COLUMBIANA COUNTY EDUCATIONAL SERVICE CENTER
PRESCHOOL 2016-2017

Child	Mother	Father
Birthdate	Employer	Employer
Address	Work Address	Work Address
City, State, Zip	Work Phone	Work Phone
Home Phone	Cell Phone	Cell Phone
Middle Name	Email	Email

Two other close friends, relatives, neighbors who can be contacted in case of an emergency if you, the parent cannot be reached:

Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone	Phone
Relationship to Child	Relationship to Child

People who may pick up my child or receive my child at home (must be 16 years old): MUST BRING PHOTO ID

Name	Relationship to Child
Name	Relationship to Child

Doctor and Dentist preferred in case of an emergency

Doctor or Clinic	Dentist or Clinic
Address	Address
City, State, Zip	City, State, Zip
Phone	Phone

List any special diets/allergies your child may have (special snacks must be provided by the parent)

_____

_____

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

Please complete the back of this page also

Emergency Transportation

Complete Part I OR Part II. DO NOT COMPLETE BOTH

Part I: Permission to Transport Child

I give permission for the program staff to arrange for transportation and have my child_____
(child's name)
transported to _____ for emergency medical care or to _____
(hospital or clinic) (dentist or clinic)
for emergency dental care, OR to the nearest available source of assistance.

Parent Signature:_____ Date:_____

Part II: Refusal to Grant Permission

I **DO NOT** give permission to the program staff to arrange for transportation and have my child transported for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following actions be taken:

_____

Parent
Signature:_____Date:_____

****

Emergency Medical Authorization

Complete Part I OR Part II. DO NOT COMPLETE BOTH

Part I: In the event reasonable attempt to contact me at _____or to contact _____
(phone) (other parent or guardian)
at _____ have been unsuccessful, I hereby give my consent for the administration of any
(phone)
treatment deemed necessary by _____ or in the event the designated preferred practitioner is
(preferred doctor)
not available, by other licensed physician, and then transfer child to _____ or any hospital
(dentist or clinic)
reasonably accessible by ambulance. I agree also to be responsible for payment of such transport. I understand that my child's record may also be released to the hospital staff and/or physician upon treatment. This authorization does not cover major surgery unless the medical opinions of other licensed physicians concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent Signature:_____ Date:_____

Part II: I **DO NOT** give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the following actions to be taken:

_____

Parent Signature:_____Date:_____

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To be completed by medical professional. MUST BE RETURNED BY 9/23/2016

CHILD'S NAME_____ DATE of BIRTH_____

This is to certify that I have examined and have found that he/she:

1) Has had immunizations required by Section 3313.671 of the Ohio Revised Code for admission to school, or has had the immunizations required by the Ohio Department of Health for infants and toddlers, or is to be exempted from these requirements for medical or religious reasons.

DTP	1	2	3	4	5*
Polio	1	2	3	4	5
MMR**	1		Measles	Mumps	Rubella
Hepatitis B	1	2	3		
HIB	1				
Chicken Pox					

** If measles, mumps, rubella not given as MMR, give date for each immunization
**** Physicians Please Note Your Instructions**
**** The 5th DTP and 4th Polio should be administered just prior to: preschool or school entrance.

2) Is free from apparent communicable disease and is in suitable condition to attend a preschool program, based on his/her medical history and physical condition at the time of this examination.

Physician's Signature	
Physician Name (Print)	
Physician Address City, State, Zip Code	
Parent(s)/Guardian Name	

A medical statement is required annually. It may be completed on an annual schedule according initial examination date or it may be completed on a schedule as required by the program for annual updates. It must be current for the child's enrollment year (within the past 12 months.)

Date of Examination	
Child's Name	
Child's Birthdate	

Physical Assessment

Did the examination reveal any abnormalities in the following areas?

	Yes	No	Findings
General Appearance			
Lymph Nodes			
Eyes			
Ears			
Nose/Threat			
Teeth/Gums/Tongue/Palate			
Heart			Blood Pressure: /
Lungs			
Abdomen			
Genitalia			
Skeletal System			
Neuro Muscular			
Allergies			Type: Treatment:

Required Screenings

Please indicate the results of any screenings.

Screening	Date	Results	Follow-up Required? (When)		
			Yes	No	Date
Vision (@ 2 yrs. beg. at age 3)					
Hearing (@ 2 yrs. beg. at age 3					
Speech					
Hematocrit (1st year enrollment)					
Height					
Weight					
Lead*					
TB*					
Urinalysis*					
Other: Sickle Cell, etc.*					

*Check state/local health department requirements and/or policies and recommendations of the program's Health Services Advisory Committee.

1. Allergies (list all allergies affecting the child and any special precautions or treatments indicated for these allergies.)_____
   _____
   _____

2. Medications, food supplements, modified diet, or fluoride supplements (list all medications currently being administered to the child.)_____
   _____
   _____

CHILD'S HEALTH INFORMATION continued

3. Chronic Physical Problems (List all chronic physical problems affecting the child.)_____
_____
_____

4. History of Hospitalization (List dates of all hospitalizations of the child.)_____
_____
_____

5. Diseases (List all diseases the child has had.)_____
_____

Name of Person Completing This Form:	Date:

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Request for the Administration of Medication by Authorized Preschool Staff

Rule 3301-37-04 of the Ohio Administrative Code specifies the requirements for administering medication to children in preschool programs in public school or chartered non-public schools. This form must be completed as outlined below.
NOTE: A separate form must be completed for each medication.

Section I. Parent request for administration of medication, food supplements, modified diet, or fluoride supplements (to be completed when prescription or non-prescription medication is to be administered).

I hereby request and give permission to the authorized preschool staff to administer the following medication to my child:

Name of Child	Age of Child	Name of Medication to be administered
Dosage	Time(s) of Dosage	Signature of Parent and Date

Section II. Physician's or Dentist's Instructions (to be completed when prescription medication is to be administered)

_____ is under my care and should receive _____
(name of child) (name of medicine)
as follows:_____. Specific instructions for administration:_____
(dosage)
Possible side effects:_____. Expiration date (may not exceed six

months from date of this request)_____.

Signature of Physician and/or Dentist	Date	Phone Number
Please print physician's/dentist's names		

Section III. Medication Given by Authorized Preschool Staff Member

_____ was given _____as follows:
(name of child) (name of medicine)
_____, at the following time(s) on the following date(s):

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Preschool Staff Member

Date and Time of Dosage	Amount of Dosage	Signature of Authorized Preschool Staff Member

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PLEASE COMPLETE

Part 1

To Whom It May Concern:

I (We) hereby give permission to the Columbiana County Educational Service Center Preschool Program for my child's participation in video conference, DRUND, and the news media to photograph, videotape, print, reproduce, duplicate and/or distribute pictures of my son/daughter_____.
(Child's name)

It is understood that such pictures may appear in publications and/or media presentations of the Columbiana County Educational Service Center as well as newspapers of general circulation, and such pictures will only be used to inform others about programs offered and services performed by the Columbiana County Educational Service Center.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Part 2

Your child's name will be included on the class lists distributed for school events, such as Valentine Day exchange. A class roster of names, address, and phone numbers will also be made available for parents who request them. This is not distributed except upon request. Do you wish your name, address and phone number to be included in the class roster that parents may request?

Name yes no **Address** yes no **Phone Number** yes no

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date