

Lincoln Pre-Kindergarten Re-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.

___ Student Registration Form

___ Student Information Form (front and back, sign)

___ 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)

___ Completed Medical Assessment

___ Records Release

___ Proof of Residency (piece of mail w/ current address)



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 checkboxes.

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 checkboxes.

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 checkboxes for two emergency contacts.

List Medical Contacts, In Case Of Emergency:

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

Section III - Child's Health Information

Child's Chronic Medical/Health Needs

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

Please complete both pages of form

For office use:
EMIS ID# _____
School year 20____-20____

TIFFIN CITY SCHOOLS STUDENT REGISTRATION FORM

STUDENT INFORMATION (Please Print)

- Columbian High School (9-12)
- Tiffin Middle School (6-8)
- Kroyt 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)		Legal First Name: (as it appears on birth certificate)		Middle Name:		
Street address:		City:		Zip Code:		
Check one: <input type="checkbox"/> Male <input type="checkbox"/> Female		Home Phone Number:				
Entering Grade:		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:						
<p>Please select each ethnicity that applies:</p> <input type="checkbox"/> W - White - People who have origins in any of the original people of Europe, North Africa, or the Middle East <input type="checkbox"/> B - Black or African American - Persons having origins in any of the black racial groups in Africa <input type="checkbox"/> 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. <input type="checkbox"/> 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 <input type="checkbox"/> 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:

PART 1: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Local Hospital/Emergency Room _____

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 designated 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.

Signature of Parent/Guardian _____ Date _____

PART 2: 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 wish the school authorities to take the following action:

Signature of Parent/Guardian _____ Date _____

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 _____



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 _____

Table with 2 columns: Immunizations and Exempt from Immunization. Rows include Complete for Age, In Process, Religious Conviction, Health, and Other.

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Large empty rectangular box for entering limitations or health conditions.

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.

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 _____

Address _____ City, State, Zip _____

- Proper I.D. or Notarized _____ 09/18/2017

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.