

Office of Early Learning and School Readiness
**Preschool
Enrollment Form**

Revised 11/30/18

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 _____	Please select 1, 2 or 3 to set call order of phone number used to reach you: _____
Home Address _____	Cell Phone _____ Call Order _____
City _____ State _____ Zip _____	Home Phone _____ Call Order _____
Employer Name _____	Work Phone _____ Call Order _____
Employer Street Address _____	City _____ State _____ Zip _____

Alternate Family Information:

Family/Guardian Name _____	Cell Phone _____ Call Order _____
Family Street Address _____	Home Phone _____ Call Order _____
City _____ State _____ Zip _____	Work Phone _____ Call Order _____
Employer Name _____	
Employer Street Address _____	City _____ State _____ Zip _____

Section II - Authorization for Emergencies

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

Name _____	Name _____
Street Address _____	Street Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____

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

Home _____ Call Order _____	Home _____ Call Order _____
Cell _____ Call Order _____	Cell _____ Call Order _____
Work _____ Call Order _____	Work _____ Call Order _____

List Medical Contacts, In Case Of Emergency:

Physician _____	Dentist _____
Street Address _____	Street Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone _____	Phone _____

Section III - Child's Health Information

Child's Chronic Medical/Health Needs

Please complete both pages of form

Child's History of Hospitalization:

Child's Disease History:

Child's Allergies/Treatment:

Child's Dietary Needs/Restrictions:

NOTE: A MEDICATION FORM MUST BE COMPLETED FOR EACH MEDICATION ADMINISTERED WHILE IN PROGRAM ATTENDANCE

Child's Medication/s:

Section V - Registration Authorizations

I authorize the following to be listed on the parent roster: My child's name Yes No

Family name Yes No

Phone numbers Yes No

Annual Class Roster: Each year the program prepares a roster for each group of children. This roster will not be furnished to any persons other than parents of children enrolled in our program.

Cell Home Work

Exempt from immunizations because of religious conviction: Yes No

Child immunization records attached: Yes No

Date

Signature of Authorized
Family Member/Guardian



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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 notes or 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 Assistant
Advanced Practice Registered 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.