



St. Helen School

Living Virtue · Building Character

Dear Preschool Parents,

On behalf of the preschool team at St. Helen, welcome to our program! We are looking forward to a productive partnership with you to ensure our children can achieve their highest potential. We recognize that in order to be successful in school, our children need support from both the home and school. We know a strong partnership with you will make a great difference in your child's education. As a proactive team we will prepare students to be confident in their skills for Kindergarten.

Our Step up to Quality program, designated with a Gold rating, strives to target math, science, social studies, language arts, religion (faith formation), social and emotional standards while turning the learning into a memorable experience in a faith-filled environment. Our highly qualified staff has daily communications, utilizes Class Dojo, weekly newsletters, and enrichment projects sent home. Staff also conferences with families twice a school year to discuss goals and student performance. Lessons are built around each child's individual learning needs.

Registration Required Forms & Documents:

- Registration fee: \$150 per family
- Completed Registration Packet
- Birth Certificate
- Immunization/Shot Record
- Baptismal Certificate
- Custody Papers (If applicable)
- Child Medical Form

Preschool Hours and Late Pick-Up Procedures:

Our preschool hours are 8:00-2:50 pm, Monday through Friday for the five day full day program. The half day program starts at 8:00 am and pick-up is 11am. Your child may be dropped off as early as 7:35 am. If your child arrives later than 8:00 am, they are considered late, and must be taken to the main office to be signed in. We ask that you bring your child on time, as tardiness has a trickle effect on the class and is a disruption.

Contact Information:

It is critical that we have current information on your child's emergency form including accurate names, phone numbers, and addresses. If there are any changes in your contact information or pick up people, please notify us immediately. In addition, it is always helpful to know if there are any changes in your routine at home or in your child's life that may affect. Please communicate to us through Class Dojo or email. We ask that you connect to Class Dojo immediately. This provides a window into our class, teacher/school information, and specific updates on your child.

Preschool Orientation:

Prior to the start of next school year, we will hold a Preschool Orientation for all preschool parents. It will cover important information and procedures for the upcoming school year. Parents are strongly encouraged to attend. We will notify all preschool families about the details of this event once we have them.

We feel privileged to be a part of this school family and thank you for your support.

Sincerely,

The Preschool Staff

Updated 01/15/2025





| | Student 1 (youngest) | Student 2 | Student 3 |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| First Name | | | |
| Middle Name | | | |
| Last Name | | | |
| Nickname | | | |
| Grade Level (25-26)) | | | |
| Date of Birth | | | |
| Place of Birth | | | |
| Gender | Male / Female | Male / Female | Male / Female |
| Last 4 digits SS# | | | |
| Religion | Catholic / Non-Catholic | Catholic / Non-Catholic | Catholic / Non-Catholic |
| Student Lives with: | | | |
| Hispanic | Yes or No | Yes or No | Yes or No |
| Race (Circle One) | American Indian/Native Alaskan Asian Black Native Hawaiian/Pacific Islander White Multi-Racial | American Indian/Native Alaskan Asian Black Native Hawaiian/Pacific Islander White Multi-Racial | American Indian/Native Alaskan Asian Black Native Hawaiian/Pacific Islander White Multi-Racial |
| The EdChoice Scholarship (Circle One) | Applying for EdChoice Receive EdChoice/Renewal I Choose not to apply | Applying for EdChoice Receive EdChoice/Renewal I Choose not to apply | Applying for EdChoice Receive EdChoice/Renewal I Choose not to apply |
| School Previously attended | | | |
| My child has been recommended for, or is currently on an: IEP, 504 Plan, RIMP, Title 1 Services | IEP: Yes / No 504 Plan: Yes / No RIMP (Grades K-3): Yes / No Title 1 Services: Yes / No | IEP: Yes / No 504 Plan: Yes / No RIMP (Grades K-3): Yes / No Title 1 Services: Yes / No | IEP: Yes / No 504 Plan: Yes / No RIMP (Grades K-3): Yes / No Title 1 Services: Yes / No |
| Incoming 4 th Grader: Did your child earn a promotion score on the 3 rd grade reading Test? | Yes / No N/A | Yes / No N/A | Yes / No N/A |
| My child was retained? What grade level? | Yes / No Grade: _____ | Yes / No Grade: _____ | Yes / No Grade: _____ |
| My child was asked to leave a previous school? | Yes / No | Yes / No | Yes / No |

| | Yes | No |
|-------------------------------------------------------------------------------------------------|-----|----|
| Do you agree to have your name and phone # available on a class roster? | | |
| Do you agree to allow St Helen Preschool to use photos of your child on social media platforms? | | |
| Do you agree to allow St Helen Preschool to post photos of your child in the hallway? | | |

_____I understand that my cell phone and any alternate phone #'s listed will be used for our parent notification system.

_____I would like documents sent home in Spanish when available.

Parent/Guardian Signature: _____ **Date:** _____

Sacrament Information

Student 1 Name: _____

| Sacraments | Received (Yes or No) | Date | Church | City/State |
|-----------------|-------------------------|------|--------|------------|
| Baptism | | | | |
| First Communion | | | | |
| Reconciliation | | | | |
| Confirmation | | | | |

Student 2 Name: _____

| Sacraments | Received (Yes or No) | Date | Church | City/State |
|-----------------|-------------------------|------|--------|------------|
| Baptism | | | | |
| First Communion | | | | |
| Reconciliation | | | | |
| Confirmation | | | | |

FATHER/GUARDIAN

Name of Father/Guardian: _____ Father Step Father Guardian
Last First

Home Address: _____
Address Street City State Zip
 Same as Child (ren) Different as Child (ren)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Marital Status (Circle One): Single / Married / Divorced / Widow

Employer: _____ Job Title: _____

If Military (Circle One): Active / Reserve / Retired / Contractor

Religion: _____ Are you an active member of St. Helen Parish? Yes No

If other than English, what language do you speak? _____

MOTHER/GUARDIAN

Name of Mother/Guardian: _____ Mother Step-Mother Guardian
Last First

Home Address: _____
Address Street City State Zip
 Same as Child (ren) Different as Child (ren)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Marital Status (Circle One): Single / Married / Divorced / Widow

Employer: _____ Job Title: _____

If Military (Circle One): Active / Reserve / Retired / Contractor

Religion: _____ Are you an active member of St. Helen Parish? Yes No

If other than English, what language do you speak? _____

Additional Questions:

1. Do you currently have any siblings that live in the same household, attend St. Helen School?
 - a. If yes, please list:
 - i. Name _____ Grade: _____
 - ii. Name _____ Grade: _____
 - iii. Name _____ Grade: _____
2. Are there any legal restraints prohibiting a parent/guardian from having access to the listed student(s) data?
 - i. ____ Yes (please provide custody or court documentation)
 - ii. ____ No
3. Communication to families (newsletters, etc) will be via email, auto-calls, and occasional text message. Family information may also be accessed through our school website, www.sainthelenschool.org. Click on "Current Families".
4. What phone number would you like listed as your **PRIMARY** form of contact? _____

EMERGENCY CONTACT/PICKUP INFORMATION
(Must be different from Parent/Guardian listed above)

| Name | Phone Number | Relationship to Student |
|------|--------------|-------------------------|
| | | |
| | | |
| | | |

5. How did you hear about St. Helen School? _____

New Student Enrollment Process Statement:

I understand that completion of this application DOES NOT guarantee enrollment. Student(s) must successfully complete the screening process, complete all registration forms and submit all required documentation. The non-refundable fee of \$150 per family is due with this application to be considered for enrollment. All students will be in a probationary period for the first seven weeks of the school year. St. Helen will notify you upon completion of the enrollment process and acceptance.

Handbook:

Parent/Guardian and student agree to abide by the policies and procedures in the Parent/Student Handbook. A copy is available at https://www.sainthelenschool.org/_files/ugd/de0d58_ac0311585ef94b97b7c5ba44e0623126.pdf or a paper copy may be requested from the school office

I affirm and certify that all the information and answers to questions herein are complete, true and correct to the best of my knowledge and belief. I understand that any misrepresentation, falsification, or omission of any facts called for in the application may render this application void and will be cause for withdrawal from St. Helen School whenever discovered.

Signature: _____

Date: _____

Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| Student Name: <i>(First Name and Last Name)</i> _____ | | Student Date of Birth: <i>(mm/dd/yyyy)</i> _____ |
| Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand. | 1. In what language(s) would your family prefer to communicate with the school? _____ | |
| | Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed. | |
| Prior Education Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child. | 2. What language did your child learn first? _____ | |
| | 3. What language does your child use the most at home? _____ | |
| Additional Information Please share additional information to help us understand your child's language experiences and educational background. | 4. What languages are used in your home? _____ | |
| | 5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years/months? _____ If yes, what was the language of instruction? _____ | |
| 7. Has your child attended school in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month Day Year | | |
| Parent/Guardian First Name: _____ Parent/Guardian Last Name: _____ Parent/Guardian Signature: _____ Today's Date: <i>(mm/dd/yyyy)</i> _____ | | |

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: <https://www2.ed.gov/about/offices/list/ocr/ellresources.html>



(Appendix A, continued)

*****COMPLETED BY SCHOOL EMPLOYEE*****

1. **Check.** Confirm the following statements related to the administration of Ohio's language usage survey:

- The district or school presented the language usage survey, to the extent practicable, in a language and form that the parent or guardian understood.
- The district or school informed the parent(s) or guardian(s) of the form's purpose. The language usage survey only is used to understand students' linguistic experiences and educational background.
- The district or school reports information from the language usage survey in the appropriate Educational Management Information System (EMIS) records.
- For students enrolling from other U.S. schools and districts, school officials request previous language survey data and refer to the information when identifying English learners.
- Results of the language usage survey are kept with the student's cumulative records and follow the student if he/she transfers to another district or school.

2. **Note.** Record additional information to assist the review of the language usage survey.

3. **Record.** Indicate responses from the language usage survey in the table below. Refer to the Language Usage Survey Annotations on page 2 for item-specific guidance.

| | |
|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Student's native language See Language Usage Survey Question 2. Report for <u>all</u> students in EMIS.</p> | <p>_____</p> |
| <p>Student's home language See Language Usage Survey Question 3. Report <u>only</u> for English learners in EMIS.</p> | <p>_____</p> |
| <p>Potential English learner See Language Usage Survey Questions 2-4.</p> | <p><input type="checkbox"/> Yes. Assess the student's English proficiency. <input type="checkbox"/> No. Do not assess the student's English proficiency.</p> |
| <p>Immigrant student status See Language Usage Survey Questions 5-7. Report for <u>all</u> students in EMIS.</p> | <p><input type="checkbox"/> Yes, the student is an immigrant child. <input type="checkbox"/> No, the child is not an immigrant child.</p> |

4. **Validate.** Complete the information below.

Signature of validating school employee

Date (mm/dd/yyyy)

Printed name of validating school employee

Name of school or school district

ST. HELEN SCHOOL

EMERGENCY MEDICAL AUTHORIZATION

Student Legal Name (Last-First-Middle) Birth Date
Address City Zip School District
Grade Home Room Teacher
Primary Contact Mother/Guardian Father/Guardian
Place of Employment
Cell #
Home #
Work #

Authorized persons to assume responsibility for school dismissal and provisions of care when a parent/guardian cannot be reached:

- 1. Phone Relationship
2. Phone Relationship

Insurance: Private - Name Medicaid/Medicare - Name None

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:

Doctor Phone
Dentist Phone
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 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:

Blank lines for action details

Signature of Parent/Guardian Date

IMPORTANT NOTE:

STUDENTS WILL NOT BE ALLOWED TO ATTEND CLASS UNTIL ALL FORMS ARE COMPLETED, SIGNED, AND RETURNED TO THE SCHOOL OFFICE. ADDITIONALLY, IMMUNIZATION RECORDS MUST BE ON FILE PRIOR TO THE FIRST DAY OF SCHOOL.

COMPLETE BOTH SIDES

ST. HELEN SCHOOL
Health History (Parent Fills Out)

| | | |
|----------------|----------------------------------------------------------------------|------------------------|
| Student's Name | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth / / |
|----------------|----------------------------------------------------------------------|------------------------|

Student Health Conditions

| | | |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> YES , my child receives regular medical/health care for the following conditions: | | <input type="checkbox"/> NO medical conditions |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Ear problem/hearing difficulty | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Emotional concerns | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Behavior concerns | <input type="checkbox"/> Headaches | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Birth/congenital malformations | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Vision problems (glasses, contacts) |
| <input type="checkbox"/> Bone/muscle/joint problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blood problems | <input type="checkbox"/> Juvenile arthritis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bowel/bladder problems | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Neuromuscular disorder | <input type="checkbox"/> Other _____ |

DOES YOUR CHILD HAVE ANY LIFE THREATENING ALLERGIES? YES NO (If yes, please list and describe symptoms.)

DOES YOUR CHILD USE AN EPI-PEN? YES NO

| | | |
|-----------------------------------------------------------------------------------|-------------|---------------|
| Please list any prescription medication that your child takes on a regular basis. | | |
| Medication and dose | Time | Reason |
| | | |
| | | |
| | | |
| | | |

MEDICATION ADMINISTRATION

MEDICATION WILL NOT BE ADMINISTERED AT SCHOOL UNLESS FORM A AND FORM B HAVE BEEN SIGNED AND DATED BY THE PROVIDER AND PARENT.

I release and agree to hold the St. Helen School Board, its officials, and its employees harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian: _____ **Date:** _____

Updated: 02/02/2024

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? *(check all that apply)*

- No
 Yes - *check all that apply* Food Medication Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? *(check one)*

- No
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? *(check one)*

- No
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? *(check one)*

- No
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? *(check one)*

- No
 Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

- No
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? *(check one)*

- No
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No
 Yes - written instructions from the child's health care provider must be on file.
 N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable



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 _____

| Immunizations: | | Exempt from Immunization: | |
|------------------|----------------------------------------------------|---------------------------|----------------------------------------------------|
| Complete for Age | <input type="radio"/> Yes <input type="radio"/> No | Religious Conviction | <input type="radio"/> Yes <input type="radio"/> No |
| In Process | <input type="radio"/> Yes <input type="radio"/> No | Health | <input type="radio"/> Yes <input type="radio"/> No |
| | | Other | _____ |

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

[Empty box for 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.

Immunizations Record

Please get a list of your child's immunizations to date from your family doctor and include that here:

Records de Vacunas

Por favor obtenga el último record de vacunas de su hijo e incluyala aqui.

Child Screening Program
Sarah Wrazen, Child Screening Specialist
660 South Main Street
Dayton, Ohio 45402
937.528.6460 Email: s.wrazen@gesmv.org

For Office Use:

CHILD CARE:

Date of Admission:

0-3 3-6

County: _____

Typical

Referral: _____

Rescreen ___/___/___ ASQ +SE ITC

Rescreen Results: _____

PERMISSION TO SCREEN

Goodwill Easter Seals Miami Valley (GESMV) Child Screening Team has permission to perform an onsite developmental screening on my child and/or review my child's parent-completed Ages and Stages Questionnaires (ASQ). My child's early childhood program has permission to submit a screening for my child into the secure GESMV ASQ Online Enterprise System for review and follow-up on screening results. GESMV may release screening results and exchange information with my child's early childhood program. In the event of suspected delay or concern, GESMV has permission to make a referral and exchange information with Help Me Grow (applicable children 0-36 months only), your child's home school district (children ages 3-5 years), and/or your child's physician (if physician contact information is listed below). Intervention services are voluntary programs and parents may accept or refuse participation once a Help Me Grow or school district professional contacts the family. If concerns are present on your child's screening, GESMV will attempt to contact you by phone or email to discuss these assessment options and gather additional developmental information. At times, GESMV may run general data reports to share with community stakeholders to determine the effectiveness and scope of the online screening partnership. This shared data will **NOT** include identifiable child information including names or family contact information.

Male / Female (please circle)

Child's Name (First) (Middle) (Last)

Date of Birth ___/___/___ Number of Weeks Premature ___ (if under 2 yr.)

LANGUAGES OTHER THAN ENGLISH SPOKEN IN THE HOME: _____

Signature of Legal Guardian

Phone (Best)

Legal Guardian's Name (Please Print)

Email

Relationship to Child

Ethnicity/Race (optional)

Address

City

State

Zip Code

County

Home School District

in the event of a suspected developmental concern, a copy can be sent to your child's doctor/clinic:

Child's Doctor/Clinic Name

Street Name (Doctor)

YES NO (please circle) Does your child receive any current intervention services?

YES NO (please circle) Does your child have a current IFSP (Help Me Grow)

YES NO (please circle) Does your child have a current IEP for special needs preschool (school district)?

YES NO (please circle) Does your child receive private therapy?

Birth Certificate

Please make a copy of your child's birth certificate and include that here.

Certificado de Nacimiento

Por favor obtenga una copia de certificado de nacimiento de su niño e incluyala aqui.