health or medical condition? (*check one*)

- No
 Yes - Please explain:

Does the special health or medication condition require child staff to perform a procedure, or perform child specific, care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

- No
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

- No
 Yes - Please explain:

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

- No
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement, or medical food.
 N/A - Program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

- No
 Yes - Please explain:

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No
 Yes - Written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication"
 N/A - child does not attend a full time program

Office of Early Learning and School Readiness
**Preschool and School Age Child Care
Medication Form**

This form meets Ohio Administrative Code. Programs may use this form or build their own including all required information.

*A separate medication form is required for each prescription and non-prescription medication administered.

Student Name: _____ DOB: _____

Student address: _____

School: _____ Grade: _____ Class: _____

To Be Completed by the Physician/Dentist:

Medication Name: _____ Dose: _____

Dosage Time/s: _____ Reason for medication: _____

Start date: _____ Stop date: _____

Special Instructions: _____

Potential adverse reactions to be reported:

Physician/Dentist Signature: _____ Date: _____

Physician/Dentist Phone Number: _____ Fax: _____

Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy and as instructed by my child's physician/dentist.

I agree and am responsible to:

- Deliver my child's medicine to school in it's original container
- Ensure prescription medication is labeled by a pharmacist or healthcare provider
- Ensure the medication is current within the past 12 months and provide new medication upon expiration
- Administer the first dose of any new medication, except in case of emergency
- Tell the school as soon as possible if there is a change in the use of my child's medicine
- Tell the school if my child gets a new healthcare provider
- Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes. I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone: _____ Emergency Alternate Phone: _____



This form meets Ohio Administrative Code. Programs may use this form or build their own including all required information.

Section I - Child Medical Information

Child's Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Immunizations:		Exempt from Immunizations:	
Complete for Age	<input type="checkbox"/> Yes <input type="checkbox"/> No	Religious Conviction	<input type="checkbox"/> Yes <input type="checkbox"/> No
In Process	<input type="checkbox"/> Yes <input type="checkbox"/> No	Health	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Other: _____	
Limitations or health conditions, including allergies, medications, and dietary restrictions			

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name: _____

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 _____

Emergency Medical Authorization

This form meets the requirement for Ohio Revised Code Section 3313.712. Programs may use this form or build their own.

Program Name _____

Student Name _____ Phone _____

Address _____

Purpose - To enable parents and guardians 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.

Residential Parent or Guardian:

Mother's Name _____ Daytime Phone: _____

Father's Name _____ Daytime Phone: _____

Other's Name _____ Daytime Phone: _____

Name of Relative or Childcare Provider _____

Relationship _____ Daytime Phone: _____

Address _____

Emergency Contact¹ #1 _____ Daytime Phone: _____

Address _____

Emergency Contact #2 _____ Daytime Phone: _____

Address _____

Emergency Contact #3 _____ Daytime Phone: _____

Address _____

¹Emergency contact information is required in accordance with Ohio Administrative Code Rule 3301-37-08 (for preschool programs) and Rule 3301-32-10 (for school aged child care programs).

PART I OR II MUST BE COMPLETED:

PART I - TO GRANT CONSENT I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

Signature of Parent/Guardian _____ Date _____

Address _____

PART II - REFUSAL TO CONSENT I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency room treatment, I wish the school authorities to take the following action (written instructions must be completed):

Signature of Parent/Guardian _____ Date _____

Address _____

Authorized Pick-Up List

The people listed below have my authorization to pick up my child from the program. I will inform my child's director/teacher, each time a special pick-up is necessary. I understand that my child will only be released to individuals listed below, if I am unavailable. I also realize that they will be required to provide proper identification each time that they arrive at the center. If an individual is not listed on this form, a telephone call WILL NOT be sufficient to release the child to that individual.

Parent/Guardian Signature _____

Child's Name _____

Please Print:

Name	Relation to Child	Phone (Home, Work, Cell)
------	-------------------	--------------------------

Name	Relation to Child	Phone (Home, Work, Cell)
------	-------------------	--------------------------

Name	Relation to Child	Phone (Home, Work, Cell)
------	-------------------	--------------------------

Name	Relation to Child	Phone (Home, Work, Cell)
------	-------------------	--------------------------

Name	Relation to Child	Phone (Home, Work, Cell)
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These people are NOT allowed to pick up my child. PLEASE NOTE: A copy of the court decision for custody cases MUST be on file in order for the program NOT to release a child to his/her non-custodial parent.

Name	Relation to Child	Phone (Home, Work, Cell)
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Name	Relation to Child	Phone (Home, Work, Cell)
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