

Dear Parents,

Thank you so much for sharing your child with us for the next nine months! We promise to take great care of them and make sure they enjoy their school experiences. Before school begins, we would love to learn a little bit more about your very special child. Please take just a few minutes to share a little with us about your preschooler.

Here are some things you might want to tell us:

- Does your child have a nickname? What name would you prefer we use at school?
- Does your family have any pets?
- Does your child have any siblings? We would love to know their names and ages
- Is your preschooler allergic to anything?
- Has your son or daughter attended preschool before?
- What is your preschooler looking forward to most about coming to school?
- What do YOU most want your son or daughter to gain from coming to preschool?

Also, please let us know of any special things about your child that will help us make their preschool experience the very best for him or her. If you could send us a photo of your child, that would be great too!

Please bring the letter about your child the first day of school. Thanks so much in advance! See you soon!

Sincerely,

Zion Lutheran Preschool Teacher and Aides

## Zion Lutheran Preschool 2019/2020 School Calendar

Thursday, August 29	Orientation/Open House - ALL students 6:30pm - 7:30pm
Tuesday September 3	Tues/Thurs classes begin
Wednesday, September 4	Mon/Wed/Fri classes begin
Monday, October 14	NO SCHOOL - Staff inservice
<b><u>Parent/Teacher Conferences</u></b> <b><u>*CONFERENCES DURING SCHOOL HOURS*</u></b>	
Monday, November 25	NO SCHOOL
Tuesday, November 26	NO SCHOOL
Wednesday, November 27 thru Friday, November 29	NO SCHOOL - Thanksgiving Break Happy Thanksgiving!
Sunday, December 15	Christmas Program 11:00am Service
Monday, December 23 thru Friday, January 3	Christmas Break MERRY CHRISTMAS
Monday, January 6	School resumes - Mon/Wed/Fri classes
Tuesday, January 7	School resumes - Tues/Thurs classes
Monday, January 20	NO SCHOOL - Martin Luther King Day

*\*Dates are subject to change.\**

*\*A revised calendar will be sent home if any changes are made.\**

## Zion Lutheran Preschool 2019/2020 School Calendar

Friday, February 14	NO SCHOOL - Staff inservice
Monday, February 17	NO SCHOOL - President's Day
Monday, April 6 thru Monday, April 13	NO SCHOOL - SPRING BREAK HAPPY EASTER
Tuesday, April 14	School resumes - Tues/Thurs classes
Wednesday, April 15	School resumes - Mon/Wed/Fri classes

### Parent/Teacher Conferences

#### \*CONFERENCES DURING SCHOOL HOURS\*

Thursday, May 7	NO SCHOOL
Friday, May 8	NO SCHOOL

Tuesday, May 19	Last day of class - Tues/Thurs classes 3's end of year celebration
Wednesday, May 20	Last day of classes MWF & M-F FIELD DAY!
Wednesday, May 20	4's graduation 6:30pm

*\*Dates are subject to change.\**

*\*A revised calendar will be sent home if any changes are made.\**

Ohio Department of Job and Family Services  
**CHILD ENROLLMENT AND HEALTH INFORMATION  
 FOR CHILD CARE**

**This form shall be completed prior to the child's first day of attendance and updated annually and as needed.**

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code		Home Telephone Number	
Parent/Guardian Name				Relationship to Child	
Home Address				Home Telephone Number	
City				State	Zip
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name				Relationship to Child	
Home Address				Home Telephone Number	
City				State	Zip
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
<b>Emergency Contacts: Parents <u>cannot be listed</u> as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness <u>if you cannot be reached</u>. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.</b>					
Name			Name		
City		State	City		State
Telephone Number		Relationship to Child	Telephone Number		Relationship to Child
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State		Telephone Number	

Child's Name

**Allergies, Special Health or Medical Conditions, and Food Supplements**

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 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care 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, take action if a reaction occurs, or give emergency medication to your child? *(check one)*

- No  
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a 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 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? *(check one)*

- No  
 Yes - please explain

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

- No  
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.  
 N/A - program does not administer any medications.

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 the JFS 01217 "Request for Administration of Medication."  
 N/A - child does not attend a full time program.



**Please help our staff by answering the following questions:**

Is your child  Right Handed  
 Left Handed  
 No Preference

Name you wish your child to be called, recognize and begin writing:

Does your child have any particular fears, habits or expressions that we should be aware of? Please describe:

In general, how does your child react to anxiety or a stressful situation? Please describe:

To the best of your knowledge, does your child have any language, learning or physical disabilities? If so, please describe:

Whom does the child live with:

<input type="checkbox"/> mom/dad	<input type="checkbox"/> adoptive parent(s)
<input type="checkbox"/> mom	<input type="checkbox"/> foster parent(s)
<input type="checkbox"/> dad	<input type="checkbox"/> grandparent(s)
<input type="checkbox"/> mom/stepdad	<input type="checkbox"/> legal custodian
<input type="checkbox"/> dad/stepmom	

Does the child reside fulltime at home address?  yes  no

If no, where else does the child reside and how often? (i.e. at dad's every weekend)

Please list all people living with the child at home address including parent, sibling etc.

Name \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Church Affiliation \_\_\_\_\_

Does child attend Sunday school? \_\_\_\_\_ Church? \_\_\_\_\_

School District child will attending in Kindergarten? \_\_\_\_\_



**EMERGENCY MEDICAL AUTHORIZATION FORM**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

\_\_\_\_\_

**Purpose:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address \_\_\_\_\_

Other's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address \_\_\_\_\_

**PART I OR II MUST BE COMPLETED**

**(SEE REVERSE SIDE)**

**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(s) \_\_\_\_\_ Emergency Rm. Phone \_\_\_\_\_

\_\_\_\_\_ Emergency Rm. 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 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.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

\_\_\_\_\_  
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:

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**BLANKET PARENT PERMISSION  
FOR ACTIVITIES AWAY FROM THE CENTER**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Father's Day Phone \_\_\_\_\_ Mother's Day Phone \_\_\_\_\_

The above named child has my permission to participate in all center activities. I am willing to have my child take part in walking trips and trips involving the use of motor vehicles or public transportation. I understand that a notice will be sent home providing specific information about any activity which will occur outside the center's facility.

Emergency contact if parent/guardian is not available:

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Photo Release

### RELEASE FOR USE OF PHOTOS IN PUBLICATIONS AND ON WEBSITE

I, \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_ (name of child) and I give Zion Lutheran Preschool of Dayton, Inc. the perpetual, royalty-free right to use such child's photo in any manner they wish, whether combined with other photos or text:

\_\_\_ YES \_\_\_ NO in Zion Lutheran Preschool's publications

\_\_\_ YES \_\_\_ NO on Zion Lutheran Preschool's Website

I understand that both the website and the publication may have a large audience and my child's photo will be available to the general public. I further understand that Zion Lutheran Preschool of Dayton, Inc. assumes no liability or responsibility whatsoever concerning any consequences of such use.

Parent Name or Legal Guardian \_\_\_\_\_

(please print)

Signature \_\_\_\_\_

Date \_\_\_\_\_

Phone Number \_\_\_\_\_

### Abstract

Abstract text block containing two lines of text.

Main body of text, consisting of several paragraphs of illegible text.

Text block at the bottom of the page, possibly a conclusion or reference.

August 1, 2018

Parents,

Our Zion Lutheran Facebook Page is up and running. Below are some important things you need to know.

\*Please **initial beside each statement** acknowledging that you have read and understand.

\_\_\_\_\_ This is a public page and can be viewed by anyone.

\_\_\_\_\_ All posts and pictures will be reviewed before they are posted.

\_\_\_\_\_ Parents need to be conscious of faces of other children in pictures that share to the page and understand they may not be posted if there are children pictured that do not have permission to be published on Facebook.

Please indicate below whether you allow your child's face to be viewed on our Facebook Page.

\_\_\_\_\_ **Yes, I DO** give permission for my child's photo or video, with their face visible, to be displayed on Zion Lutheran Preschool's Facebook page. I understand this is a public page and can be viewed by anyone. I can revoke my permission at any time.

Child's Name \_\_\_\_\_

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

\_\_\_\_\_ **No, I DO NOT** give permission for my child's photo or video, with their face visible, to be displayed on Zion Lutheran Preschool's Facebook page. I can grant permission at any time if I change my mind.

Child's Name \_\_\_\_\_

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

**ZION LUTHERAN PRECHOOL  
Preschool Directory**

Zion Lutheran Preschool of Dayton, Inc. is required to offer a parent directory to all parents/guardians of enrolled children. This would include your child's name, parent(s)/guardians names, home phone number and email address. Please choose one of the below options:

I/We do not wish to be included in the parent directory

Name \_\_\_\_\_ Date \_\_\_\_\_

I/We grant permission to be included in the parent directory\*\*

Name \_\_\_\_\_ Date \_\_\_\_\_

\*\*Please complete the following information as you would like it to appear in the directory:

Child's name \_\_\_\_\_

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

Telephone number \_\_\_\_\_

Email address \_\_\_\_\_

Child's Name \_\_\_\_\_

Child's Home Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_

Dad's Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mom's Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Allergies/Medical Conditions? \_\_\_\_\_

Out of town Emergency Contact Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Child's Name \_\_\_\_\_

Child's Home Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_

Dad's Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mom's Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Allergies/Medical Conditions? \_\_\_\_\_

Out of town Emergency Contact Name \_\_\_\_\_

Day Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_



Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT FOR CHILD CARE**

Child's Name ( <i>print or type</i> )	Date of Birth
<input checked="" type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. <input checked="" type="checkbox"/> This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).	
<b>Signature</b> of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number
Street Address	
City, State and Zip Code	

**ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS**

**Exceptions to Immunization requirements pursuant to 5104.014 ORC** (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature
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<b>Optional Recommended Assessments/Screenings</b>			
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
<b>Measurements</b>		<b>Notes</b>	
Height			
Weight			
BMI			

## **Signed Handbook Statement**

I hereby request that my child be enrolled in Zion Lutheran Preschool. I understand that my child is registered for the full school term and tuition is due whether or not my child is able to attend classes. In the event of necessary withdrawal, thirty days notice in writing or one month's tuition must be given to the Preschool director.

I agree to furnish all registration forms; including a completed child's medical statement signed by a physician and a signed emergency medical authorization form; prior to my child's admittance to preschool.

My signature indicates that I have received and read the parent handbook and will abide by all policies and rules outlined in it.

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Please print name

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Child's name

---

Signature of Parent or Guardian

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Date

1

**VERIFICATION OF PARENT/GUARDIAN REVIEW AND RECEIPT  
OF CENTER POLICIES AND PROCEDURES  
(5101:2-12-30, OAC)**

- Licensing Information**
- Center Program Information**
- Guidance and Management Policy**
- Supervision of Children Information**
- Food Information**
- Procedures for Emergencies and Accidents**
- Management of Illness**
- Transportation of Children**
- Swimming Policy (if applicable)**
- Outdoor Play Policy**
- Parent Participation Policy**
- Evening/Overnight Care Information (if applicable)**
- Fees, Overtime Charges**
- Registration, Permanent Disenrollment Information**
- Enrollment and Health Information which is required for admission**
- Additional Center Policies (if applicable)**

**I have received and reviewed all of the above information.**

**Parent/Guardian Name (print)** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Snack Ideas for Preschool

- muffins
- cinnamon or raisin bread
- granola bars
- applesauce
- fresh fruit
- bananas, mandarin oranges, strawberries, apples, blueberries, kiwi, pineapple, peaches, pears, grapes, cantaloupe, watermelon
- fruit salad
- veggies with ranch dressing or hummus
- carrots, cucumbers, celery, peppers, broccoli
- cheese and crackers (string, cube or cream cheese or cheese slices)
- pretzels
- goldfish
- cereal
- yogurt with fruit and granola
- yogurt cup or tub of yogurt
- bagels with cream cheese
- chex mix
- soft pretzels and cheese
- cheeze-it crackers
- hummus with veggies or pretzels
- pudding
- waffles
- animal crackers

## GENERAL GUIDELINES FOR KEEPING CHILDREN HOME FROM SCHOOL DUE TO ILLNESS

It is sometimes difficult to decide when and how long to keep an ill child home from school. The timing of the absence is often important in order to decrease the spread of disease to others, and to prevent your child from acquiring any other illness while his/her resistance is lowered.

**CHICKEN POX:** A skin rash consisting of small blisters, which leave scabs. A slight fever may or may not be present. There may be blisters and scabs all present at the same time. Your child should remain home until all blisters have scabbed over, usually 5-7 days after the appearance of the first crop of blisters.

**COMMON COLD:** Irritated throat, watery discharge from the nose and eyes, sneezing, chilliness and general body discomfort. Your child should remain home if symptoms are serious enough to interfere with your child's ability to learn. Medical care should be obtained if symptoms persist beyond 7-10 days, fever develops, or discharge becomes yellow to green.

**FEVER:** If your child's temperature is 100 degrees Fahrenheit or greater (or 1 or 2 degrees above the child's normal temperature) he/she should remain home until she/he has been without fever for a full 24 hours. Remember, fever is a normal symptom indicating the presence of an illness.

**FLU:** Abrupt onset of fever, chills, headache and sore muscles. Runny nose, sore throat, and cough are common. Your child should remain home from school until symptoms are gone and the child is without fever for 24 hours.

**HEAD LICE:** Lice are small grayish-tan, wingless insects that lay eggs called nits. Nits firmly attach to the hair shafts, close to the scalp. Nits are much easier to see and detect than lice. They are small white specks, which are usually found at the nape of the neck and behind the ears. Following lice infestation, your child may return to school after receiving treatment with a pediculicide shampoo, AND ALL NITS HAVE BEEN REMOVED.

**IMPETIGO:** Blister-like lesions, which later develop into crusted pus-like sores. Your child should remain home from school until receiving 48 hours antibiotic therapy and sores are no longer draining.

**PAIN:** If your child complains, or behavior indicates, that she/he is experiencing persistent pain, she/he should be evaluated by a physician before your child is sent to school.

**PINKEYE:** Redness and swelling of the membranes of the eye with burning or itching, matter coming from one or both eyes, or crusts on the eyelids. Your child should remain home from school until receiving 24 hours of antibiotic therapy and discharge from the eyes has stopped. Spread of infection can be minimized by keeping the hands away from the face, good hand-washing practices, using individual washcloths and towels, and NOT touching any part of the eye with the tip of medication applicator while administering the antibiotic ointment.

**SKIN RASHES:** Skin rashes of unknown origin should be evaluated by a physician before your child is sent to school.

**STREP THROAT AND SCARLETT FEVER:** Strep throat begins with fever, sore and red throat, pus spots on the back of the throat, tender swollen glands of the neck. With scarlet fever, there are all the symptoms of strep throat as well as a strawberry appearance to the tongue and rash of the skin. High fever, nausea, and vomiting may also occur. Your child should remain home from school until receiving a full 24 hours of antibiotic therapy and until without fever or vomiting for 24 hours. Most physicians will advise rest at home 1-2 days after a strep infection.

Antibiotics ordered for strep infections are to be taken for 10 days or until all medication is gone. Only when these directions are followed correctly is the strep germ completely eliminated from the body, no matter how well the child feels after the first few days of receiving medication.

**VOMITING AND DIARRHEA (INTESTINAL VIRAL INFECTIONS):** Stomach ache, cramping, nausea, vomiting and/or diarrhea, possible fever, headache, and body aches. Your child should remain at home until without vomiting, diarrhea or fever for a full 24 hours. If your child has had any of these symptoms during the night, she/he should not be sent to school the following day.

PLEASE KEEP THESE GUIDELINES FOR FUTURE REFERENCE.