St. Mary of the Falls Preschool
Registration Form
2017-2018

Student's Name: _____ _____ _____
Last First Name Used

Date of Birth: _____ Sex: M F

Address: _____ _____ _____
Street City Zip

Home Phone: _____

Father's Name: _____ Address: _____

Employer: _____ Occupation: _____

Work Phone: _____ Cell Phone: _____

Mother's Name: _____ Address: _____

Employer: _____ Occupation: _____

Work Phone: _____ Cell Phone: _____

Names & birth dates of brothers and sisters: _____

_____

_____

Parish Name: _____

Please enclose a $100.00 non-refundable registration fee.
Checks should be made out to St. Mary of the Falls

Registering for Program _____

St. Mary of the Falls Preschool
Student Information Form

Student's Name: _____ Date of Birth: _____

Information about your child:

Has your child previously attended a preschool or day care: Yes _____ No _____

If yes, name the school or center: _____

Does your child attend Sunday preschool classes? _____ Library Story Hour? _____

Other classes or lessons? _____

Does your child play with other children? _____ If yes, what ages? _____

Does your child play well with others? _____Alone? _____

Favorite toys or games? _____

Special fears or concerns: _____

Any allergies, serious illness or injuries that may affect your child's participation in class activities?

_____

_____

Please share any other information which would help us in working with your child.

_____

_____

_____

Name of Person completing this form:

_____

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

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

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

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

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

PHYSICAL EXAMINATION

Student's name	Sex ☐ Male ☐ Female	Date of birth / /
Height	Weight	BMI percentile / BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments _____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results _____ µg/dL

HCT Results

PRESCHOOL ONLY

Tuberculin Test

Date _____ Type _____ Results _____

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows _____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

Health Care Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	Zip

Adapted from the Ohio Department of Health

LETTER TO PRESCHOOL PARENTS/GUARDIANS
INFLUENZA VACCINE

TO: Parents/Guardians

FROM: School Health Clinic

DATE: _____

SUBJECT: Influenza Vaccine

Dear Parents/Guardians,

The Ohio Department of Health recently revised the School Immunization Requirements for Preschool Students to include an annual Influenza Vaccine (beginning the 2015-2016 school year and every year thereafter).

If your child has received the Influenza Vaccine, please provide the date the vaccine was received below.

If your child will be receiving the vaccine please indicate below and provide the date that it was received to the school after it has been given.

If you are declining to have your child receive the influenza vaccine, please indicate below.

STUDENT NAME _____

- ☐ My child had the Influenza vaccine on _____ (OR)
- ☐ My child will receive the Influenza vaccine this school year and I will provide the date to the clinic staff once it has been received (OR)
- ☐ I have declined to have my child immunized against Influenza this school year. (You must provide a signature below to indicate that you have declined.)

_____
Parent/Guardian Signature

LETTER TO PARENTS
IMMUNIZATIONS

TO: Parents of Preschool Students
FROM: School Health Clinic
DATE: _____
SUBJECT: Missing Immunizations

The Immunization Requirements for Preschool were recently revised. The following immunizations have been added to the immunization requirements for Preschool Attendance in the 2015-2016 school year; Hepatitis A, Prevnar (PVC) and Influenza.

According to school health records:

☐ Your child has no record of immunization on file in school. You must provide the school with the records of your child's immunizations. If your child has not been immunized, you must obtain the necessary immunizations and provide the school with the record.

☐ Your child's immunization record is incomplete. You must obtain a record of your child having received the following immunizations:

☐ DPT - Diphtheria, Pertussis (Whooping Cough), Tetanus
1st_____ 2nd_____ 3rd_____ 4th_____ 5th _____(not required)

☐ Polio
1st_____ 2nd_____ 3rd_____ 4th _____(not required)

☐ MMR-Measles, Mumps, Rubella
1st_____ 2nd_____(not required)

☐ HIB - Hemophilus Influenzae B
1st_____ 2nd_____ 3rd_____ 4th_____

☐ Hepatitis B
1st_____ 2nd_____ 3rd_____

☐ Varicella (Chickenpox)
1st_____ 2nd_____(not required)

☐ Hepatitis A.
1st _____ 2nd _____

☐ Three (3) or Four (4) doses of Prevnar (PCV) depending on the vaccine and the age when started. One (1) dose if given after 24 months of age.
1st _____ 2nd _____ 3rd _____ 4th _____

☐ Annual Influenza

If your child has not received these immunizations, you must obtain them and provide the school with the record.

If your doctor says immunization might be harmful to your child, you must send a written statement, signed by your doctor. If you object to immunization for good cause, for example religious convictions, you must submit a signed statement. Forms are available from the school clinic.

FILL OUT ONLY IF YOU ARE DIVORCED

St. Mary of the Falls School

Information Regarding Legal Custody

to be completed as part of the registration/reregistration agreement

Date: _____

Child's Name: _____ Grade: _____

Address of child's residence: _____

_____

Child lives with:
_____ both parents
_____ mother as custodial parent
_____ father as custodial parent
_____ grandparent(s) with legal custody
_____ other (Please explain.) _____

Residential parent/guardian:

Name: _____
Address: _____
City, Zip: _____
Phone: _____

Is there a court order (or pending order) affecting the custody and/or residence of the child?

Please attach a certified copy of the entire court order including the case number and those sections referring to visitation rights and contacts with the school. Also include the page bearing the judge's signature and court seal. This copy should include any and all modifications made as of the date of registration of the child in the school. It is also the responsibility of the parents to inform the principal of any subsequent modifications during the child's tenure at the school.

Non-residential parent:

Name: _____
Address: _____
City, Zip: _____
Phone: _____

Does the non-residential parent have visitation rights? _____

Is there a court decision that states that the non-residential parent should NOT receive school information or attend school activities? _____
Is the non-residential parents responsible for paying tuition? _____

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