HILLSBORO CHRISTIAN ACADEMY

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Hillsboro, OH 45133
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Pre-School Enrollment Application

Student Information

Last Name	First Name	Middle Name	Grade Entering

Date of Birth	Age	Gender	Social Security Number	School District

Check One:	Check One:	Does this child receive any special services?
Student lives with: ☐ Both natural parents ☐ Mother & Step-father ☐ Father & Step-mother ☐ Father only ☐ Mother only ☐ Grandparent(s) _____ ☐ Foster parents If custody is defined by the court in any way, proof must be provided.	Race/Ethnicity: ☐ White/Caucasian ☐ Black/African-American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander Previous Pre-school: _____	<u>Current Special Services:</u> Check all that apply: ☐ IEP (Service Plan) ☐ 504 ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Gifted ☐ Other

	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 wort 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

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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.

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*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 is 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:**_____

Ohio | Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

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	☐Yes	☐No	Religious Conviction	☐Yes	☐No
In Process	☐Yes	☐No	Health	☐Yes	☐No
			Other:_____		
Limitations or health conditions, including allergies, medications, and dietary restrictions _____ _____ _____ _____					

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name:_____

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

Check box of examining medical professional:

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

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

Signature of Medical Professional _____ Date of Exam _____

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

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 Contact[1] #1_____ Daytime Phone:_____

Address_____

Emergency Contact #2_____ Daytime Phone:_____

Address_____

Emergency Contact #3_____ Daytime Phone:_____

Address_____

[1] Emergency 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).

Please complete both pages of the form

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_____

Please complete both pages of the form

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)

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