

Medina County Career Center

1101 West Liberty Street

Medina, Ohio 44256

330/725-8461

866/896-6222

**EARLY CHILDHOOD EDUCATION
PRESCHOOL APPLICATION FORM
2018-2019 School Year**

| | |
|---|--|
| <p style="text-align: center;">For Office Use Only</p> <p>Date/time Received _____</p> <p>Received by _____</p> <p>Proof of Income _____ Birth Certificate _____</p> <p>Admittance date _____ Enrollment date _____</p> <p>Class _____ Category _____</p> <p>Medical Form on File YES NO</p> <p>Effective Date _____ Expires _____</p> | <p>Program of Interest (Please check only one)</p> <p><input type="checkbox"/> A.M. (M,T,W,Th) 8:00 a.m.- 11:15 a.m. Must be 4 by your school districts guidelines.</p> <p><input type="checkbox"/> P.M. (M,T,W,Th) 11:15a.m.- 2:30 p.m. Must be 4 by your school districts guidelines.</p> <p><input type="checkbox"/> Full Day (M,T,W,TH) 7:45a.m.-5:00p.m.</p> |
|---|--|

Child: Last First Middle

Name: _____ Sex: [M / F] Date of Birth: ____/____/____

Place of Birth _____

Child's Social Security Number: _____ Home School District: _____

Does your child have any special needs and/or handicaps? Yes No If yes, please explain _____

List any known allergies/medical problems _____

Parent Roster: May we include you on our parent roster? Yes No

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.

Mother/Guardian: (Person child lives with)

Last First Middle

Name: _____ Social Security # _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (____) _____ Cell Phone #: (____) _____

Company/Employer Name: _____

Work Phone #: (____) _____ E-Mail _____

Father/Guardian:

Last First Middle

Name: _____ Social Security # _____

Address (if different from Parent 1): _____

City: _____ State: _____ Zip: _____

Home Phone #: (____) _____ Cell # _____

Company/Employer Name: _____

Work Phone #: (____) _____ Second Work Phone #: (____) _____

We need a security code for your child in case another person picks up. It will be your responsibility to give it to this person. The child will not be released without this information.

CODE WORD _____

Family guidelines for determination of fees for sliding fee scale for the **2017-18** school year.
Annual Gross Income

| Family size | Level I \$0 | Level II | Level III | Level IV | Level V | Level VI | Level VII |
|-------------|----------------|---------------------|---------------------|---------------------|---------------------|--------------------|-----------------|
| 2 | \$0 - \$16,020 | \$14,571 - \$18,212 | \$18,213 - \$21,855 | \$21,856 - \$25,497 | 25,498 - \$26,954 | \$26,955 - 29,140 | \$32,040 and up |
| 3 | \$0 - \$20,160 | \$18,311- \$22,887 | \$22,888- \$27,465 | \$27,466 - \$32,042 | \$32,043 - \$33,873 | \$33,874 - 36,620 | \$40,320 and up |
| 4 | \$0 - \$24,300 | \$22,051 - \$27,562 | \$27,563 - \$33,075 | \$33,076 - \$38,587 | \$38,588 - \$40,792 | \$40,793 -44,100 | \$48,600 and up |
| 5 | \$0 - \$28,440 | \$25,791 - \$32,237 | \$32,238 - \$38,685 | \$38,686- \$45,132 | \$45,133 - \$47,711 | \$47,712 - 51,580 | \$56,880 and up |
| 6 | \$0 - \$32,580 | \$29,531 - \$36,912 | \$36,913 - \$44,295 | \$44,296 - \$51,677 | 51,678-54,630 | \$54,631-\$59,060 | \$65,160 and up |
| 7 | \$0 - \$36,370 | \$33,271 - \$41,587 | \$41,588 - \$49,905 | \$49,906 - \$58,222 | \$58,223 - 61,549 | \$61,550 - 66,540 | \$73,460 and up |
| 8 | \$0 - \$40,890 | \$37,011 - \$46,262 | \$46,263 - \$55,515 | \$55,516 - \$64,767 | \$64,768 - \$68,468 | \$68,469 -\$74,020 | \$81,780 and up |

For family units with more than 8 members, add \$3,740 for each additional member.

*If you feel your family would qualify for financial assistance, please complete the following questionnaire and supply proof of income. Please estimate the amounts of income that you and your family (include spouse and children/dependents, if any) receive from the following sources last month:

- a. Father's employment \$ _____
- b. Mother's employment \$ _____
- c. Your parents/relative/friends who live with you \$ _____
- d. Alimony \$ _____
- e. Child support \$ _____
- f. Welfare: ADC/GA \$ _____
- g. Social Security benefits \$ _____
- h. Unemployment benefits \$ _____
- i. Workers compensation \$ _____
- j. Interest/dividends/savings/instruments \$ _____
- k. Other: _____ \$ _____

Gross (total) monthly income \$ _____

Number of persons supported by this income # _____

Print names of anyone living in this household that was not listed on the first page

 *Proof of income can be a duplicate copy of last two pay stubs from employed family members, Medicaid card, ADC card, Social Security check stub, income tax return, or some other written form of documentation of your family income. This documentation will be copied and immediately returned to you. You may ask a secretary in the Adult Education office to copy it for you. It must be attached to this form in order to be considered for financial assistance.

The information on this application form is complete and true to the best of my knowledge.

Parent Signature

Child's Name

Medical Information:

Physician: _____ Phone #: (____) _____
 Dentist: _____ Phone #: (____) _____
 Preferred Hospital: _____
 Insurance Provider: _____ Policy #: _____ Phone #: (____) _____

Emergency Transportation Authorization:

State Law requires that we have written authorization from a child's legal guardian to seek medical help in the event of a medical emergency. Signing the statement of this letter will provide us with that authorization.

Our policy, in the event of a medical emergency is to contact you first. If we can't contact you, we will try to contact any others you may designate. In the event that we are unable to contact you or designated representative(s), or if the medical emergency warrants immediate response, we will act, on your behalf and in the best interests of the child

Authorization Date: ____ / ____ / ____ Parent's Signature: X _____
 Special Instructions (if any): _____

II. Refusal To Grant Permission: Parent's Signature: X _____:
 What action should be taken? _____

Immunization Dates:

DPT: _____
 Polio: _____ * _____
 MMR: _____
 HIB: _____
 Other: _____ Please Specify: _____
 Child Immunizations attached

Emergency Contact/Authorized Pick-up People: MUST have two additional people other than the parents.

The child will only be released to a designated individual unless prior arrangements are made. If, based on the opinion of the instructor, this individual appears to be impaired, the child will NOT be released.

Contact (1) Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone #: _____ Second Phone #: _____ Relationship to Child: _____
 Emergency Contact: Yes No Authorized to Pick Up: Yes No

Contact (2) Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone #: _____ Second Phone #: _____ Relationship to Child: _____
 Emergency Contact: Yes No Authorized to Pick Up: Yes No

Please give your emergency contact person the CODE word for pick up.

Child's Name

| <u>Names of other Children in the Family:</u> | <u>Birth Date</u> |
|--|--------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Preschool Screening Authorization:

I/We _____
(Parent/Guardian – Please print name)

give the Medina County Career Center Public Preschool Program permission to administer appropriate screens. These will include but not be limited to assessing basic developmental skills, speech, language, hearing, and vision.

Agree to Preschool Screening: Yes No

The information on this application form is complete and true to the best of my knowledge.

X _____
Signature of Parent/Guardian

Date

MEDIA RELEASE

I allow for my child's picture to be taken for media purposes related to publicity and or daily/special events for the Medina County Career Center

Child's Name _____

Parent's Name _____

Date _____

I do not give permission for pictures to be taken of my child.

Child's Name _____

Parent's Name _____

Date _____