WICKLIFFE CITY SCHOOL DISTRICT

Inspiring Students to Learn, Lead, and Serve

Documentation Required to Enroll Children in Preschool	
	All registration forms must be fully completed for each child
	Proof of Residency must be provided
	Birth Certificate for each child-(copy)
	Parent/Guardian ID-(copy)
	Custody Papers for each child (if applicable)-(copy)
	Copy of IEP (if child has special needs)-(copy)
	Medical Statement/Physician signature-included in packet
	Current Immunization Records for each child

ACCEPTABLE FORMS OF PROOF OF RESIDENCY

- Utility Bill (Telephone bill, cable bill and mortgage statement not accepted as proof of residency)
  □ Gas □ Electric □ Water
- Rental Agreement / Purchase Agreement / Construction Agreement
- Notarized Letter from Homeowner

(REGISTRATION MAILING ADDRESS)

WICKLIFFE ELEMENTARY

1821 Lincoln Road
Wickliffe, OH 44092

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ENROLLMENT FORM

Important! Read before completing this form.

The laws of the State of Ohio (Ohio Revised Coed Section 3313.64, 3313.08, 3319.04, 3327.06) provide that a school age child under the age of 18 years can attend school only in the district in which his/her parent(s) or other court appointed guardian have established legal residence.

Children found to be attending school in defiance of the residency conditions set forth above are to be removed from the school district rolls and not to be permitted to continue to attend in that district. The District reserves the right to charge tuition for student attendance in violation of the residency requirement.

Date:_____ School Year:_____ Is this a temporary address? _____

Student Information					
Last Name	**First Name**	**Middle Name**	**Date of Birth**	**Gender**	**Birth City**

Student lives with: ☐ Both parents (same residence) ☐ Both parents (shared custody)

☐ Biological Mother ☐ Biological Father ☐ Relative/Guardian ☐ Court Placement ☐ Other _____

Residential Parent / Guardian Information	
☐ Mother ☐ Father ☐ Guardian ☐ Other	☐ Mother ☐ Father ☐ Guardian ☐ Other
Name:	Name:
Address:	
City: State: Zip:	
Home Phone:	
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:

Non-Residential Parent Information – if Applicable	
Select Relationship: ☐ Mother ☐ Father	
Name:	Home Phone:
Address:	Work Phone:
Email:	Cell Phone:

Student ethnic background **(If a selection is not made, the child will be classified as Multi-Racial)**

Is student Hispanic/Latino? Yes ☐ No ☐ Please further indicate student's ethnicity by selecting **ALL** that apply:

☐American Indian-Alaskan Native ☐ Asian ☐ Black/African American

☐White ☐Native Hawaiian/Pacific Islander (Multiracial- choose all that apply)

HEALTH RECORD

Rule 3301-37-05 of the Administrative Code requires preschool programs to secure health information from a child's parent no later than the first day of attendance unless otherwise indicated.

Name of Child (print or type)	Date of Birth	Name of Parent or Guardian

1. Allergies (List all allergies affecting the child and any special precautions or treatments indicated for these allergies). _____

2. Medications (List all medications currently being administered to the child). _____

3. Chronic Physical Problems (List all chronic physical problems affecting the child). _____

4. History of Hospitalizations (List dates of all hospitalizations of the child). _____

5. Diseases (List all diseases the child has had). _____

6. Please list any dietary supplements and/or fluoride supplements._____

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Statement of Understanding

I, _____, state the following to be true:

1. I am the parent/guardian and legal custodian of the minor child(ren) listed:

Name	Birth date
_____	_____
_____	_____
_____	_____

2. My residence is _____ and I intend to reside there on a permanent basis with the above-referenced child(ren). I began residence at this location on _____, _____; and intend on continuing to reside at this location.

3. I rent/own/other (circle one) the real property where I reside;
   Should another situation exist, please explain:
   _____
   _____

4. I do not maintain a primary residence outside of the _____ Local School District boundaries;

5. I have provided the _____Local School District registration personnel an official copy of any and all current court orders from the Domestic Relations, Juvenile, Probate or any other Court which has exercised jurisdiction over the custody or residency of the child(ren) which are being registered with the Local Schools;

6. The child(ren) which are being registered are not currently expelled or excluded from any other school;

7. I agree to immediately inform the School District, Office of the Supervisor of Student Services, of any change in my residence and/or standing as legal custodian and/or legal guardian of the child(ren) which are being registered, and to provide a certified copy of any court order which affects the custody or residency of said child(ren), which may be issued in the future.

_____ _____

Parent/Guardian Date

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EMERGENCY MEDICAL CONTACTS AND TRANSPORTATION AUTHORIZATION

TO BE COMPLETED BY ADULT HAVING LEGAL AUTHORITY OVER THE STUDENT

The purpose of this form is 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.

Student Name_____ Date of Birth_____ Home Phone_____
(Last) (First) (Area Code)
Address _____ City_____ Zip Code_____

In situations where the parent cannot be reached the student may be released to the following:

Name:_____ Relationship:_____ Daytime Phone:_____Cell:_____

Name:_____ Relationship:_____ Daytime Phone:_____Cell:_____

Name:_____ Relationship:_____ Daytime Phone:_____Cell:_____

PART I - TO GRANT CONSENT

I hereby give my consent for the following medical care providers and local hospital/emergency room to be called:

Doctor:_____Phone:_____Dentist:_____Phone:_____

Medical Specialist:_____ Phone:_____Local Hospital:_____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 the 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. 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.

Signature of custodial/residential parent:_____**Date**_____

PART II - DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

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 custodial/residential parent:_____

Address:_____**Date**:_____

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PARENT ROSTER INFORMATION

In accordance with Rules 5101:2-12-54 of the Ohio Administrative Code, a roster for each group of children, which includes names and telephone numbers of parents, custodians, or guardians of children attending the center must be prepared annually and given to parents, custodians, or guardians upon request.

I _____would like my name and telephone number to be included on this roster.

I _____would **not** like my name and telephone number to be included on this roster.

_____ _____

Signature **Date**

PHOTOGRAPH, VIDEO, AND INTERVIEW RELEASE

Child's Name:_____

I hereby give permission to use photographs/videos of me and/or my family and information obtained through personal interviews in any of their publications, press releases, marketing, fundraising or community relations activities.

Signature: _____

Relationship to Subject: _____

AUTHORIZATION TO RELEASE FORM

If I am unavailable, the following people have permission to pick up my child,

Name:	
Address:	City:
Home Phone:	Cell :

Name:	
Address:	City:
Home Phone:	Cell Phone:

I understand that they will be asked for a photo ID and I am to call ahead if I am unable to pick up my child.

_____ _____

Parent Signature **Date**

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DEVELOPMENTAL AND HEALTH SCREENING PARENTAL CONSENT

The Ohio Department of Education's Office of Early Childhood & School Readiness requires that each child obtain a health screening and developmental screening. Therefore, I understand that in order for my child to participate in the preschool program he or she will be screened at school within the first 60 days.

Parent Signature _____ **Date** _____

PARENT INTERVIEW

Name of Child: _____ Date: _____

FAMILY STATUS

Is this child your ☐ Natural ☐ Adopted ☐ Foster child?

Is there any divorce? ☐ Yes ☐ No

Have there been any deaths in immediate family? ☐ Yes ☐ No

Are you working with any other community service that you would like us to know about? List agencies. _____

_____

What does your child like to play with at home? _____

_____

_____

Does your child play with friends outside the home other than school? _____

_____

Does your child participate in outings such as shopping, visiting relatives, etc.? _____

_____

Describe the way in which you handle behavior problems? _____

_____

_____

Is there anything else that you would like us to know about your child? _____

_____

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List all school aged siblings/step-siblings who live at home with the child for whom this form is being completed

First Name	Last Name	M.I.	Gender	Age	Birth Date	Legal Guardian

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We are required by the Ohio Department of Education to report income levels for families of ALL students enrolled in ODE licensed preschool programs. Following are the Poverty Guidelines published by the US Dept of Health and Human Services. *Please circle the appropriate family size unit and income level for your household.* Please note these are annual amounts. If your household brings in more than the amount in the 200% column, just write the word "more" in the outside margin and circle it. We do not need to know the amount. YOU MAY CHOOSE TO DO AS INSTRUCTED ABOVE OR CHECK THE REFUSE TO ANSWER BELOW. EITHER WAY WE MUST RECEIVE THIS FORM BACK FROM YOU.

Please return this form with other registration materials.

Student Name _____

United States Department of Health and Human Services

FEDERAL POVERTY GUIDELINES*

Size of Family Unit	100% Poverty Level	101% - 125% Poverty Level	126% - 150% Poverty Level	151% - 175% Poverty Level	176% - 200% Poverty Level
1	0-$12,140	$12,141- 15,175	$15,176- 18,210	$18,211- 21,245	$21,246- 24,280
2	0-$16,460	$16,461- 20,575	$20,576- 24,690	$24,691- 28,805	$28,806- 32,920
3	0-$20,780	$20,781- 25,975	$25,976- 31,170	$31,171- 36,365	$36,366- 41,560
4	0-$25,100	$25,101- 31,375	$31,376- 37,650	$37,651- 43,925	$43,926- 50,200
5	0-$29,420	$29,421- 36,775	$36,776- 44,130	$44,131- 51,485	$51,486- 58,840
6	0-$33,740	$33,741- 42,175	$42,176- 50,610	$50,611- 59,045	$59,046- 67,480
7	0-$38,060	$38,061- 47,575	$47,576- 57,090	$57,091- 66,605	$66,606- 76,120
8	0-$42,380	$42,381- 52,975	$52,976- 63,570	$63,571- 74,165	$74,166- 84,760

* Annual Family Income

_____ **Refuse to Answer**

Parent/Guardian Signature _____ Date:_____

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MEDICAL STATEMENT

1. Based on his/her medical history and physical condition at the time of this examination, this child is free from apparent communicable disease and is in suitable condition for enrollment in a preschool program. *As required by Rules 5101:2-12-37 and 5101:2-13-37, the child must be examined within **thirteen months** prior to the date of admission.*

Child's Name:_____ Birth Date:_____

Present Age:_____ **Exam Date**:_____

Sex: ☐ M ☐ F Height_____ Weight_____

Vision screening date_____ (if applicable) Hearing screening date_____ (if applicable)

2. This is to certify that I have examined this child and found that: This child has had the immunizations required by section 3313.571 of the Ohio Revised Code for admission to school, or has had the immunizations required by the state department of health according to the child's age, or is to be exempted from these requirements for medical or religious reasons. (Please provide documentation for exemptions.)

IMMUNIZATION RECORD: (Enter month/day/year of each immunization)				
DTP	**Polio**	**HIB**	**MMR**	**HEP B**
1.	**1.**	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**	**2.**
3.	**3.**	**3.**		**3.**
4.	**4.**	**4.**	**TB Test**	**Vercelli**
5.			**1.**	**1.**

Name of Physician (please print or stamp)_____ Phone:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Signature of Examining Physician _____ **Date:**_____

DENTIST INFORMATION

Name of Dentist (please print)_____ Phone:_____

Street Address:_____ City:_____ State:_____ Zip Code:_____

Education Rights of Homeless Students - McKinney-Vento Act

What is McKinney-Vento?

The McKinney-Vento Homeless Assistance Act is the primary federal (U.S) law dealing with the education of children and youth in homeless situations. The McKinney-Vento Act protects the right of homeless children and youth to get to, stay in, and be successful in school while they or their families are homeless. The law focuses on maintaining school stability and school access and providing support for academic success for homeless kids. The law also requires schools and states to use child-centered, best-interest decision making when working with homeless children and their families to choose a homeless child's school, services, and other needed resources.

Tuition Information

- Tuition statements will be mailed approximately the 15th of each month
- Children will be removed from the program if payment is not received in reasonable time
- Payment/ deposit (if applicable) can be made in the following ways:
    - can be made by cash or checks payable to Wickliffe Elementary School. Please write the student's name on the memo line