Steubenville City Schools

Student Registration Form

Preschool

For Office Use Only / Leave Blank

Student # _______________

Student Name ____

School Year ______________ ***Teacher*** ____

Steubenville City Schools

Steubenville, Ohio 43952

School Registration Form

Student # Enrolling in Grade Date
(office only)

Legal Name Nickname
(Last) (First) (Middle)

Street Address
(Street) (City) (State) (Zip Code)

Date of Birth Age Place of Birth

Gender Male Female Social Security Number

The United States Department of Education, under the No Child Left Behind Act, mandates that school districts collect and report the following racial and ethnic data. The purpose for collecting this information is to "ensure equal access" to education for all students.

Racial/Ethnic Code: (Required by the State of Ohio) Is Child Hispanic? Yes No If No Check all that apply

American Indian or Alaska Native Asian Black or African American
Native Hawaiian or Pacific Islander White

Is this child a U.S. Citizen Yes No Language spoken in the home

With whom does this child reside?
(Last) (First) (M.I.)

Does this person have legal custody? Yes No
If NO then who does have legal custody?

Legal Name
(Last) (First) (M.I.)

Current Address
(Street) (City) (State) (Zip Code)

Home Phone Cell Phone

RESIDENCY: Information concerning person(s) with whom the student is living.

Father Stepfather Guardian Foster Father

Name Home Phone Cell Phone

Employer Business Phone

Mother Stepmother Guardian Foster Mother

Name Home Phone Cell Phone

Employer Business Phone """"Maiden Name

Are you, as legal guardian, residing with a relative or friend in the Steubenville School District?
Yes? No?
State law requires that the school receive a copy of a divorce or separation decree, if applicable
The court papers show that I have legal custody of the student Yes No

List Student's siblings and grade level

(Last, First Name) (Grade) (Last, First Name) (Grade)

(Last, First Name) (Grade) (Last, First Name) (Grade)

CHILD’S Name:

HEALTH HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy? Yes No

If yes, explain briefly

How old was the mother when this child was born?

Was this infant born: full term early late What was this infant's birth weight?

Did the infant have any sickness or problems while in the nursery? Yes No

If yes, explain briefly

DEVELOPMENTAL HISTORY Please give the approximate age at which this child:

walked alone was toilet trained spoke in sentences dressed self

How does this child's development compare to other children, such as his or her brothers/sisters/playmates?

about the same slower faster

HEALTH CONDITIONS Please check any that this child has had:

_____Abnormal spinal curvature (scoliosis, etc.)
_____Allergies or hay fever
_____Anemia
_____Arthritis
_____Asthma or wheezing
_____Bed wetting at night
_____Behavior problem
_____Birth or congenital malformation
_____Cancer, Type
_____Chronic diarrhea or constipation
_____Concern about relationship with siblings or friends
_____Cystic Fibrosis
_____Diabetes
_____Eczema
_____Emotional problems
_____Eye problems, poor vision
_____Frequent headaches
_____Frequent skin infections
_____Frequent sore throat infections
_____Heart disease, type
_____ Hepatitis
_____ Kidney Disease, type
_____ Measles ('Old Fashioned' or 'Ten Day')
_____ Meningitis or encephalitis
_____ Multiple ear infections (3 or more)""
_____ Mumps
_____ Near-drowning or near-suffocation
_____ Nervous twitches to tics
_____ Poisoning
_____ Poor hearing
_____ Pregnancy
_____ Rheumatic fever
_____ Seizures or epilepsy
_____ Sickle cell disease
_____ Stool soiling
_____ Substance abuse
_____ Suicide attempt
_____ Toothaches or dental
_____ Urinary tract infection
_____ Wetting during day

ALLERGIES Please list and describe allergies or reactions to:

Medicines/drugs

Foods/plants/animals/other

Recommended treatment if allergy is serve

INJURIES AND ILLNESSES Please list any severe injuries or illnesses:

Injuries Illnesses	Age of Child	If Hospitalized (check)

Completed By: Relationship to Child:

SECTION 3313.712, OHIO REVISED CODE

(Pursuant to Am. H.B. 1175)

(A) Annually the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, have provided to the parent or legal guardian of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division *(B)* of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide the parent or legal guardian of such pupil, either as part of any registration form which is in use in the district, or as a separate form an identical copy of the form contained in division (B) of this section.

When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local, or joint vocational school district to which the pupil is transferred. Upon request of his parent Or guardian, authorities of the school in which the pupil is enrolled may permit such parent or guardian to make changes in a previously filed form, or to file a new form.

If a parent or guardian does not wish to give such written permission, he shall indicate in the proper place on the form the procedure he wishes school authorities to follow in the event of a medical emergency involving his child.

Even if a parent or guardian gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extra-curricular activity authorized by the appropriate school authorities, the authorities of the school in which the pupil is enrolled shall make reasonable attempts to contact the parent or guardian before the treatment is given. The school shall present the pupils emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.

(B) The emergency medical authorization form provided for in division (A) of this section is as follows: *(See reverse side).*

STEUBENVILLE CITY SCHOOLS
NEEDS ASSESSMENT QUESTIONNAIRE FOR PARENTS

Dear Parents,

We value your input and ideas. We would like you to take a few minutes to complete this questionnaire and return it to school with your child(ren).

Name: **Name of Child(ren)**

1) Would you be willing to participate in a district support group? Yes No

2) Would you be willing to attend workshops on various topics related to parenting and helping your child succeed in school? Yes No

3) Please check the workshop days and times you would prefer:

Monday Tuesday Wednesday Thursday

Mornings Afternoon Evenings (6-8)

4) Please check your preference for location of workshops:

Your Home School High School Conference Center Other

5) Please check workshop topics that you are interested in and most likely to attend:

_____ Parenting Class

_____ Discipline

_____ Self-Esteem

_____ Stress/Coping Skills

_____ Parents with Careers

_____ Single Parenting

_____ Homework Help

_____ Wellness Program

_____ Available Community Services

_____ Reading and Writing with your Child

_____ Step Families

_____ Creativity and Critical Thinking

_____ Make-It-Take-It

_____ Other:

6) Please list any other ideas that you may have to increase parental involvement.

Thank you for your time and ideas! Form used in Steubenville City Schools since 1990.

Steubenville City Schools
Home Assessment

Name of Child: (Last) (First) (Middle) Grade:

Parents' Names: Home Phone:

Parents' Occupations:

Home Address: (Street) (City) (State) (Zip)

Form Completed By:

Relationship to Child: Mother Father Other Caregiver

Home Survey

Please answer each question by placing a check mark on the appropriate line or lines.

1. Which items are found in your home?
   Check all that apply:
   _____telephone
   _____television
   _____radio, stereo, or record player
   _____pictures, paintings. or posters
   _____pets

2. How many hours do you or your spouse usually, work outside the home? (If both parents work, check the hours of the parent who works the most.)
   Check one:
   _____0 hours per week(child's mother and father do not work outside the home)
   _____ 1 to 10 hours per week
   _____11 to 20 hours per week
   _____21 to 30 hours per week
   _____31 to 40 hours per week
   _____more than 40 hours per week

3. How often do you or your spouse find time to play with your child?
   Check one:
   _____almost every day
   _____3 or 4 times a week
   _____3 or 4 times a month
   _____seldom or never

4. How often do you or your spouse find time to have a long talk with your child about his or her activities during the day. or other similar topics?
   Check one:
   _____almost every day
   _____3 or 4 times a week
   _____3 or 4 times a month
   _____seldom or never

Please continue to the next page

5. When your child is at home, what percent of the time does the mother assume responsibility for the child's care?
   Check one:
   ______0 percent of the time (never)
   ______1 to 25 percent of the time
   ______ 26 to 50 percent of the time
   ______ 51 to 75 percent of the time
   ______ 76 to 100 percent of the time

6. When your child is at home, what percent of the time does the father assume responsibility for the child's care?
   Check one:
   ______ 0 percent of the time (never)
   _______1 to 25 percent of the time
   _______26 to 50 percent of the time
   _______51 to 75 percent of the time
   _______76 to 100 percent of the time

7. What have you or your spouse helped your child learn?
   Check all that apply:
   ______ songs and nursery rhymes
   _______alphabet and numbers
   ______ names of colors
   ______ names of animals, plants, and other things
   ______ telling time

8. How many children's books does your child have?
   Check one:
   ______ 0 books
   _______1 to 5 books
   ______ 6 to 10 books
   ______ more than 10 books

9. How often do you or your spouse find time to read to your child?
   Check one:
   ______almost every day
   ______3 to 4 times a week
   ______3 to 4 times a month
   ______seldom or never

10. How often does your child watch television?
    Check one
    ______seldom or never
    ______1 to 4 hours
    ______1 to 2 hours
    ______3 to 4 hours
    ______5 or more hours a day

11. How often do you or your spouse allow your child to choose the foods for his or her snacks or meals
    Check one:
    ______almost everyday
    ______3 to 4 times a week
    ______3 to 4 times a month
    _____ seldom or never

12. How often do you or your spouse allow your child to choose the clothes he or she will wear that day?
    Check one:
    ______almost every day
    ______3 to 4 times a week
    ______3 to 4 times a month
    ______seldom or never

Please check to make sure that you have answered every item. Then in the space below, write any additional comments you wish to make about your child's home *activities.*

Comments/Concerns:

EMERGENCY MEDICAL AUTHORIZATION

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 cannot be reached.

Student Name

School District

Address

School Attended

Telephone

PART I OR II MUST BE COMPLETED

PART I
TO GRANT CONSENT

In the event reasonable attempts to contact me at (phone no.) or (other parent or guardian), at (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. , preferred physician, or Dr. , preferred dentist. 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 medial opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Date

Signature of Parent or Guardian

Address

DO NOT COMPLETE PART II IF YOU 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 which the school authorities to take the following action:

Date

Signature of Parent or Guardian

Address

Preschool Information Sheet

School Year

Child's Name
(Last) (First) (Middle)

Transportation Authorization:

I authorize the school system to transport my child on the regular scheduled school bus.

I do not authorize the school system to transport my child on the regular scheduled school bus.

Child Information;

I give my permission to release my child's name, telephone number and my name to parents in the preschool classroom.

I do not give my permission to release my child's name, telephone number and my name to parents in the preschool classroom

Authorization to Release Child:

Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Relationship to Child:	Relationship to child:	Relationship to child:

Please note special circumstances of which the center should be aware.

STEUBENVILLE CITY SCHOOLS
PRESCHOOL SURVEY SHEET

NEW STUDENTS

1) """"""""""""""My child will attend Preschool during the """""""""""""""""""""""""""""""school year

Center Preferred:

East Garfield

Wells Academy

West Pugliese

Child's Name:
(Last) (First) (Middle)

Parent's Name:

Address:
"""(Street) """""""""""""""""""""""""""""""" (City) """""""""""""(State) """""""""""""" (Zip)

Phone: Home:

Work:

* Latchkey is available at West Pugliese Elementary and Wells Academy
* Elementary Schools latchkey hours of operation are from 7:15 -8:30 A.M. and 3:00 - 5:30 P.M.

2) Days (select one)

Monday, Wednesday, Friday only

Tuesday, Thursday only

Monday thru Friday (5 days)

3) Is bus transportation needed? YES NO

4) If so, when? To school from school both to and from school

5) The following information is required according to State guidelines and will be kept confidential.

Family Income

Number of Children in Family

Steubenville City Schools

Permission for Preschool Statewide Assessment Project

I give my permission for my child.____"""""""to participate in a preschool statewide assessment project.

________________________________ ____________________
Parent's Name Date

Steubenville City Schools
Nutrition Assessment

Child Health Record:

Name """"""""Sex Male Female Birth date
(Last) (First) (Middle)

1. Dietary Habits
   What foods do your child especially like?

2. Are there any foods your child dislikes?

3. Does your child take vitamins and mineral supplements? Yes No What Kind?

   Do they contain iron? Yes No

   Do they contain fluoride? Yes No

   Were they prescribed? Yes No

4. Is there any food your child should not eat for medical, religious, or personal reasons? Yes No

5. Is your child on a special diet? Yes No What Kind?

6. Has there been a big change in your child's appetite in the last month? Yes No

7. Does your child take a bottle? Yes No

8. Does your child eat or chew things that aren't food? Yes No

9. Does your child have trouble chewing or swallowing? Yes No

10. Does your child often have

    a. Diarrhea? Yes No

    b. Constipation? Yes No

11. Do you have any concerns about what your child eats? Yes No

12. About how often does your child eat a food from each of the following group? Approximate Number of Times a Week

a. Milk, cheese, yogurt	0*	1*	2	3	4	5	6	7	7+
b. Meat, poultry, fish, eggs; or Dried beans/peas, peanut butter	0*	1*	2	3	4	5	6	7	7+
c. Rice, grits, bread, cereal, tortillas	0*	1*	2	3	4	5	6	7	7+
d. Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes	0*	1*	2	3	4	5	6	7	7+
e. Oranges, grapefruit, tomatoes (fruit/juice)	0*	1*	2	3	4	5	6	7	7+
f. Other fruits and vegetables	0*	1*	2	3	4	5	6	7	7+
g. Oil, butter, margarine, lard	0*	1*	2	3	4	5	6	7	7+
h. Cakes, cookies, sodas, fruit drinks, candy	0*	1*	2	3	4	5	6	7	7+

* Starred answers may require follow-up. Explain details or give additional comments here.

STEUBENVILLE CITY SCHOOLS

Authorization to Disclose Immunization Information

Name of Child Date of Birth

I. as the parent or guardian of the above named child.

Herby authorize (Name of Provider(s)):

to disclose the specific and individually identifiable immunization records of the above named child to (Name of School);

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* on the back of this form. 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 Educational 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)*

Steubenville City Schools

Preschool Physician/Dentist Form

Student's Name
(Last) (First) (Middle)

My Child's Physician

Physician Name

Address
(Street) (City) (State) (Zip)

Phone #

My Child's Dentist

Dentist Name

Address
(Street) (City) (State) (Zip)

Phone #

Steubenville City Schools
Dental

TO BE COMPLETED BY PARENT

Child's Name   Date of Birth
"(Last)"""""""" (First) "" (Middle)

Address   Phone
"""""" (Street) """""""""""""" (City) (State) (Zip)

Preschool Center   Sex Male Female

1. Is the child now receiving
   Topical Fluoridated Application Yes No Unknown

   Fluoridated water Yes No Unknown

   Fluoridated Supplement Diet? Yes No Unknown (Tablets, liquid)

2. Does the child have any trouble with teeth, gums, or mouth, that the parent knows about?

3. Child (has has not) previously seen a dentist, Dentist name """""""""Date of last visit

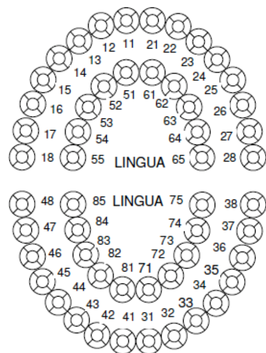
4. Child (is is not) under a physician's care. Physician's name

5. Child (is is not) receiving medication Type

6. Child is reported to have: (Check all that apply)
   Allergies Heart/Vascular Disease Asthma Liver Disease Bleeding Rheumatic Fever
   Diabetes Sickle Cell Disease Epilepsy Other (list below)

TO BE COMPLETED BY DENTAL CARE PROVIDER

ORAL CONDITIONS BEFORE TREATMENT   Examination and treatment record (List recommended services in order)



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

Dental Needs Check one or more
________A. Treatment (restoration, pulp therapy, extraction) ________B. Cleaning ________C. Fluoride

________D. Other ________E. No Problems Approximate number of visits _________

CHILD ORAL HEALTH SUMMARY
All planned treatment (____ is, _____ is not) complete. If not, explain here, as well as items checked.

________a. Routine recall visits ________c. Dietary problem(s) ________e. Harmful oral habits

________b. Special home emphasis, ________d. Developmental Problems ________f. Needs fluoride supplement

Signature____ Date________________________

IMMUNIZATIONS REQUIRED FOR PRESCHOOL ENROLLMENT

1. 4 DOSES OF DPT (Diphtheria, Pertussis, Tetanus)

2. 3 DOSES OF POLIO- 4th dose on or after the fourth birthday

3. 1 DOSE OF MMR (Measles, Mumps and Rubella)

4. 3 or 4 HIB VACCINES is usually given, but at least one dose of the HIB (H. Influenza type B) is required to enter Preschool

5. 3 DOSES OF HEP B (Hepatitis B) VACCINE

6. 1 DOSE VARICELLA VACCINE

Child Medical Statement

Childs' Name________________________________ Date of Birth______________

Height ______________ Weight____________

Limitations or health condition (including allergies, medications, dietary restrictions)

Immunizations	**Please circle one**	
Complete for age	Yes	No
In Process	Yes	No

Exempt from Immunizations	**Please circle one**	
Religious conviction	Yes	No
Health concern	Yes	No
Other:		

This child has been examined and is in suitable condition to participate in group care

Signature of examining Physician/ Physicians Assistant or Advanced Practice Nurse (circle one) Address : Phone:	Date of exam

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program				Reason not completed (Check which applies)	
Assessments/Screenings	Completed **Please circle one**		Date Completed	Health professional decision	Examples: religious conviction, insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			