

# Lincoln Pre-Kindergarten Enrollment Packet

The items listed below ***MUST*** be in each child's file ***prior*** to the first day of school. Failure to provide required documentation may result in your child being placed on a waitlist until all documents have been received by the office.

## Forms that need completed and returned by 6/1/18

Student Registration Form

Student Information Form

Emergency Medical Form

Pre-K Tuition Registration Form

**(please include a copy of your 1040 tax form or copy of your most recent pay stub)**

ODJFS Family Information Sheet

Completed Medical Assessment

Photo Release

Child release

Counseling (**Dino School**)

Military Student Data Form

Records Release

Emergency Weather Release

Field Trip/Swimming

## Student Documents that must be returned to us by 6/1/18

Custody Papers

Copy of Birth Certificate, Baptismal Certificate, Passport, Certified Record of Birth (**must provide one**)

Proof of residency (piece of mail w/ current address)

Immunization Record

Copy of IEP (if applicable)



Department of Education

Office of Early Learning and School Readiness
Preschool Registration Form

Revised 3/14/2017

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

Section I - Student & Family Information

Child's Name, Date of Birth, Family/Guardian Name, Home Address, City, State, Zip, Employer Name, Employer Street Address, Cell Phone, Home Phone, Work Phone, Call Order selection boxes.

Alternate Family Information:

Family/Guardian Name, Family Street Address, City, State, Zip, Employer Name, Employer Street Address, Cell Phone, Home Phone, Work Phone, Call Order selection boxes.

Section II - Authorization for Emergencies

List 2 Emergency Contacts for use ONLY if the parents cannot be contacted:

Name, Street Address, City, State, Zip for two emergency contacts.

Please select 1, 2 or 3 to set call order of phone number used to reach emergency contact:

Home, Cell, Work phone numbers and Call Order selection boxes for two emergency contacts.

List Medical Contacts, In Case Of Emergency:

Physician, Dentist, Street Address, City, State, Zip, Phone for two medical contacts.

Section III - Child's Health Information

Child's Chronic Medical/Health Needs

Large empty box for entering child's chronic medical/health needs.

Please complete both pages of form

# TIFFIN CITY SCHOOLS STUDENT REGISTRATION FORM

## STUDENT INFORMATION (Please Print)

For office use:

EMIS ID# \_\_\_\_\_

School year 20\_\_\_\_ - 20\_\_\_\_

- Columbian High School (9-12)
- Tiffin Middle School (6-8)
- Kront 2-3 Elementary School
- Noble 4-5 Elementary School
- Washington K-1 Elementary School
- Lincoln Pre-Kindergarten School

Student's Legal Last Name: (as it appears on birth certificate) \_\_\_\_\_

Middle Name: \_\_\_\_\_

Legal First Name: (as it appears on birth certificate) \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Check one:  Male  Female

Home Phone Number: \_\_\_\_\_

Entering Grade: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Birthplace: (City/State/Country) \_\_\_\_\_

Is the student a US Citizen? Yes \_\_\_\_\_ No \_\_\_\_\_

Ethnicity: Is the student of Hispanic/Latin heritage? Yes \_\_\_\_\_ No \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_

Please select each ethnicity that applies:

- W - White - People who have origins in any of the original people of Europe, North Africa, or the Middle East
- B - Black or African American - Persons having origins in any of the black racial groups in Africa
- A - Asian - Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- I - American Indian or Alaskan Native - Persons having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment
- P - Native Hawaiian or Other Pacific Islander - Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

### WHO DOES THE STUDENT LIVE WITH?

Check all that apply:	Print First/Last Name	Cell Phone Number	E-mail Address	Employer	Work Phone Number
<input type="checkbox"/> Father					
<input type="checkbox"/> Mother					
<input type="checkbox"/> Stepfather					
<input type="checkbox"/> Stepmother					
<input type="checkbox"/> Legal guardian					
<input type="checkbox"/> Foster Parent					
<input type="checkbox"/> Grandparent					

**Tiffin City Schools**  
**EMERGENCY MEDICAL AUTHORIZATION FORM**  
 (Ohio Revised Code 3313.712)

Student's Name \_\_\_\_\_  
 (Please print) Last First Middle Initial

Student's Address \_\_\_\_\_  
 Currently living with  Father  Mother  
 Other \_\_\_\_\_

Phone # \_\_\_\_\_ Grade \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_

Parent/Guardian e-mail \_\_\_\_\_

School Year \_\_\_\_\_

**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. This information will be shared as necessary with teachers, bus drivers, administrative staff, health personnel including student nurses, and other school personnel.

**EMERGENCY CONTACTS:** Please list names in the order they should be contacted if parents cannot be reached.

	Name	Address	Home Phone	Cell Phone	Work Phone
Parent					
Parent					
Legal guardian if not parent					
Emergency Contact #1					
Emergency Contact #2					
Emergency Contact #3					
Emergency Contact #4					

**It is extremely important that you provide ANY pertinent medical history or information about existing conditions that may affect your child at school:**

Medical information: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

**PART 1 OR 2 MUST BE COMPLETED:**

<p><b>PART 1: TO GRANT CONSENT</b></p> <p>I hereby give consent for the following medical care providers and local hospital to be called:</p> <p>Doctor _____ Phone _____</p> <p>Dentist _____ Phone _____</p> <p>Local Hospital/Emergency Room _____</p> <p><small>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 above named doctors, or, in the event the designed practitioner 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 for such surgery, are obtained prior to the performance of such surgery.</small></p> <p>Signature of Parent/Guardian _____ Date _____</p>	<p><b>PART 2: REFUSAL TO CONSENT</b></p> <p>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:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Signature of Parent/Guardian _____ Date _____</p>
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# Lincoln Pre-Kindergarten Tiffin City Schools Pre-K Tuition Registration

Child's Name \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Current District In Which You Reside \_\_\_\_\_

Number In Household \_\_\_\_\_ Yearly Family Income \_\_\_\_\_

**\*\*Please provide a copy of your 1040 tax form or most recent pay-stub\*\***

**\*\*Family income statistics are required to determine student fee rates. Proof of income is required to qualify for free or reduced rates for the 2018-2019 school year.**

**For households with more than 8 persons, add \$4,320 for each additional person.**

# in Household	100%	125%	150%	175%	200%
1	\$12,140	\$15,175	\$18,210	\$21,245	\$24,280
2	\$16,460	\$20,575	\$24,690	\$28,805	\$32,920
3	\$20,780	\$25,975	\$31,170	\$36,365	\$41,560
4	\$25,100	\$31,375	\$37,650	\$43,925	\$50,200
5	\$29,420	\$36,775	\$44,130	\$51,485	\$58,840
6	\$33,740	\$42,175	\$50,610	\$59,045	\$67,480
7	\$38,060	\$47,575	\$57,090	\$66,605	\$76,120
8	\$42,380	\$52,977	\$63,570	\$74,165	\$84,760
Annual Cost	None	\$250	\$500	\$750	\$1,000

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Ohio Department of Job and Family Services  
**FAMILY INFORMATION**  
**FOR STEP UP TO QUALITY PROGRAMS (SUTQ)**

Child's Name (Last)	(First)	Nickname (if any)
<i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff who care for your child.</i>		
Who is in the child's family?		
Who lives at home with your child?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) <input type="checkbox"/> Yes <input type="checkbox"/> No? Additional Details?		
Are there any cultural or religious practices of your family of which we should be aware? (dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No? Additional Details? (center based, in home, with family, with parents, etc.)		
How often does your child drink during the day (milk, juice, water, etc.)?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Child Care Licensing requires a form be completed for children with food allergies and/or dietary restrictions)		

What time does your child normally go to bed at night and wake up in the morning?

What time(s) and for how long does your child usually nap?

Does your child have trouble sleeping? (Night terrors, trouble going to sleep, etc.)  Yes  No? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature

Date



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	<input type="radio"/> Yes <input type="radio"/> No	Religious Conviction	<input type="radio"/> Yes <input type="radio"/> No
In Process	<input type="radio"/> Yes <input type="radio"/> No	Health	<input type="radio"/> Yes <input type="radio"/> 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.



**TIFFIN CITY SCHOOLS**  
**DIRECTORY INFORMATION & PHOTO RELEASE FORM**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Building \_\_\_\_\_ Grade \_\_\_\_\_

The Family Educational Rights and Privacy Act (FERPA) gives parents or students over age 18 certain rights with respect to educational records, including the right to refuse to allow Tiffin City Schools permission to release any or all of the types of information listed below about the student as directory information.

The types of information listed below have been designated as directory information by FERPA and Tiffin City Schools Board of Education Policy and may be disclosed throughout the school year without prior notification:

- Student's name
- Address
- Participation in officially recognized activities and sports
- Weight and height of members of athletic teams
- Dates of attendance
- Awards received
- Honors
- Date of graduation
- Date of birth

*If a parent or eligible student refuses to allow Tiffin City Schools permission to release any or all of the types of information about the student as directory information, the parent or eligible student must notify Tiffin City Schools in writing by the first day of school by returning this form to the building principal. Failure to return this form will be considered implied permission to use/release directory information as identified.*

***RETURN ENTIRE FORM***

**Check one box below.**

- Tiffin City Schools **HAS PERMISSION** to use/release directory information of my student, including photos and other information as identified above in school district communications including, but not limited to school newsletters, the district website, district media broadcasts, and external media stories about the district.
  
- Tiffin City Schools **DOES NOT HAVE PERMISSION** to use/release directory information of my student, including photos and other information as identified above in school district communications including, but not limited to school newsletters, the district website, district media broadcasts, and external media stories about the district.

Parent/Guardian Name (or student if 18 years of age) **PRINTED** \_\_\_\_\_

Parent/Guardian (or student if 18 years of age) **SIGNATURE** \_\_\_\_\_

Date \_\_\_\_\_

Student's name \_\_\_\_\_ Grade \_\_\_\_\_

Student Name: \_\_\_\_\_

Child Release Form- Regularly Authorized Adults  
Lincoln Pre-Kindergarten  
Tiffin City Schools

I, \_\_\_\_\_ (parent/guardian),  
authorize the release of my child, \_\_\_\_\_, to the  
following adults during the school year.

Name and Relationship	Home Phone	Cell Phone

I, \_\_\_\_\_ (parent/guardian) ,do not  
authorize the release of my child, \_\_\_\_\_, to the  
following adults during the school year.

Name and Relationship	Home Phone	Cell Phone

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

- Please immediately notify teacher if there are any changes of persons authorized to pick up your child or changes in phone numbers.
- In the event that the child is to be taken from the school by those not on the list, the parent/guardian must send a form/letter authorizing the release of the child.
- The parent shall also notify the person who picks up the child that picture identification will be requested. The teacher or paraprofessional shall check the photo identification.
- Under no circumstances will a child be released without prior authorization.

Tiffin City Schools  
School Counseling Program

Dear Parents,

School counseling services are available to students at Tiffin City Schools who are referred by school staff and administrators. School counseling typically addresses issues with grief, anger management, anxiety, peer stress, study skills, divorce, conflict resolution, social skills, depression, self-esteem, etc.

Counseling services are voluntary and parents will be contacted if their student is referred. Please complete the information below and on the back side of this sheet.

Please mark one of the following:

Yes, my child may speak with the counselor if needed throughout the school year.

No, I do not want my child to speak with the counselor.

Phone number you can be reached at during school hours if your child is referred for counseling services: \_\_\_\_\_

Please include any information that you feel would be helpful for me to know about your child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's Name \_\_\_\_\_

Grade \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

## MILITARY STUDENT DATA

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

School Building attending: \_\_\_\_\_

**ESSA** (Every Student Succeeds Act) requires all school districts to collect military information of student(s).

Districts are required to identify students whose parent(s) or legal guardian(s) have been an active member of the Armed Forces or National Guard at any point during the current school year.

Check the option that best describes your child(ren) Military Student Identifier status at any point during the school year. If your child is reported with an (A) or (B) value, and the parent/legal guardian becomes discharged at any point during the school year, the student(s) will continue to be reported with the established value for the entire school year.

\_\_\_\_\_ (\*) Not Applicable - (Not a Military Student)

\_\_\_\_\_ (A) Active Duty - Student is a dependent of a member of the  
Active Duty Forces.  
(Army, Navy, Air Force, Marine Corps, or Coast Guard)

\_\_\_\_\_ (B) National Guard - Student is a dependent of a member in the National  
Guard or Air National Guard

Phone: (419) 447-2515

Tiffin City Schools  
244 South Monroe St.  
Tiffin, Ohio 44883

Fax: (419) 448-5202

**Parent/Guardian/Student Consent for Records Release**

Date of request: \_\_\_\_\_ Date record sent or picked up: \_\_\_\_\_

Student's full name: \_\_\_\_\_ Name when enrolled: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Current grade (if applicable): \_\_\_\_\_ Current school (if applicable): \_\_\_\_\_

**We are requesting the following information/records for the above student:  
(check applicable items):**

- Most recent Multi-Factored Evaluation (MFE), including any medical information relevant to the education of this student.
- Most recent Individualized Education Plan (IEP) and EMIS form, including any medical information relevant to the education of this student.
- Test Scores/Proficiency Scores
- Health/Immunization Records
- High School Transcript/Grades/Credits Earned; Year of Graduation \_\_\_\_\_  
OR last grade completed/last year attended TCS \_\_\_\_\_
- Judgment entry/Custody documents
- Records related to excessive tardiness/absenteeism (HB410)
- The following records only: (please specify) \_\_\_\_\_  
\_\_\_\_\_

**Reason for Request- Please list name and address where information is to be sent.**

- Changing school districts \_\_\_\_\_
- College entrance \_\_\_\_\_
- Employment \_\_\_\_\_
- Information to be sent to non-custodial parent (name) \_\_\_\_\_  
(address) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

With the understanding that the district cannot assume responsibility for the confidentiality of educational information disclosed, I authorize you to release educational information regarding the student named above in the manner indicated.

Signature of Parent/Guardian/Student	Relationship to Student	Date
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Address	City, State, Zip
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<ul style="list-style-type: none"> <li><input type="checkbox"/> Proper I.D. or Notarized</li> </ul>	09/18/2017
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Form must be notarized if not picked up in Columbian High School Office. Mail back to Columbian High School, 300 S. Monroe St., Tiffin, OH 44883. Please call Columbian at 419-447-6331 if you have questions. Thank you.

**Tiffin City Schools**  
**SEVERE WEATHER/EMERGENCY**  
**EARLY SCHOOL DISMISSAL**

Student Name:

Grade:

School:

Homeroom:

*In the event of early dismissal of school due to any reason (heavy snow/ice, etc...), I am requesting that the directions for the above named student be followed. Please check one of the following:*

**Non-Bus Students**

My student is to go home immediately in the event of early dismissal.

My student is to remain at school until a parent or designated adult picks him/her up. The designated adult is:

	( )		
<b>Name</b>		<b>Phone</b>	<b>Address</b>
	( )		
<b>Name</b>		<b>Phone</b>	<b>Address</b>
	( )		
<b>Name</b>		<b>Phone</b>	<b>Address</b>

**Bus Students**

My student is to be transported by bus and will be delivered to his/her typical designated stop.

My student is to remain at school until a parent or designated adult picks him/her up. The designated adult is:

	( )		
<b>Name</b>		<b>Phone</b>	<b>Address</b>
	( )		
<b>Name</b>		<b>Phone</b>	<b>Address</b>
	( )		
<b>Name</b>		<b>Phone</b>	<b>Address</b>

Signature:

Date:



**Department of Education** Office of Early Learning and School Readiness  
**Field Trip/Swimming Permission Form**

Revised 7/11/2016

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

### Section A - Trip Details

Destination \_\_\_\_\_ Date of Trip \_\_\_\_\_

Departure Time \_\_\_\_\_ Return Time \_\_\_\_\_

#### Mode of Transportation

Walking    School Bus    Public Transit    Parent Drivers

#### Field Trip or Swim Trip

Field Trip    Swim Trip

### Section B - Trip Consent

I give permission for \_\_\_\_\_ to attend the above field trip/swimming/water activity.  
Child's Name  
(please print or type)

Authorized Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

If participating in or near water two feet or more in depth, please complete:

- Child is a swimmer
- Child is not a swimmer