

Dear Parents,

Thank you for your interest in the Bellevue City Schools public preschool program. The preschool application is attached.

Application Directions:

- 1) Please be sure to fill out every page of the application completely. You **must** provide the names and phone numbers of 2 emergency contacts and a doctor and dentist on the Emergency Medical Authorization Form.
- 2) The following documents **MUST** be submitted with the application. Applications will not be processed with documents missing.
  - Verification of Income - Verification can be in the form of a pay stub, W-2, or 1040 tax form. Applications **will not** be processed without this information. Preschool tuition is based on a sliding fee schedule according to family size and income. **Enrollment priority is given to income eligible families.** Income eligibility is based on annual gross income and total number of family members living in your home.
  - Copy of your child's certified birth certificate\*\*\*
  - Proof of residency\*\*\* (Copy of current utility bill or account statement, lease agreement, or real estate tax bill with name and address on it)
  - Custody papers, if applicable\*\*\*\*\*\*Returning students do not need to provide this information unless there have been changes from the previous school year.
- 4) A \$30.00 non-refundable supply fee may be due once your child is accepted into the preschool program. **Do not send any money with the application.** You will be billed for this at a later date, if applicable to your family.
- 5) The **Child Medical Statement** and **Dental Health Record** can be turned in later. The Child Medical Statement will need to be filled out by your child's physician. Please note that a lead and hemoglobin screening are now required for preschool as part of the physical examination. The Dental Health Record will need to be filled out by your dentist. Once these forms are completed, please forward them to the address below. You can send the Preschool Application in before the health forms are completed. If your child is returning to the preschool program for a second year, the Dental Health Record is not required. Returning students will need to have an **updated physical within 13 months** of their previous preschool physical.

**The Child Medical Statement and Dental Health Record for first time students must be turned in within 30 days after preschool begins.** If they are not turned in within 30 days, your child will not be able to attend preschool.
- 6) Please return the required application materials and verification of income document to:  
**Bellevue City Schools Board of Education 125 North Street Bellevue, OH 44811**  
\*Applications from current preschool families will be accepted beginning **February 1st**. Applications from the general public will be accepted beginning **February 20<sup>th</sup>, 2012**. Applications will be dated and processed in the order received.

If you have any questions regarding the preschool program, please call Mrs. Mueller at 567-214-4334. After June 8<sup>th</sup>, please call 419-484-5000.

Sincerely,

*Mandy Mueller, Supervisor*

Bellevue City Schools Preschool

***Bellevue City Schools Preschool Program***  
***125 North Street***  
***Bellevue, OH 44811***  
***567-214-4334 or 419-484-5000 (After 6/8/12)***

**PROGRAM INFORMATION**

The Bellevue City Schools Preschool Program will be located in the new Bellevue Elementary School. The preschool program offers morning and afternoon sessions Monday through Friday. The morning class meets **9:00-11:30a.m.**, while the afternoon class meets **12:45-3:15 p.m.** Parents wishing to enroll their child for less than five days per week should speak with the preschool supervisor. Children who are 3 by August 1<sup>st</sup> are eligible for enrollment.

**PROGRAM PHILOSOPHY**

The BCS preschool program is based on the following research-based beliefs:

- Each child is a unique individual and must be appreciated and valued for his/her individuality.
- Children grow and develop at different rates and each child's rate is separate and distinct from that of any other child.
- Children are naturally curious and eager to learn. They learn best when they are able to follow many of their own interests and desires to learn.
- Learning is active - something a child does, rather than something that is done for him or her.
- Play is a child's "job" and way of learning.
- Children learn from each other. As they learn, children develop a sense of responsibility and achievement. They learn to respect themselves and others.
- Confidence is developed in an atmosphere of trust where children can try new things and learn to solve problems.
- A rich learning environment, one deliberately designed with much to explore and discover, is essential in helping young children learn basic skills. Concrete and sensory materials are important in this environment, as they are basic learning tools for the young child.
- The most important variable in a young child's learning is the educator. Parents are a child's first and most important educator.

The BCS preschool program provides for the development of the whole child - physically, emotionally, socially, and intellectually. The program is licensed by the Ohio Department of Education (ODE). The curriculum is aligned with the Early Learning Content Standards developed by ODE. We provide activities to encourage learning in the way that children learn best -- through interaction with other children and caring adults in a supportive environment. Activities are planned to meet the needs and abilities of each child in the class.

Our goal is to provide your child with a positive first school experience where she/he enjoys learning. Together, we can build your child's foundation for a lifetime of learning!

**Bellevue City Schools**

**PRESCHOOL REGISTRATION FORM**

*Please complete ALL sections*

Date of Application

Legal Last Name	First	Middle	Suffix	Grade
Address		City	Zip	
EMS ID (Office Use Only)		Phone: <input type="checkbox"/> unlisted	Cell:	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	City of Birth	County of Residence	

Ethnicity: Is this student Hispanic/Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes, Hispanic/Latino	(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other:
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**Race: Regardless of what you selected above, please continue to answer the following by marking one or more of the boxes you consider your child's race to be:**

- A** Asian (Origins in any of the original peoples of the Far East or the Indian subcontinent)
- B** Black or African American (Origin in any of the black racial groups of Africa)
- I** American Indian or Alaskan Native (Origin in any of the original people of North/South America, including Central America)
- P** Native Hawaiian or Pacific Islander (Origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands)
- W** White (Origins in any of the original peoples of Europe, North Africa, or the Middle East)

**Father's information (do not list step-father)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

**Mother's Information (do not list step-mother)**

Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

**Legal Guardian (if other than parents listed above) attach legal documentation**

Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Marital Status of Parents:  Married  Single  Separated  Divorced  Remarried  Widowed  Never Married

Student resides with:  Biological/Adoptive Parents  Mother only  Father only  Grandparents  
 Mother/Stepfather  Father/Stepmother  Foster Family  Other:

*If parents are divorced or legally separated who is custodial parent? Please circle Father Mother Joint Custody*

**SIBLINGS**

Name:	Age	Name	Age
Name:	Age	Name	Age
Name:	Age	Name	Age

**Student Education Information**

Has student previously attended preschool/daycare?  No  Yes If, yes, Program: \_\_\_\_\_

Is child currently receiving any special education programs or services:  No  Yes If yes, check the following:

_____ Autism	_____ OHI--Other Health Impaired
_____ CD--Cognitive Disability	_____ SLD--Specific Learning Disability
_____ Deafness--Hearing Impairment	_____ Speech/Language
_____ ED--Emotional Disturbance	_____ TBI--Traumatic Brain Injury
_____ MD--Multiple Disabilities	_____ VI--Visually Impaired
_____ OH--Orthopedic Handicap	_____ DD--Development Delay

**Former School Information**

Name of School District \_\_\_\_\_

Name of Previous School attended: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

**Personal Preferences**

Class Choice: (1) AM (2) PM \_\_\_\_\_ I am interested in fewer than 5 days per week.

(Please circle the preferred choice. Class choice is not guaranteed.)

List of people authorized to pick up your child from school (must be over 18 years of age).

NAME

RELATIONSHIP

Phone #

In accordance with Rule 3301-37-04 of the Ohio Revised Code, a roster for each classroom, which includes names, addresses and telephone numbers of parent(s)/guardian(s) of children attending the preschool program must be prepared annually and given to parents/guardians upon request, but to no other person.

I **would/would not** (please circle one) like my name and telephone number to be included in this roster.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**To the best of my knowledge, the above information is correct and may be filed with my my child's records.**

Signature of Person Enrolling Student \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Date \_\_\_\_\_

Superintendent \_\_\_\_\_

Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

_____ Birth Certificate
_____ Immunization Record
_____ Proof of Residency
_____ Custody Papers

**ENROLLMENT INFORMATION**

Placement: _____
Teacher: _____
Poverty Level: _____
Start Date _____

**VERIFICATION OF INCOME**

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Birthdate

Verification of current employment and salary is needed in order to determine the preschool program tuition for your child.

List all household members, including the preschool child, and their family relationship

_____	_____
_____	_____
_____	_____

Total yearly gross household income \_\_\_\_\_

Please attach one of the following:

- \_\_\_\_\_ W-2
- \_\_\_\_\_ 1040 Tax Form
- \_\_\_\_\_ Check stub
- \_\_\_\_\_ Other \_\_\_\_\_

Child is eligible for medical card:    YES    NO

SNAP or ODJFS financial assistance case number (if applicable) \_\_\_\_\_

\_\_\_\_\_  
Print name of parent/guardian

\_\_\_\_\_  
Street address, City, Zip

\_\_\_\_\_  
Home phone number

**Penalties for misrepresentation**

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for receipt of state funds, that program officials may verify the information on the application, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal laws.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

**For Office Use**

\_\_\_\_\_  
Signature of person verifying income

\_\_\_\_\_  
Date

# EMERGENCY MEDICAL AUTHORIZATION FORM

Child's name \_\_\_\_\_ Grade Preschool  
Home Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_  
School district \_\_\_\_\_ Building \_\_\_\_\_

The purpose of this form is to enable parent(s)/guardian(s) to authorize the provision of emergency treatment for your child who becomes ill or injured while under school authority, when you cannot be reached.

## Residential parent(s)/guardian(s)

Mother/guardian name \_\_\_\_\_ Phone: Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_  
Father/guardian name \_\_\_\_\_ Phone: Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

Contact information if parents cannot be reached in case of emergency: **(2 contacts required)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_ Cell Number \_\_\_\_\_  
Address \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_ Cell Number \_\_\_\_\_  
Address \_\_\_\_\_

## PART I OR PART 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.

Physician \_\_\_\_\_ 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 doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This 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.

List below facts concerning your 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 treatment, I wish the school authorities to take the following action \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_

## CONSENT TO RELEASE CHILD'S PHOTO/VIDEO AND OTHER INFORMATION

To publicize the achievements of our preschool students and the great work they do, we like to occasionally publish our students' photos, activities, and/or achievements in our school publications or release the information to local newspapers. We may also post the information on the school's website. Student names will NOT be included with photos or news stories.

We understand that you may not want to have your child's photo, activities, and/or achievements published. Please fill out this form to let us know your wishes.

School district \_\_\_\_\_ Classroom teacher \_\_\_\_\_

Student's name \_\_\_\_\_

- I consent to have my child's photo, activities, and/or achievements published in school newspapers/newsletters, release to local newspapers, and posted on the school's website as it relates to activities and participation in the preschool program.
- I do not want my child's photo, activities, and/or achievements published in school newspapers and/or newsletters, released to local newspapers or posted on the school's website.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

### For Office Use

\_\_\_\_\_  
Signature of preschool teacher

\_\_\_\_\_  
Date

Office of Early Learning and School Readiness

**Child Medical Statement**

Childs' Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Limitations or health condition (including allergies, medications, dietary restrictions)


Immunizations	Please circle one	
	Complete for age	Yes
In Process	Yes	No

Exempt from Immunizations	Please circle one	
	Religious conviction	Yes
Health concern	Yes	No
Other:		

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

Signature of examining Physician/ Physicians Assistant or Advanced Practice Nurse (circle one)	Date of exam
Address :	
Phone:	

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program			Reason not completed (Check which applies)		
Assessments/Screenings	Completed Please circle one		Date Completed	Health professional decision	Examples: religious conviction, insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

## DENTAL HEALTH RECORD

Child's name \_\_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_

Parent/guardian name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

1. Has the child previously seen a dentist?  No  Yes Dentist's Name \_\_\_\_\_
2. Does the child have any trouble with teeth, gums, or mouth?  No  Yes
3. Oral condition before treatment: Missing  Decayed  Filled
4. Examination and treatment record

tooth letter	surface	description of work	date service performed	procedure number

8. Is baby bottle tooth decay present?  No  Yes
9. Is the child receiving: Topical Fluoride Application?  No  Yes  
     Fluoride Supplement Diet?  No  Yes If yes, tablets \_\_\_ liquid \_\_\_  
     Fluoridated water?  No  Yes
10. Is all planned treatment complete?  No  Yes If not, itemize on chart below.

tooth letter	surface	description of work

11. Approximate number of visits required for treatment? \_\_\_\_\_
12. Next scheduled appointment \_\_\_\_\_
13. Comments: \_\_\_\_\_

Dentist's Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date of examination \_\_\_\_\_