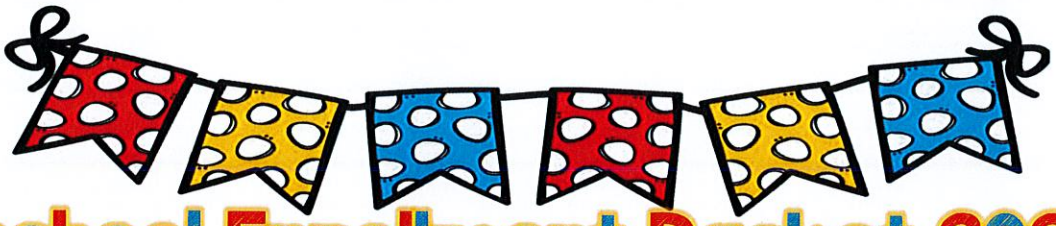

Preschool Enrollment Packet 2022-23

3 and young 4's

Child must be **3** on or before **August 1st** of the calendar school year and **INDEPENDENTLY POTTY TRAINED**.

Class Days, Times, and Fees

Please choose from the following options:

Monday/Wednesday 9:30AM-12:00PM

Tuesday/Thursday 9:30AM-12:00PM

TUITION: $95/mo. ($85 for Dayspring attendees) + $95 supply fee for the year.

A PAID SUPPLY FEE AT REGISTRATION ENSURES YOUR SPOT!

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4 and 5 year olds

Child must be **4** by **August 1st** of the calendar school year and **INDEPENDENTLY POTTY TRAINED**.

Class Days, Times, and Fees

A.M. class **Monday, Tuesday, Wednesday, Thursday** 9:00am-11:30am

P.M. class **Monday, Tuesday, Wednesday, Thursday** 12:30pm-3:00pm

TUITION: $135/month ($125 Dayspring attendees) + $135 supply fee for the year

A PAID SUPPLY FEE AT TIME OF REGISTRATION WILL ENSURE YOUR SPOT!

SUPPLY FEES ARE NON-REFUNDABLE, NO EXCEPTIONS.

2431 Marion-Mt. Gilead Rd.

Marion, OH 43302 (740)389-3684 ext. 225

dayspringchristianpreschool@yahoo.com

Thank you for your interest in Dayspring Christian Preschool! Attached are enrollment forms and information regarding our programs. When completing the enrollment forms, **PLEASE WRITE N/A IN ANY AREA YOU WOULD LIKE TO LEAVE BLANK** as the state requires all fields to be filled. Also, be sure to **sign permission** to have your child transported in the event of a medical emergency.

Please turn in forms with your supply fee so any corrections can be made.

A PAID SUPPLY FEE WILL HOLD YOUR CHILD'S SPOT AND IS NON-REFUNDABLE.

The **"Medical Statement"** is a **physical form** that **MUST BE COMPLETED BY THE CHILD'S DOCTOR** prior to the first day of school. All students are required to have had a physical exam within the last calendar year of our start date (Sept. 6, 2022).

You can mail forms, drop them by the main church office, or scan and email to dayspringchristianpreschool@yahoo.com. Classes fill quickly so first come, first served.

Again, thank you for your interest and I hope to hear from you soon!

Sincerely,

Lara Fogle,

Director

PRESCHOOL REGISTRATION CONTACT FORM

Child's Full Name_____ Date of Birth_____ M/F___

Address_____

City_____ Zip_____

Home Telephone_____

E-mail_____

Father's Name_____ Mother's Name_____

Cell # _____ Cell#_____

If separated or divorced, with which parent does the child reside?_____

Names and ages of siblings_____

Class for which you are registering?

3-4 Monday, Wednesday AM 9:30-12:00

3-4 Tuesday, Thursday AM 9:30-12:00

4-5 Monday, Tuesday, Wednesday, Thursday AM 9:00-11:30

4-5 Monday, Tuesday, Wednesday, Thursday PM 12:30-3:00

FOR OFFICE USE ONLY

Date Received_____

Check Number_____

Amount_____

Tuition 3-4 $95.00/month

$85.00 Dayspring Regular Attendees

Tuition 4-5 $135.00/month

$125.00 Dayspring Regular Attendees

Supply Fee

3-4 $95.00 **Supply fees cover supplies used throughout the year. Your child will**

4-5 $135.00 **need only a book bag.**

SUPPLY FEE IS DUE AT TIME OF REGISTRATION. THIS WILL HOLD YOUR SPOT! Supply Fee is NON REFUNDABLE!

Dear Families,

Several times a week our teachers post pictures on our Dayspring Christian Preschool Facebook page so that you may see all of the fun things that our classes are doing! We will ONLY post children's faces for whom we receive signed permission!

I give Dayspring Christian Preschool permission to post pictures of my child_____ to the preschool

(Child's name)

Facebook page.

_____ _____

Parent/Guardian Signature Date

Overview of Policies & Procedures

- Tuition is due during the first week of the month. Accounts that are more than one month behind will result in the child staying home until the account comes current. Tuition must be paid for all months in which the child is officially enrolled. ***Written withdrawal from the program is required in order to release liability from tuition obligation.***
- Yearly tuition is divided into 9 monthly payments plus a supply fee. Tuition will not be prorated for absences, holidays, or for unforeseen circumstances related to weather, the church campus, or illness.
- Closings and delays ae reported via REMIND text service and our preschool Facebook page.
- Sick children are not permitted. All must be fever, vomit, and diarrhea free for a minimum of 24 hours.
- Communicable diseases must be reported to staff and staff will communicate the information via written notice to families.
- All children must be independently potty trained.
- We have an open door policy for visiting parents! Siblings are not permitted to visit during class time per the State of Ohio.
- Drop-off and pick-up occur at the front preschool door via car line. We can help your child in and out of the car but are not allowed to buckle seat belts and car seats. Please pull over to our parking lot to buckle. Only those designated as parent/guardians and emergency contacts are approved to pick up children. Please list all other possible pick-up people on a separate paper and submit too preschool.

- In the case of custody issues, court papers must be submitted to the director for the child's file.

- Children will take turns with the "snack sack" and provide a snack to share. We are a peanut free program and per the state, may not serve popcorn. Grapes and strawberries must be quartered.
- **Children requiring medication be kept on site must have Request to Administer Medication and Care Action Plan forms on file along with the medication ONE WEEK PRIOR TO THE START OF SCHOOL. A meeting with the director is also required.**
- Behavior is managed first through redirection, distraction, and a possible calm down period separate from the group. Serious or on-going issues will be addressed in writing and with parent, teacher, and director discussion. Dayspring Christian Preschool reserves the right to release a child from the program at any time.
- Our staff is current in all state required professional development and health trainings and are mandated reporters.
- Our classes maintain state required teacher:child ratios or better at all times.
- Evacuation plans are posted in each classroom. Parents will be advised via Facebook, REMIND and WMRN radio.
- In case of injury or illness, incident reports are kept in children files.
- Our curriculum is thematic, play, and faith based. We focus on developing the whole child.
- Staff includes director Lara Fogle, 4-5 team Lara Fogle & Sierra Jones. 3-4 team members are Teri Shipley, Diane Jankowski, & Kim Tyree.

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth	First Day at Program/Home 9/6/2022
Home Address			City
State	Zip Code	Home Telephone Number	
Parent/Guardian Name #1		Relationship to Child	
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City		State	Zip
Email Address *(if applicable)*		Cell Phone *(if applicable)*	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?
WORK NUMBER CELL NUMBER circle one or both

Parent/Guardian Name #2		Relationship to Child	
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City		State	Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?
WORK NUMBER CELL NUMBER circle one or both

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**Do Not Give *Permission* to Transport**	
Program or Home Name Dayspring Christian Preschool		**OR** **Do not sign both**	Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☑ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below*):

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below*)

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER: ☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	**Initials of Examining Health Care Practitioner**
	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent**
	Date