CIRCLEVILLE CITY SCHOOLS

PRESCHOOL REGISTRATION PACKET

2018-2019

Welcome to Circleville City Schools! To begin the enrollment process, you will need to contact our Preschool Administrator at 740.474.2495 ext. 49100. Once enrollment has been confirmed, an employee of our District Office will call you to set up an appointment to complete registration. Your child will NOT need to be present for the registration.

Please bring the completed packet and all required documents to your scheduled appointment. The list of required documents is available in the packet.

If you have any questions in regards to registering your child, please contact the District Office at 740.474.4340 ext. 48005. Our office hours are Monday through Friday 8:00 a.m. to 4:30 p.m.

CIRCLEVILLE CITY SCHOOLS
NEW STUDENT ENROLLMENT PROCEDURES

We want to welcome you to Circleville City Schools. Student registration is by appointment only. An employee of our District Office will call to schedule an appointment for registration. All new students must be registered by a custodial parent or legal guardian. The registration process includes the completion of enrollment forms as well as providing required documents. Lists of required documents are provided below. Registration will be considered incomplete until we have received all forms and required documentation.

Enrollment packets can be found on our website at www.circlevillecityschools.org and will be available at all buildings. To print the packet go to *Parent Resources* and click on *Student Registration*.

Kindergarten students must be five years old on or before August 1st.

- ☐ Custodial parent/ guardian photo I.D.
- ☐ Copy of Certified Birth Certificate
- ☐ Immunization Records
- ☐ Proof of Residency
    - Verification of your address must be provided through TWO (2) acceptable forms of documentation. Examples of acceptable forms of documentation include but are not limited to the following:
        - Official Rental/Lease Agreement
        - Property Tax Statement
        - Utility Bill (within 30 days)
            - *Only ONE (1) utility bill will be accepted for verification. You will need to provide us with another type of documentation for your second verification.*
        - Mortgage Coupon/ Closing Settlement Statement of purchase
        - Ohio Driver's License or State issued I.D.

OR

- ☐ Special Circumstances
    - Applicant resides with another person. The person with whom you are living with MUST COMPLETE THE RESIDENCE VERIFICATION AFFIDAVIT II form and have it notarized. They MUST ALSO PROVIDE PROOF OF RESIDENCY to school officials through TWO (2) acceptable forms of documentation. Acceptable forms of documentation include but are not limited to the examples above.
- ☐ Copy of Custody Orders, if parents are divorced and/or legally separated

ADDITIONAL PRESCHOOL ONLY REQUIREMENTS

~In addition to the documentation requested above, preschool parents will also need to provide the following documentation at the time of registration.

- ☐ Proof of Income- *if you are applying for the Tiger Cub Academy Preschool you will not need to provide proof of income*
  - Please bring in one of the following:
    - Individual Income Tax Form (current year)
    - Check stub (will need at least two consecutive copies)
    - Written statement from employer
    - Documentation of current status as recipients of public assistance
- ☐ Physical Examination Form
- ☐ Dental Health Record Form

Completing this preschool application does not necessarily guarantee that your child will be attending our program next school year. Proof of income must be verified and the application approved.

For Office Use Only:

- ☐ DASL
- ☐ Google Docs

Preschool Income Verification Level _____

Special Needs:

- ☐ Registration Form
- ☐ Records Request
- ☐ Copy of IEP
- ☐ Copy of ETR
- ☐ Foster Placed with Special Needs
- ☐ Scanned and Emailed forms

Foster Placed:

- ☐ Registration Form
- ☐ Foster Placed Paperwork
- ☐ Journal Entry
- ☐ Scanned and Emailed forms

Notes:

PRESCHOOL IMMUNIZATION REQUIREMENTS

Ohio State Law requires that the following immunizations be obtained for school enrollment. Students who do not have the required immunizations will be excluded from school per Ohio State Law until such record is provided. **You must bring an immunization record with the month/date/year for each of the shots below to preschool registration in order to complete enrollment requirements.**

4 - DTaP

3- Polio

1 - MMR

3 - Hepatitis B

1 - Varicella (chicken pox) – (or documentation of having disease)

Please contact your family physician or the Pickaway County Health Department at (740) 477-9667 to arrange for your child to receive an update on his/her immunizations. The health department might be able to provide vaccinations to your child for a minimal amount or on a sliding fee scale. You must call the Health Department at (740) 477-9667 to make an appointment. A parent (or legal guardian) and a copy of the child's current immunization record must accompany the child to the Health Department. If you have any questions concerning your child's immunizations, please contact the District School Nurse's office at (740) 474-2345, ext. 47048 or the Health Department at (740) 477-9667.

In closing, if your child has any serious medical concerns (i.e. seizures, diabetes, hemophilia, heart condition, etc.) or will require medication during school hours, please contact the District School Nurse's office at (740) 474-2495, ext. 49099 before the start of school and list this information on the Emergency Medical Form. There are certain permission forms that will need to be completed and it may be necessary to create a care plan to ensure your child's health at school. Please remember that student health information will be shared with school personnel unless you request otherwise. **In addition, all preschoolers will receive a vision and hearing screening in the fall as part of our school health program.** We look forward to meeting your child in the fall!

Thank you,

Jaime McKeivier, BSN, RN, LSN

District School Nurse

Circleville City Schools

740-474-2495, ext. 49099

jaime.mckeivier@cvcsd.com

REGISTRATION FORM

School Year: _____

Has your child ever been enrolled in the Circleville City School District? ☐ Yes ☐ No
If yes, what school building did they attend? _____

Student's Legal Name: _____
First Middle Last

Preferred Name: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Grade _____ Place of Birth: _____
City State Country

Home Address: _____County_____
Street # Lot #, Apartment#, P.O. Box City Zip

Primary Phone: _____ (This number will be used for the **OneCallNow Phone System**. This system is used for school delays, closings, special announcements, etc.)

Parent/Guardian Information:

Mother's Maiden Name: _____

Status of biological parents: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married

Student resides with: ☐ Mother ☐ Father ☐ Guardian

If divorced, who has legal custody? ☐ Mother ☐ Father ☐ Shared If shared, who is residential? _____

Are you the biological/adoptive parent (s) of the child? ☐ Yes ☐ No If no, what is your relationship to the child? _____

If foster/guardian, what district did the natural parent(s) reside in at the time you received custody? _____
(If other than Circleville, assignment of tuition is required)
Foster Agency:
_____
Case Worker: _____ **Phone:** _____

☐ Father ☐ Guardian
Please Check One

Name: _____

Address: _____

_____

Home Phone: _____
Cell: _____
Work: _____

Place of Employment: _____

☐ Mother ☐ Guardian
Please Check One

Name: _____

Address: _____

_____

Home Phone: _____
Cell: _____
Work: _____

Place of Employment: _____

REGISTRATION FORM

Step-Mother (if applicable): _____
Work Phone: _____
Cell: _____

Step-Father (if applicable) _____
Work Phone: _____
Cell: _____

Citizen Status of Student

☐ U.S. Citizen ☐ Non-U.S. Citizen ☐ Exchange Student

Racial/Ethnic Group

Is the student Hispanic or Latino? ☐ Yes ☐ No

What is the student's race? You must choose at least one.

☐ White ☐ American Indian or Alaskan Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

Language

Native Language _____ Language spoken in the home _____

Special Services:

Has your child been identified or received services for one of the following? (**Please check all that apply**)

☐ Individual Educational Plan (IEP) ☐ 504 Individualized Accommodation Plan

☐ English as Second Language (ESL)

Has your child ever been identified as gifted? ☐ Yes ☐ No

Is this student currently expelled or under suspension from any other school district? ☐ Yes ☐ No

---

I attest as evidenced by my signature below that all of the above information is correct to the best of my knowledge:

Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian E-Mail: _____

CIRCLEVILLE CITY SCHOOLS
Residence Verification Form – Affidavit I

I certify that I am a resident of the _____ *School District* at the following address:

Address: _____
City/Zip Code: _____
Date of Occupancy: _____

Verification of the above residence must be provided to school officials through ***two*** acceptable forms of documentation. Examples of acceptable forms of documentation include, but are not limited to the following:

☐ Official Rental/Lease Agreement
☐ Mortgage Coupon/Closing
☐ Property Tax Statement
☐ Settlement Statement of purchase
☐ Current Utility Bill ****only one utility bill will be accepted for documentation****
☐ Ohio Driver's License or State issued ID
☐ Other _____

☐ **Special Circumstances**
Applicant resides with another person. The person with whom you are living with ***MUST COMPLETE THE RESIDENCE VERIFICATION AFFIDAVIT II FORM*** and ***HAVE IT NOTARIZED***. They ***MUST ALSO PROVIDE PROOF OF RESIDENCY*** to school officials through ***two*** acceptable forms of documentation. Acceptable forms of documentation include but are not limited to the examples above.

Please list other children enrolled with Circleville City Schools:

Student(s)	**Date of Birth**	**Grade**

I further certify that the above information is true and accurate. I understand that if residency at any time is verified to be false that immediate withdrawal can occur.

Parent/Guardian Signature Relationship to Child Date

REVISED 1-16

CIRCLEVILLE CITY SCHOOLS

Special Circumstances Verification Form Affidavit II

To be completed by the person(s) with which you claim to reside

I, _____, being duly cautioned, do solemnly swear or affirm the following:

1. I am the owner or renter of the residence at
   _____

   in _____, Ohio located in the _____

   School District.

2. The following individual(s) is/are living at my above stated residence and have so since the ____day of _____, 20___.

   _____
   _____
   _____
   _____

3. I acknowledge and understand that if the above information is not true and correct, that knowingly swearing of affirming the truth thereof constitutes criminal falsification, a violation of Ohio Revised Code Section 2921.13, a first degree misdemeanor, punishable by a maximum fine of $1,000.00 and/or a maximum term of imprisonment of six months. Inaccurate and/or falsified information will result in immediate withdrawal of stated student(s) from Circleville City Schools.

4. Owner/renter of the above residence must provide two forms of proof of residency. ***See Affidavit I Special Circumstances.***

I agree that Circleville City Schools, if they deem necessary, has the right to investigate my residency. I agree to allow the release of ownership, rental, and utility information to a representative of Circleville City Schools.

Signature: _____
(Property owner/Lessee)

Sworn to and ascribed in my presence this _____day of _____, 20_____

_____
Notary Public

Stamp or Seal 3/15

CIRCLEVILLE CITY SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION FORM

NOTIFY THE SCHOOL OF ANY CHANGE IN PHONE OR EMERGENCY NUMBERS

Student Name _____ School _____

Address_____Telephone_____

The following is required by section 3313.712 of the Ohio Revised Code.

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. Only individuals listed on this form will be permitted to pick up a child upon providing proof of identification.

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_____
Address_____Phone_____
Name_____ Relationship_____
Address_____Phone_____

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 the above-named doctor, or, in the event the designated preferred physician 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 of such surgery, are obtained prior to the performance of such surgery.**

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

PART II – (REFUSAL TO GRANT 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:
_____
_____

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

SCHOOL: _____

STUDENT'S NAME: _____

PARENTS/GUARDIANS:

PLEASE COMPLETE CONFIDENTIAL INFORMATION TO BE SHARED WITH TEACHING STAFF AND EMS IF NECESSARY – If an emergency situation occurs, every effort will be made to transport your child to the hospital of choice. But, if necessary, protocol of EMS personnel is to transport to the nearest hospital.

1. **Does your child have *asthma* diagnosed by a physician? Yes_____No_____**
   If yes, please list any treatments given or medication taken_____
   _____

2. **Does your child have *allergies* (reactions to medications, foods, or insects) diagnosed by a physician? Yes_____ No_____ If yes, please list the care or medication required _____**
   _____

3. **Does your child have *ADD or ADHD* diagnosed by a physician? Yes_____ No_____**
   If yes, and he/she takes medication, please list medication, amount, and time of administration
   _____

4. **Does your child have a *seizure disorder* diagnosed by a physician? Yes_____ No_____**
   If yes, and he/she takes medication, please list medication, amount and time of administration_____

5. **Does your child have a *cardiac (heart) defect* diagnosed by a physician? Yes_____ No_____**
   If yes, please list any restrictions and medications, amount, and time of administration_____
   _____

6. **Does your child have a *bleeding disorder/tendency* diagnosed by a physician? Yes_____ No_____**
   If yes, please give diagnosis or description of problem _____
   _____

7. **Does your child have *diabetes* diagnosed by a physician? Yes_____ No_____ Type_____**
   If Type 1, please list insulin pen/insulin pump and time glucose is checked or insulin is given_____

8. **Does your child have *vision/hearing impairment*? Yes_____ No_____**
   Wear glasses, contact lenses, or hearing aid(s)/auditory device? _____
   _____

9. **Any other pertinent medical information or medications being given that could affect your child while in school_____**
   _____

AUTHORIZATION TO DISCLOSE IMMUNIZATION INFORMATION

Name of Child _____ Date of Birth _____

I, _____ as the **parent or guardian** of the above named child, hereby authorize (**name of doctor(s**) _____

_____

_____

to disclose the specific and individually identifiable immunization records of the above named child to ***Circleville City Schools*** for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the Department of Health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section*. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law. **Please note: medical records provided to schools that receive federal funding are protected by the Family Education Rights and Privacy Act (FERPA).**

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that above named child has been immunized the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

_____ _____ _____

(Signature of Personal Representative) *(Date)* *(Relationship/Authority)*

****

Note: *This Authorization was revoked on:* _____ _____

(Date) *(Signature of Staff)*

AUTHORIZATION TO DISCLOSE IMMUNIZATION INFORMATION

Fill out this section if you do not want the school to contact your health care provider.

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Child/Patient)

signed by _____ on _____
(Name of person who signed authorization) *(Date of Signature)*

be rescinded, effective _____.
(Date)

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the revocation date is legal and binding.

_____ _____ _____ _____
(Signature of Client/Patient) *(Date)* *(Signature of Witness)* *(Date)*

_____ _____ _____
(Signature of Personal Representative) *(Date)* *(Relationship/Authority)*

N52-04

CIRCLEVILLE CITY SCHOOLS

Circleville, Ohio 43113

Parent Authorization for Release of Confidential Information

Student's Name		Grade		Date of Birth	

I hereby request and authorize that confidential information concerning my child be released to:

☐	☐	☐	☐	☐
Student Services Department 100 Tiger Drive Circleville, Ohio 43113 740.477.6663 Fax: 740.477.6681	**Circleville District Office** 388 Clark Drive Circleville, Ohio 43113 740.474.4340 Fax: 740.474.6600	**Circleville Elementary** 100 Tiger Drive Circleville, Ohio 43113 740.474.2495 Fax: 740.477.6681	**Circleville Middle School** 360 Clark Drive Circleville, Ohio 43113 740.474.2345 Fax: 740.477.6684	**Circleville High School** Guidance Department 380 Clark Drive Circleville, Ohio 43113 740.477.5553 Fax: 740.477.5571

Date Mailed: _____ **Date Faxed:** _____

DISTRICT IRN # 043760

Records to be released should include those that apply to student:

Attendance/ Academic Records (Assessment Data, Grading Scale, etc.)
Special Education Documents (ETR/MFE, IEP, Reports, Diagnostics, etc.)
General Education Documents (504 Plans)
ESL, Gifted Education, SSID

Has your child been identified or received services for one of the following? Please check below.

	Special Education and Related Services (ETR/IEP)
	Gifted Education (WEP)
	504 Plan (Accommodation in General Education Setting)
	ESL (English as Second Language)
	NOT APPLICABLE

COMPLETE THE FOLLOWING INFORMATION ABOUT THE LAST SCHOOL ATTENDED:

School Name					
School Address					
City		**State**		**Zip**	
School Phone			**School Fax**		

LAST DATE OF ATTENDANCE: _____

Reason for Request

	Child has moved into Circleville City School District
	My child has been accepted at Circleville City Schools under Open Enrollment
	Child is COURT PLACED in Circleville City School District

Parent/Guardian Name PRINTED: _____

Parent/ Guardian Signature: _____

Parent/ Guardian Current Address: _____

Confidential Dental Health Record

Child's Name _____ Sex: M F Birthdate: _____
Dentist: _____ Address: _____ Phone _____

PART A: To be completed by Parent/Guardian:

1. Is the child now receiving fluoride? If "yes", include length of time

Topical Fluoride Application? No _____ Unknown _____ Yes _____

Fluoridated water? No _____ Unknown _____ Yes _____

Fluoride supplement diet? (tablets, liquid) No _____ Unknown _____ Yes _____

2. Does the child have any trouble with teeth, gums, or mouth that the parent knows about?
   No _____ Yes _____

3. Child (____has _____has not) previously seen a dentist
   Dentist name: _____ Date of last visit: _____

4. Child (_____is_____is not) under a physician's care
   Physician's name: _____ Date of last visit: _____

5. Child (_____is_____is not) receiving medication
   Type
   _____

6. Child is reported to have:

Allergies _____	Liver Disease _____
Asthma _____	Rheumatic Fever _____
Bleeding _____	Sickle cell disorder _____
Diabetes _____	Heart/Vas. Disorder _____
Epilepsy _____	Other _____

PART B: Parental Consent:

I have been informed of my child's dental health plan and agree to the recommended treatment.

Parent signature: _____ Date: _____

PART C: To be completed by dental care provider:

1. Oral conditions before treatment:

Missing: ⊗

Decayed: ●

Filled: ⊙

Indicate restorations you perform in item 2.

2. Examination and Treatment Record:

Tooth ID	Surfaces	Description of work	Treatment Approved	Date Performed	A.D.A.#	Fee

3. Dental needs:

Treatment _____ Fluoride _____ Approx # of visits ____
(restoration, extraction,
Pulp therapy) _____ Cleaning _____ Approx cost _____

No problems ____ Other _____

4. Child Oral Health Summary

All planned treatment (____is____is not) complete. If not, explain here:

_____

Routine recall visits _____ Developmental problems _____
Dietary problems _____ Special home emphasis, oral hygiene ____
Needs fluoride supplement _____ Harmful oral habits _____

Dentist signature _____ Date _____

Ohio | Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 7/11/2016

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's Assistant
- ☐ Advanced Practice 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.