420 Washington Ave.
Cuyahoga Falls, Ohio 44221
Ph: 330-945-5600 Fax: 330-945-6222

Welcome to the Summit Preschool Program

We are looking forward to working with you and your family this upcoming school year.

Attached is the Registration Packet for the Preschool Program. All forms need to be completed.

- *Please be reminded that your child will need a complete medical and dental examination before entering the program.*
- *Provide a new Proof of Residency*
  Mortgage Statement, Rental/Lease Agreement, and utility bill
  (no junk mail, cell phone bill or credit card statement will be accepted.)

Itinerant Registration Checklist

Please provide all attached forms when completed

____ Emergency Information / Transport Authorization form – to be completed by parent

____ Health Record – to be completed by parent

____ Photo/Roster Release Form – to be completed by parent

All the above items must be completes and turned into the preschool office before your child can attend the classroom.

The registration packet can be turned into the Preschool office located at:
420 Washington Ave. Cuyahoga Falls, Oh. 44221

Or you may email them to:
BrandieK@cybersummit.org

Summit Preschool Registration

Student's Name ______________________________
Last First Middle

City of Birth ____________ Date of Birth ____________

Social Security # ____________ District of Residence ____________

Student Address ____________ Home Phone ____________

Street address

____________ ____________

City Zip code

Gender

Male Female

Is the student of Hispanic/Latino heritage? Yes No **If NO**, you may check all applicable boxes below

White(non-Hispanic) Black/ African American Asian

Native Hawiian or other Pacific Islander Native American/ Alaskan Native

Parent Name ____________ DOB ____________

Address ____________ Race ____________

(Only If different from Student)

____________ Phone # ____________

City

Work # ____________

Email

Parent Name ____________ DOB ____________

Address ____________ Race ____________

(Only If different from Student)

____________ Phone # ____________

City

Work # ____________

Email

Is student residing with both parents? Yes No If NO, who is legal custody vested in?

___ Mother ___ Father ___ Co-Custody ___ Other ____________

IT IS STATE LAW THAT A CERTIFIED COPY OF THE COURT ORDRERD CUSTODY DECREE BE PRESENTED AT THE TIME OF ENROLLENT , OR WHEN ANY CHANGE IS MADE PERTAINING TO CUSTODY

If student is not residing with natural or adoptive parent(s), complete the following:

Guardian/Custodian ____________

Relationship: ____________ Home Phone ____________

Address: Work Phone

Parents: Please answer all the following questions

1. What language did your child first speak when he/she learned to talk? ____________
2. What language does your child use most often at home? ____________
3. What language do you use most often with your child? ____________
4. What language do the adults most often speak at home?

Mother ____________ Father ____________ Relatives ____________

5. How long has your child attended school in the U.S.? Years ______ Months ______
6. Check your child's dietary needs:

No Restrictions Vegetarian No Pork Products

Parent Signature ____________ Date ____________

Summit Preschool Emergency Information & Transport Permission

Student Full Name ______________________ Date of Birth ______________

Medical and Dental Information:

Doctor/Physician		Dentist	
Doctor Name	______________	Dentist Name	______________
Address	______________	Address	______________
City	______________	City	______________
Phone		Phone	

Allergy & Medication Information:

Allergies: NO

YES: please list all allergies ______________

Reactions/Recommended treatment if severe:

Medications: Yes No

Describe below medicine your child takes regularly:

Name of medication:	______________	Name of medication:	______________
taken for:	______________	taken for:	______________
how often:	______________	how often:	______________
at what time:		at what time:	

Emergency Contact Names & Phone Numbers

Parent Name ______________ Phone # ______________

Parent Name ______________ Phone # ______________

Emergency Contact Name #1 **(Other than the parent)** ______________ Phone # ______________

Address ______________ Relationship to child ______________

Emergency Contact Name #2 **(Other than the parent)** ______________ Phone # ______________

Address ______________ Relationship to child ______________

HEALTH CONDITIONS: Please check any that your child has had

Allergies	Anaphylactic reaction	Asthma or Wheezing
ADD/ADHD	Behavior/Emotional concerns	Birth/congenital malformations
Blood problems	Bone/joint problems	Bowel problems/constipation
Cancer	Chickenpox	Cystic Fibrosis
Diabetes	Ear Problems/poor hearing	Eye problems/poor vision
Frequent headaches	Frequent sore throats	Feeding concerns-swallowing
Heart Disease	Hepatitis	Juvenile Arthritis
Kidney disease	Lice concerns	Meningitis/Encephalitis
Seizures/Epilepsy	Toothaches/dental	Urinary tract infections

Permission to Transport in Emergency

YES, I give permission to Transport

Summit Preschool has Permission to secure emergency transport for my child in the event of illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.

No, I DO NOT give permission to Transport

Summit Preschool DOES NOT have Permission to secure emergency transport for my child in the event of illness or injury which requires emergency treatment.

Take the following action instead:

Parent Signature Date

*Emergency contacts must be available and willing to pick up your child if we are unable to reach you in the event of an emergency. They must have reliable transportation and booster/safety seat.

Summit Preschool School Health Information

(completed by Parent)

Student Full Name ______________________ Date of Birth ______________

Question		
Does your family have Medical Insurance?	Yes	No
Does your family have Dental Insurance?	Yes	No
Are you in need of Community Services? (Food/Clothing /Medical assistance)	Yes	No
Does your child need special assistance at school?	Yes	No

If yes, Explain:

Rule 3301-37-07 of the State of Ohio Administrative code specifies the requirements for administrating medication to children in preschool programs in a public school. A separate form must be completed. This form must be completed for each medication and a log kept of all dispensing or applications.

Does your child require any of the following medications?

Inhaler EpiPen Diabetic supplies Seizure medication

Other than listed above, does your child require other ongoing/ routine medical care or medication?

No Yes, explain ______________________

If so, that indicates your child may require an Emergency medication during the day. An Emergency Medical Action Plan is required from your child's Doctor.

If your child must take medication at school, please request a Medication Authorization form to be completed by you and your child's physician.

Does or has your child had tubes in their ears? Yes No

If yes, please explain (how many and date)

Does your child wear glasses? Yes No

Do you have any developmental concerns for your child? Yes No

If yes, please explain:

Additional comments:

Please add any comments or concerns you have about your child's health, development, behavior, family, or home life that you would like the school to be aware of.

If you have questions about your child's health, or community services that may be available to you please contact the preschool office and ask for the school nurse.

Parent Signature ______________________ Date ______________