EARLY CHILDHOOD EDUCATION
136 South Ludlow Street
Dayton Ohio 45402
(937) 542-3034 Fax: (937) 542-3240

Dear Parent/Guardian:

Thank you for choosing the Early Childhood Education Program (ECE) with Dayton Public Schools.
The ECE registration will be held at the Student Enrollment Center 136 S. Ludlow St 45402. Please allow at least thirty minutes to complete the paperwork. You will need to bring the following documents and required information at the time of registration to be considered for the Dayton Public Schools Preschool Programs:

1. **Legal birth certificate**
2. **Picture I.D.** (driver's license or state identification)
3. **Legal custody documentation, if applicable** (divorce decree, Children Services documents, etc.)
4. **Proof of residency, dated within the last 60 days** (utility bill, lease agreement, mortgage statement or other legal documentation)
5. **Completed shot record** (must have **(4) DPT's or DTaP shots, (3) Polio, (1) MMR, (3) HIB** *three or four doses depending on the vaccine type, the age when the child began the 1st dose*, **(3) Hep B and (1) Varicella** *(Chickenpox)*
6. **Physical check-up for your child** (The State of Ohio requires that we have a physical on file for each student. Please see that your child has a complete physical check-up. Enclosed is the form that the doctor must complete and sign.)
7. **Proof of Income** (Check-stub, W2, Social Security Statement)
8. **Dental check-up form for your child**
9. **Name and telephone numbers of two emergency contacts**
10. **Name, address and telephone numbers of your child's doctor and dentist**
11. **Childcare provider's name, address and phone number,** if applicable

We look forward to meeting you. If you have any questions or concerns, please call the Preschool Department at (937) 542-3034 or Student Enrollment (937) 542-5555.

Sincerely,

Student Enrollment Center

Student Enrollment Form

☐ Re-Enrollment ☐ Never Enrolled at DPS

DAYTON PUBLIC SCHOOLS

136 S. Ludlow Street, Dayton, Ohio 45402 (937) 542-5555

Grade:_____ Student's Legal Name: _____ Nickname:_____
For DPS Placement *First Name* *Middle Name* *Last Name* *Suffix (Generation)*

Language(s) Student Uses In Home:_____ Student's Native Language:_____ Language of Correspondence_____

Gender: Male or Female Birthdate: ☐☐☐☐☐☐☐☐☐☐ Birthplace: _____
Month Day Year *City State Country*

Is student of Hispanic/Latino origin, regardless of race? ☐ Yes ☐ No

Race *(Select at Least One)*: ☐Black/African-American ☐White ☐Asian ☐American Indian/Alaska ☐Native Hawaiian/Other Pacific Islander

Apt. Number: _____ Physical Address: _____
Number Prefix Street Name City State Zip Code

Mailing Address*)*:_____ Student's Home Phone #:_____
(Complete if Different Than Above) *Number Prefix Street Name City State Zip Code*

Name of Most Recent School/District Attended:_____
Name Phone # Fax #

Is your child currently suspended? ☐Yes ☐No

If yes, from what district?_____

Is your child currently expelled? ☐Yes ☐No

If yes, from what district _____

What is the end date? _____

Does your child have a current IEP (Special Education)?
☐ Yes ☐ No

If yes, indicate the service(s) _____

Do you have a copy of the IEP and ETR? ☐ Yes ☐ No

If yes, what is the _____/_____/_____
Month Day Year

Does your child have a 504 plan? ☐Yes ☐No

If yes, indicate the service (s): _____

Are you or your child currently homeless, doubled-up for economic reasons (living in someone else's home), an unaccompanied youth (student living with and in the care of someone who is not the custodial adult) or a student in foster care? ☐Yes ☐No

Did your child participate in extracurricular sports at his/her previous school? ☐ Yes ☐ No

If yes, list the sports: _____

☐ Yes, I agree if I selected a school outside of my quadrant I will complete the transportation waiver and transport.my student(s).

Do either parent/guardian currently work for the military?
☐Yes ☐No **If yes**, is the student a dependent of a member of the Army, Navy, Air Force, Marine Corps or Coast Guard that is either:
☐Active Duty Forces ☐Reserve Duty Forces ☐National Guard

LANGUAGE USAGE SURVEY

1. In what language(s) would your family prefer to communicate with the school? _____

2. What language did your child learn first? _____
_____

3. What language does your child use the most at home?_____
_____

4. What languages are used in your home?_____
_____

5. Has your child ever received a formal education outside of the United States? ☐ Yes ☐ No

   If yes, how many years/months_____ and what was the language of instruction?_____

6. Has your child attended school in the United States?
   ☐ Yes ☐ No

   If yes, when did your child first attend a school in the United States? _____/_____/_____
   Month Day Year

Additional Information_____
_____

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: https://www2.ed.gov/about/offices/list/ocr/ellresources.htm

For Office Use Only

Assigned School Code_____ **Date**_____ **SY**_____

Student ID#_____ **Entry Code**_____ **Staff Initial**_____

Mission Statement

To equip our students to achieve success in a global society by implementing an effective and rigorous curriculum with fidelity

(10/27/21)

Student Enrollment Form

136 S. Ludlow Street, Dayton, Ohio 45402 (937) 542-5555

Parent(s)/Guardian Information: *the student lives with:* ☐Mother ☐Father ☐Stepparent ☐Foster Parent ☐Legal Guardian ☐Sibling
Check all that applies ☐Group Home ☐Self-independent *(18 or older)* ☐Host Parent *(foreign exchange student)*

Name: _____ Relationship to the Child:_____
First Name *Last Name*

Address: Is the parent/guardian's address the same as the students? ☐Yes ☐No **If yes**, skip the address information below

Apt. Number: _____ Address: _____
Number *Prefix* *Street Name* *City* *State* *Zip Code*

Completing this section ensures you will be notified of important information affecting your student(s):

☐Email_____ ☐Home Phone_____

☐Cell Phone_____ ☐Work Phone_____

Parent(s)/Guardian Information:

Name: _____ Relationship to the Child:_____
First Name *Last Name*

Address: Is the parent/guardian's address the same as the students? ☐Yes ☐No **If yes**, skip the address information below

Apt. Number: _____ Address: _____
Number *Prefix* *Street Name* *City* *State* *Zip Code*

Completing this section ensures you will be notified of important information affecting your student(s):

☐Email_____ ☐Home Phone_____

☐Cell Phone_____ ☐Work Phone_____

List all other students currently attending Dayton Public Schools

NAME	GRADE	RELATIONSHIP TO CHILD	CURRENT SCHOOL

EMERGENCY CONTACT NUMBERS:

In case of emergency, illness or accident to _____ (child's name), the school is authorized to proceed as indicated below.

Contact #1: Name:_____ Relationship to Student:_____

Address *(If different from above)*:_____ Phone *(Home, work, cell)*:_____

Contact #2: Name:_____ Relationship to Student:_____

Address *(If different from above)*:_____ Phone *(Home, work, cell)*:_____

Contact #3: Name:_____ Relationship to Student:_____

Address *(If different from above)*:_____ Phone *(Home, work, cell)*:_____

My child should never be released to the following person(s):_____

As a parent/guardian of a student enrolled at Dayton Public Schools, I agree to review the District's Student Code of Conduct and understand that my child is responsible for behaving responsibly. The Student Code of Conduct will be provided to your child at his/her assigned school and is available on the District's website. My signature indicates I hereby certify, under penalty of perjury, that all of the information given is correct in all respects to the best of your knowledge.

Parent/Legal Guardian/Independent Student:_____ Date:_____

Dayton Public Schools Preschool Programs Health History

Child's Name _____ **Birth date** _____ **School** _____

Name of medical insurance: None_____ **Primary** _____ **Secondary** _____

Prenatal History

_____

Birth Weight _____lbs. _____oz.

Full Term ☐ Premature ☐ Late ☐

Did you receive prenatal care during the

☐ 1st ☐ 2nd ☐ 3rd trimester?

Mother's age at birth _____

Were drugs/alcohol used during pregnancy ☐ Yes ☐ No

Did baby require oxygen ☐ Yes ☐ No

Any feeding problems ☐ Yes ☐ No

Was infant breast-fed ☐ Yes ☐ No

Have jaundice ☐ Yes ☐ No

Birth defects/problems ☐ Yes ☐ No

If yes, please list

_____

_____

Does your child have any unusual birthmarks or "blue spots"? ☐ Yes ☐ No

Growth/Development

What age did your child?

Crawl_____ Sit alone_____

Walk _____ Dress self_____

Speak with meaning_____

Stop using a bottle_____

Is your child toilet trained?

☐ Yes ☐ No If yes, at what age_____

Does child wear diapers or pull-ups?

☐ Yes ☐ No

How often does your child have toileting accidents?_____

Physician/Dentist

Physician/Clinic

Name_____

Address_____

Telephone_____

Dentist/Clinic

Name_____

Address_____

Telephone_____

Does child have any of the following?

Missing Teeth ☐ Yes ☐ No

Dental Caps ☐ Yes ☐ No

Loose Teeth ☐ Yes ☐ No

Health History

Cavities ☐ Yes ☐ No

Difficulty Eating ☐ Yes ☐ No

Other Dental Problems ☐ Yes ☐ No

Describe_____

How often does your child brush teeth?

_____

Has your child ever been seen by a dentist?

☐ Yes ☐ No

Has your child had any of the following?

Allergies ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Bleeding Tendencies ☐ Yes ☐ No

Bone/Joint Disorders ☐ Yes ☐ No

Broken Bones ☐ Yes ☐ No

Chicken Pox ☐ Yes ☐ No

Developmental Delays ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Ear Infections, 3 or more ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

Hearing Difficulties ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Meningitis ☐ Yes ☐ No

MRSA ☐ Yes ☐ No

Nervous Habits ☐ Yes ☐ No

Over Weight ☐ Yes ☐ No

Phobias (Fears) ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Seizures ☐ Yes ☐ No

Sickle Cell Disease ☐ Yes ☐ No

Sickle Cell Trait ☐ Yes ☐ No

Skin Rashes/Infections ☐ Yes ☐ No

Speech/Language Impairment ☐ Yes ☐ No

Tonsil Surgery ☐ Yes ☐ No

Allergies (Identify)

Trouble Sleeping ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No

Urinary Infections ☐ Yes ☐ No

Whooping Cough ☐ Yes ☐ No

Emotional Problems ☐ Yes ☐ No

If yes, explain_____

_____

Exhibit destructive behavior ☐ Yes ☐ No

If yes, explain_____

_____

Surgery/Hospital Stay ☐ Yes ☐ No

If yes, what kind and date

_____

Has your child ever had a serious accident- broken bones, head injuries falls and/or burns?

☐ Yes ☐ No

If yes, explain_____

_____

List any diseases or conditions not listed:

_____

_____

Does your child have any allergies to the following?

Drugs_____

Plants/Animals_____

_____

Does your child take medication for allergies?

_____

Name of medication_____

_____

_____

Taken how often_____

Nutrition History

Is your child on a special diet? ☐ Yes ☐ No

If yes, explain_____

_____

Does your child have any food allergies?

☐ Yes ☐ No If yes, explain_____

_____

I understand that if my child has a medical or religious need for a special diet, I must submit the required form before my child may start.

Parent/Guardian _____ Date _____

Staff _____ Date _____

Does your child eat any non-food items? ☐ Yes ☐ No If yes, explain_____

_____
___

Does your child take vitamins? ☐ Yes ☐ No If yes, were they prescribed? ☐ Yes ☐ No

Does your child receive WIC? ☐ Yes ☐ No

Medication/Treatment

List medications taken daily or frequently

_____
___
_____
___
_____
___
_____
___

Taken how often_____

If your child receives therapy, what type and where?

_____
___
_____
___
_____
___

Does your child use an EpiPen? ☐ Yes ☐ No

Other Information

Does your child have any of the following?

Glasses ☐ Yes ☐ No

Tubes in ear(s) ☐ Yes ☐ No

Right: _____ Left: _____ Both: _____

I understand that if my child has a medical or religious need for a special diet, I must submit the required form before my child may start.

Parent/Guardian _____ Date _____

Staff _____ Date _____

Please Print

Dayton Public Schools
EMERGENCY MEDICAL AUTHORIZATION

Student's Last Name | First | Middle | Sex | Date of Birth | Home Phone

Student's Address | Zip

Father/Guardian | Employed by | Work Phone

Mother/Guardian | Employed by | Work Phone

ALTERNATIVE PERSONS TO BE NOTIFIED WHEN PARENTS CANNOT BE REACHED

(1.) Name | Phone (2.) Name | Phone

COMPLETE PART I, II, AND III. IF REFUSING CONSENT, COMPLETE PART IV.

PART I: CONSENT GRANTED

Parent/Guardian | Phone

Parent/Guardian at Phone have been unsuccessful, I hereby give my consent for: (1). Administration of any treatment deemed necessary by Dr. Preferred Physician | Phone (Optional) or Dr. Preferred Dentist | Phone (Optional) 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: Preferred Hospital or any hospital reasonably accessible.

THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS/DENTISTS CONCURRING IN THE NECESSITY FOR SUCH SURGERY ARE OBTAINED BEFORE SURGERY IS PERFORMED. PLEASE LIST BELOW FACTS CONCERNING THE CHILD'S MEDICAL HISTORY OR ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED. THE DAYTON PUBLIC SCHOOLS IS WORKING IN COLLABORATION WITH THE CENTER FOR HEALTHY COMMUNITIES TO IMPROVE ACCESS TO HEALTHCARE. TO DO THIS WORK, WE SHARE INFORMATION WITH OTHER LICENSED HEALTHCARE PROVIDERS AND/OR MEDICAID.

Has your child ever had (Please (√) check all that apply):

Heart Trouble_____ Asthma _____ Epilepsy (Seizures)_____ Diabetes (Sugar) _____ Other _____

Explain any allergy or disease causing difficulty: _____

X _____ **Signature of Parent/Guardian** | _____ **Address** | _____ **Date**

COPY OF OHIO REVISED CODE ON BACK OF THIS FORM

PART II: HEALTH INSURANCE

Do you have health insurance for your child(ren) age 19 and younger?

☐ Yes ☐ No

Insurance Provider_____

PART III: STUDENT'S MEDICATIONS

Does child **regularly** take prescribed medications? ☐ Yes ☐ No

If yes, please list medications:

_____

_____

_____

_____

_____

_____

Are any medications given during school hours?

☐ Yes ☐ No

(If yes, please obtain the Medication Administration form at your child's school.)

PART IV: CONSENT REFUSED

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 *NO ACTION OR TO:*_____

_____

_____

Signature of Parent/Guardian

_____

Address

_____

Date

Revised 3/11/16

DAYTON PUBLIC SCHOOLS

Student Enrollment Center
136 S. Ludlow St., Dayton, OH 45402
Telephone (937) 542-5555 Fax (937)542-3202

DAYTON PUBLIC SCHOOLS PRESCHOOL MEDICAL FORM

Child's Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____

EXAM RESULTS:

	Normal	Abnormal	Not Examined
General Appearance			
Posture, Gait			
Behavior			
Skin			
Hair			
Eyes: External			
Eyes: Optic Fundi			
Ears: External & Canals			
Ears: Tympanic Membranes			
Nose, Mouth, & Pharynx			
Teeth			
Heart			
Lungs			
Abdomen (include hernias)			
Genitalia			
Bones, Joints, Muscles			
Neurological			

Blood Pressure_____/_____

Vision:
Stereopsis (Random Dot E) - Pass or Fail, Not tested

Distance Acuity:
Right eye___/___ **Left eye**____/___

Hearing: **PASS** **Rt ear** **Lt ear** **Both ears**
FAIL **Rt ear** **Lt ear** **Both ears**

Laboratory Test	Date	Result
Lead Level*		
Hematocrit*		
Urine dipstick**		
Sickle Cell**		
TB Test**		

*Lab test only **required upon entry** into preschool program.
****Optional** Lab test.

***Please summarize abnormal findings including chronic physical problems, hospitalizations, or diseases. List treatment plan, services (therapy, medication, referrals):**

_____

_____

_____

***List Food Allergies, Restrictions or Modified Diets:**

_____

***List all Allergies/Treatment (include drug allergies):**

_____

Based upon the medical history and physical condition at the time of this examination, he/she is free from communicable diseases including Tuberculosis; and has received immunizations required by statute for admission to school under Section 3313.671 of the Revised Code, or has had the immunizations required by the State Department of Health for infants and toddlers. In addition the child is in suitable condition for enrollment in a day care center.

_____
DATE OF EXAM*
*Physical exam must have been done in the last 13 months and must be updated yearly for preschool.

IMMUNIZATION RECORD:
***Exempt from Immunizations:**
Medical/health concern: ❑**Yes** ❑**No**
Rationale: _____

Vaccine	Date (month/day/year)				
DPT					
Polio					
MMR					
Hepatitis A					
Hepatitis B					
Varicella					
HIB					
Pneumococcal					
Influenza (Flu)					
Other					

_____
Health Care Provider's Signature

Please Validate with Stamp
(Clinic name, address, phone)

***Additional forms may be required to address health concerns (e.g. medication, treatments, diet)**

School: _____

Program*: _____
*Preschool programs include: ECE, ECIP and Montessori

REQUIRED Screening:

Student Enrollment Center
136 S. Ludlow St. Dayton, Ohio 45402
Telephone: 937-542-5555 Fax: 937-542-3202

Dayton Public Schools Preschool Program

Title 1 ECE, ECIP, Montessori

Dental Form

Exam Date: ___/___/____ **Child's Name:** _____ **Birth date:** _____
School: _____

Exam Completed by: ☐ DMD ☐ RDH ☐ Other: Specify _____

Provider Setting: ☐ Doctor/Dentist/Clinic ☐ School/Center ☐ Other: Specify _____

Evaluation Type: ☐ Screening ☐ Exam

Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times per Day Child Brushes Teeth: _____

Uses Fluoride Toothpaste: ☐ Yes ☐ No **Takes Fluoride Supplement:** ☐ Yes ☐ No

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

General Comments on Oral Health: _____

Today's Visit:

- ☐ Visual Screening
- ☐ Full Exam
- ☐ X-Rays
- ☐ Cleaning
- ☐ Fluoride Treatment
- ☐ Oral Hygiene Instruction
- ☐ Treatment (specify)

_____
_____
_____
_____
_____

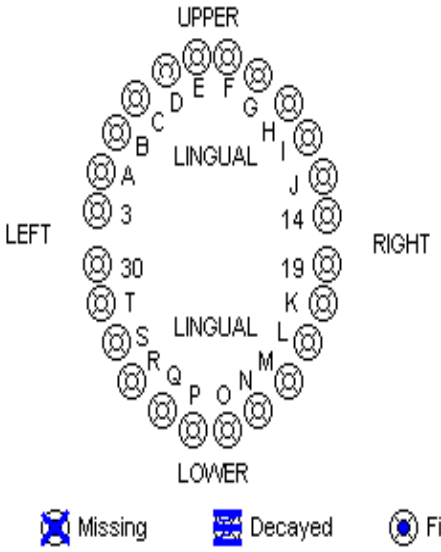
Treatment:

- ☐ No Needs
- ☐ Treatment Needed

Next Appointment Date:
_____/_____/_____

Treatment Plan:

_____
_____
_____
_____
_____



Provider Signature: _____ **Exam Completion Date:** ____/____/_____
Printed or Stamped Name/Address of Provider: _____
Address: _____ **Phone:** _____

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: _____