LORAIN CITY SCHOOLS

LORAIN CITY SCHOOLS PRESCHOOL REGISTRATION PACKET

To register for preschool, please create or update your account at https:/.lorain-oh.finalforms.com/
You will then be required to upload the following documents:

ENCLOSED FORMS:

- ☐ APPLICATION
- ☐ PHYSICAL/DENTAL FORM
- ☐ STATEMENT OF ZERO INCOME (IF NO INCOME REPORTED)

INCOME VERIFICATION

- ☐ LAST 30 DYAS OF PAYS FOR ADULTS WORKING
- ☐ MOST RECENT W2 OR 1040 TAX FORM
- ☐ CASE PROFILE FROM JOBS & FAM. SERVICES OR LMHA
- ☐ SOCIAL SECURITY AWARD LETTER
- ☐ STATEMENT OF SUPPORT IF SOMEONE IS SUPPORTING YOU
- ☐ CHILD SUPPORT PRINTOUT

IDENTIFICATION/CUSTODY DOCUMENTS

- ☐ CHILD'S BIRTH CERTIFICATE
- ☐ GUARDIANSHIP/CUSTODY DOCUMENTS (IF APPLICABLE)
- ☐ CHILD'S SHOT RECORD
- ☐ CHILD'S SOCIAL SECURITY CARD
- ☐ PARENT/GUARDIAN ID
- ☐ MEDICAL INSURANCE CARD

RESIDENCY VERIFICATION

- ☐ CURRENT UTILITY BILL OR
- ☐ LEASE AGREEMENT/MORTGAGE OR
- ☐ CURRENT BANK STATEMENT OR
- ☐ GOVERNMENT LETTER

Please note, Lorain City Schools is able to provide high quality preschool, tuition free, due to Federal and State funding, which requires us to keep record of all of the above information. Slots are limited and we have designated half day classrooms for 3yr olds who do not turn 4 prior to **09/30**. Please complete the enclosed forms and upload all required documents (including enclosed forms) to Final Forms by clicking on the small black file folder to the right of your student's name. If you have any questions, feel free to contact us at apardon@lorainschools.org or kdimacchia@lorainschools.org or 440-830-4111.

Reset Form

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBLITY SCREENING TOOL

Tell us about you (the applicant)

First Name	MI	Last Name	
Address			Today's Date
City	State	County	Zip Code
Phone Number ( )	Additional Phone Number ( )	E-mail Address	

Tell us about the people in your home

Name *(First, Middle, Last)*	**Relationship to You** (*spouse, son, friend, etc.*)	**Race**	**Hispanic or Latino** *Y or N*	**Spoken Language**	**Date of Birth**	**Gender** *M or F*	**U.S. Citizen** *Y or N*
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					

Child 1	Provider Name and Address	What hours/days do you need services? (i.e. child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Child 2	Provider Name and Address	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Child 3	Provider Name and Address	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Tell us about your finances

Will you or the people in your home receive income this month? ☐ Yes ☐ No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

Name	**Type of Income**	**Amount of Income** *(before taxes)*	**How Often Received** *(weekly, bi-weekly, etc)*	**Date Last Received**	**Work or School Schedule** *(please list times)*
					☐ Sun _____ ☐ Thurs _____ ☐ Mon _____ ☐ Fri _____ ☐ Tues _____ ☐ Sat _____ ☐ Wed _____
					☐ Sun _____ ☐ Thurs _____ ☐ Mon _____ ☐ Fri _____ ☐ Tues _____ ☐ Sat _____ ☐ Wed _____
					☐ Sun _____ ☐ Thurs _____ ☐ Mon _____ ☐ Fri _____ ☐ Tues _____ ☐ Sat _____ ☐ Wed _____
					☐ Sun _____ ☐ Thurs _____ ☐ Mon _____ ☐ Fri _____ ☐ Tues _____ ☐ Sat _____ ☐ Wed _____
					☐ Sun _____ ☐ Thurs _____ ☐ Mon _____ ☐ Fri _____ ☐ Tues _____ ☐ Sat _____ ☐ Wed _____

Do you or anyone in your household pay Child or Spousal Support? ☐ **Yes** ☐ **No**

How Much?

Signature of Applicant	**Date**

Early Childhood Education Grant
Zero Income and McKinney-Vento Statement

Families with no income must provide a written explanation of how they are meeting basic living expenses, including food, housing/shelter, utilities and transportation.

The McKinney-Vento Act provides resources for children of families that are experiencing homelessness. Preschool students experiencing homelessness are eligible for immediate enrollment in programs with Title 1 funding. Homelessness is defined as:

Individuals who lack a fixed, regular, or adequate nighttime residence and includes:

1. *Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;*
2. *Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation;*
3. *Children who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and*
4. *Migratory children who qualify as homeless because they are living in circumstances described in 1-3 above.*

I, _____, verify that neither I nor any member of my family earns/receives any income.

I, _____, verify that my family meets the definition of homelessness.

Briefly describe how your family is meeting food, housing, utilities and transportation needs:

I certify that the information above is complete and accurate to the best of my knowledge. I understand that if I knowingly give false information or misrepresentation of my income, it may result in disqualification.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Witness Printed Name: _____

Witness Signature: _____Date: _____

CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

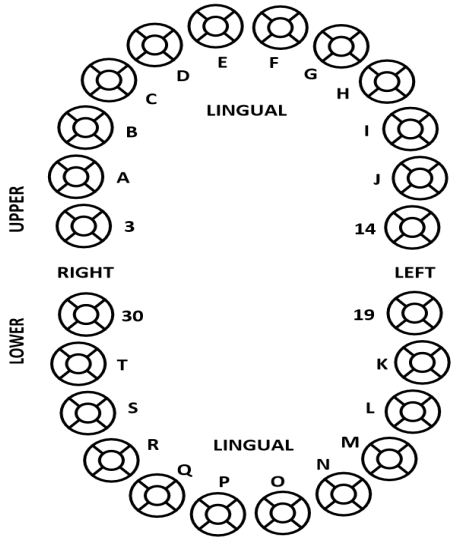
CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

ADDRESS:_____ PHONE:_____

1. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAT THE PARENT KNOWS ABOUT?

2. PAYMENT/INSURANCE INFORMATION:

3. ORAL CONDITIONS BEFORE TREATMENT:
missing (⊗), decayed (○), or filled (●); indicate restorations you perform in item 4.



4. EXAMINATION AND TREATMENT RECORD (*List recommended services in order*)

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Services Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

***DATE* DENTAL SERVICES PROVIDED: _____**

EXAM _____ FLUORIDE _____ PROPHY _____ X-RAYS _____ SEALANTS _____

TREATMENT (restoration, pulp therapy, extraction, etc) _____ *(See section below if treatment is not complete)*

OTHER _____ **DATE OF NEXT ROUTINE EXAM:** _____

DENTAL SERVICES NEEDED:

EXAM _____ FLUORIDE _____ PROPHY _____ X-RAYS _____ SEALANTS _____ OTHER _____

TREATMENT (restoration, pulp therapy, extraction, etc) _____ REFERRAL _____

Approximate number of visits to complete treatment: _____

Dates of scheduled appointment(s):_____

SUMMARY OF DENTAL SERVICES:

_____ All planned treatment **is** complete

_____ All planned treatment **is NOT** complete

_____ Treatment was Referred

_____ No treatment needed at this time; routine recall visits

Provider Signature _____ **Date** _____

Ohio | Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 3/12/2018

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

Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Immunizations:		**Exempt from Immunization:**	
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 Address _____

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.