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 <u>YOU</u> 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!

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

Sincerely,

Zion Lutheran Preschool Teacher and Aides

Zion Lutheran Preschool
2022/2023 Tentative School Calendar

Tuesday September 6	Tues/Thurs classes begin
Wednesday, September 7	Mon/Wed/Fri classes begin
Friday, October 14	NO SCHOOL - Staff inservice

Parent/Teacher Conferences
CONFERENCES DURING SCHOOL HOURS

Monday, November 21	NO SCHOOL
Tuesday, November 22	NO SCHOOL

Wednesday, November 23 thru Friday, November 25	NO SCHOOL - Thanksgiving Break Happy Thanksgiving!
Monday, December 19 thru Monday, January 2	Christmas Break MERRY CHRISTMAS
Tuesday, January 3	School resumes - Tues/Thurs classes
Wednesday, January 4	School resumes - Mon/Wed/Fri classes
Monday, January 16	NO SCHOOL - Martin Luther King Day
Friday, February 17	NO SCHOOL - Staff inservice
Monday, February 20	NO SCHOOL - President's Day

Dates are subject to change.
A revised calendar will be sent home if any changes are made.

Zion Lutheran Preschool
2022/2023 Tentative School Calendar

Monday, March 27 thru Friday, March 31	NO SCHOOL - SPRING BREAK
Monday, April 3	School resumes - Mon/Wed/Fri classes
Tuesday, April 4	School resumes - Tues/Thurs classes
Friday, April 7 thru Monday, April 10	NO SCHOOL - EASTER BREAK

Parent/Teacher Conferences
CONFERENCES DURING SCHOOL HOURS

Thursday, May 18	NO SCHOOL
Friday, May 19	NO SCHOOL
Tuesday, May 23	Last day of class - Tues/Thurs classes
Wednesday, May 24	Last day of classes MWF & M-F FIELD DAY!
Wednesday, May 24	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 MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below*):

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below*)

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:	**Initials of Examining Health Care Practitioner**
☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent** Date

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 #1		Relationship to Child	
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City		State	Zip
Email Address *(if applicable)*		Cell Phone *(if applicable)*	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2		Relationship to Child	
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City		State	Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

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 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

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**Do Not Give *Permission* to Transport**	
Program or Home Name		**OR**	Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		**Do not sign both**	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

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:

_____ mom/dad

_____ mom

_____ dad

_____ mom/stepdad

_____ dad/stepmom

_____ adoptive parent(s)

_____ foster parent(s)

_____ grandparent(s)

_____ legal custodian

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 _____

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 _____

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.

_____ _____

Please print name Child's name

_____ _____

Signature of Parent or Guardian Date

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 of 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 FUTUTRE REFERENCE.