



*South Central Local Schools*  
*Home of the Trojans*

**“Raise the Bar, Close the Gap, Accept No Excuses”**

Dear Parents,

This is the Preschool Application that you have requested for your child. Please be sure to fill the Preschool Application out completely including the doctor and dentist’s names and phone numbers on the Medical Emergency Form.

Below are a few requirements that you will need to know before returning the application.

- 1) A \$30.00 non-refundable supply fee will be due once your child is accepted into the preschool program. **Do not send any money with the application.** You will be billed for this at a later date.
- 2) Verification of Income **must** be sent with the application. Verification of income can be in the form of a pay stub, W-2, 1040 tax form, or medical card. **Applications WILL NOT be processed without this information.** Preschool tuition is based on a sliding fee schedule according to family size and income. Enrollment priority is given to income eligible families and children with an IEP. Income eligibility is based on the income earned and total number of family members living in your home.
- 3) The Medical/Physical Form and Dental Health Record can be turned in later. The Medical/Physical Form will need to be filled out by your child’s physician. **Please note that a lead and hematocrit screening are now required for preschool as part of the physical examination.** The Dental Health Record will need to be filled out by your dentist. Once these forms are completed, please forward them to the address below. You can send the Preschool Application in before these forms are completed. If your child is returning to the preschool program for a second year, the Dental Health Record is not required.  
  
**The Medical/Physical Form and Dental Health Record must be turned in within 30 days after preschool begins.** If they are not turned in within 30 days, your child will not be able to attend preschool.
- 4) Send copies of your child’s social security card, shot record, certified birth certificate, and custody papers (if applicable). Returning students do not need to send this information unless custody has changed since the previous school year.
- 5) Registration will be held at South Central Elementary on Friday, May 6, 2011. You will receive information on this after the preschool application has been turned in.

Please return the application and all other documentation to:

Townsend Building  
Attn: Preschool  
1783 County Road 294  
Vickery, OH 43464

If you have any questions, please call Debbie Graber at 419-684-5385 ext. 32 between the hours of 9:00 a.m. – 3:00 p.m.

Sincerely,

Dennis Blanchard, Principal  
South Central Elementary

*South Central Preschool Program*  
*3291 Greenwich Angling Road*  
*Greenwich, OH 44837*  
*419-752-6233*

## **PRESCHOOL PHILOSOPHY**

These are beliefs, supported by professional research, on which our developmental program is based.

- Children grow and develop at different rates and each child's rate is separate and distinct from that of any other child. This rate is often unrelated to chronological age.
- Children are naturally curious and eager to learn, and they learn best when they are able to follow many of their own interests and desires to learn.
- Learning is something a child does, rather than something that is done to him or her.
- Play is a child's "job" and way of learning.
- Children learn from each other. They learn responsibility and achievement. They learn to respect themselves and others. They learn how to learn!
- A rich learning environment, one deliberately designed with much to explore and discover, is essential in helping young children learn basic skills. Concrete and sensory materials are important in this environment, as they are basic learning devices for the young child.
- Basic skill development is considered essential in an open education learning environment. However, a variety of creative approaches to teaching and learning, including an integrated day are suggested.
- The development of initiative and self-reliance is encouraged in an atmosphere of trust and structured freedom.
- Each child is a unique individual and must be appreciated and valued for his or her individuality in all areas.
- The most important variable in a young child's learning is the educator.

Our program provides for the development of the whole child - physically, emotionally, socially, and intellectually. We provide activities to encourage learning in the way that children learn best - in play, with other children. Activities are planned to meet the needs and abilities of each child in the class.

Our basic goal is to give your child a positive first school experience. We will help him or her learn how to learn - and most importantly, to enjoy learning. We know, that with your help, we will get your child "on the right track" for a lifetime of learning!

**PRESCHOOL APPLICATION**

**For office use:**  
**Date received:** \_\_\_\_\_  
**Returning student: yes no**

**2011 - 2012 School Year**

South Central Preschool Program  
3291 Greenwich Angling Road  
Greenwich, OH 44837  
419-752-6233

Child's Full Name \_\_\_\_\_  
Last First Middle (full middle name)

Child's nickname (name to be called in class) \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Street City Zip  
City and State of child's birth \_\_\_\_\_ Male or Female (circle)

Parent(s)/Guardian(s) name \_\_\_\_\_

County of residence \_\_\_\_\_ School district \_\_\_\_\_

Home telephone \_\_\_\_\_ Emergency number \_\_\_\_\_

Father's employer \_\_\_\_\_ Phone number \_\_\_\_\_

Employer's address \_\_\_\_\_ Work schedule \_\_\_\_\_

Mother's employer \_\_\_\_\_ Phone number \_\_\_\_\_

Employer's address \_\_\_\_\_ Work schedule \_\_\_\_\_

Name of sibling Age Name of sibling Age  
\_\_\_\_\_  
\_\_\_\_\_

Names of others who reside in the home Relationship to child  
\_\_\_\_\_  
\_\_\_\_\_

Class Choice AM class PM class  
Please circle the preferred choice. Class choice is not guaranteed.

List names of people authorized to pick your child up from school (must be over 18 years of age)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In accordance with Rule 3301-37-04 of the Ohio Revised Code, a roster for each classroom, which includes names, addresses and telephone numbers of parent(s)/guardian(s) of children attending the preschool program must be prepared annually and given to parents/guardians upon request, but to no other person.

\_\_\_\_\_ I would like my name and telephone number to be included in this roster.  
\_\_\_\_\_ I would not like my name and telephone number to be included in this roster.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## CONSENT TO RELEASE CHILD'S PHOTO/VIDEO AND OTHER INFORMATION

To publicize the achievements of our preschool students and the great work they do, we like to occasionally publish our students' names, photos, and/or achievements in our school publications or release the information to local newspapers. We may also post the information on the school's website.

We understand that you may not want to have your child's name, photo, and/or achievements published. Please fill out this form to let us know your wishes.

School district \_\_\_\_\_ Classroom teacher \_\_\_\_\_

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

- I consent to have my child's name, photo, and/or achievements published in school newspapers/newsletters, release to local newspapers, and posted on the school's website as it relates to activities and participation in the preschool program.
- I do not want my child's name, photo, and/or achievements published in school newspapers and/or newsletters, released to local newspapers or posted on the school's website.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

### For Office Use

\_\_\_\_\_  
Signature of preschool teacher

\_\_\_\_\_  
Date

\*Occasional field trips will be taken and permission slips will be sent home.

## EMERGENCY MEDICAL AUTHORIZATION FORM

Child's name \_\_\_\_\_ Grade \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_  
Social security number \_\_\_\_\_  
School district \_\_\_\_\_ Building \_\_\_\_\_

The purpose of this form is to enable parent(s)/guardian(s) to authorize the provision of emergency treatment for your child who becomes ill or injured while under school authority, when you cannot be reached.

### Residential parent(s)/guardian(s)

Mother/guardian name \_\_\_\_\_ Phone: Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_  
Father/guardian name \_\_\_\_\_ Phone: Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

Contact information if parents cannot be reached in case of emergency: **(2 contacts required)**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell \_\_\_\_\_

### **PART I OR PART 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.

Physician \_\_\_\_\_ 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 above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my 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.

List below facts concerning your child's medical history, including allergist, medications being taken, and any physical impairments to which a physician should be alerted:

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

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_

#### **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 wish the school authorities to take the following action \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_



## DENTAL HEALTH RECORD

Child's name \_\_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_

Parent/guardian name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

1. Has the child previously seen a dentist?  No  Yes Dentist's Name \_\_\_\_\_

2. Does the child have any trouble with teeth, gums, or mouth?  No  Yes

3. Oral condition before treatment:  Missing  Decayed  Filled

4. Examination and treatment record

tooth letter	surface	description of work	date service performed	procedure number

8. Is baby bottle tooth decay present?  No  Yes

9. Is the child receiving: Topical Fluoride Application?  No  Yes

Fluoride Supplement Diet?  No  Yes If yes, tablets \_\_\_liquid\_\_\_

Fluoridated water?  No  Yes

10. Is all planned treatment complete?  No  Yes If not, itemize on chart below.

tooth letter	surface	description of work

11. Approximate number of visits required for treatment? \_\_\_\_\_

12. Next scheduled appointment \_\_\_\_\_

13. Comments: \_\_\_\_\_

Dentist's Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Dentist's Signature** \_\_\_\_\_ **Date of examination** \_\_\_\_\_