PRE4CLE

When our smallest students shine, **Cleveland thrives.**

Congratulations! By enrolling your child into a high-quality preschool program, you're taking a big step toward ensuring future success for your young scholar in both school and life. If you have any questions regarding enrollment, please call 216.575.0061 and we'll be happy to help you through the process.

PRE4CLE

Enrollment **Checklist**

Required Documents

- [ ] Child's birth certificate
- [ ] Complete and up-to-date immunization record (baby shots)
- [ ] A current physical with blood work (within one year)
- [ ] Dental exam (within one year)
- [ ] Proof of residency
- [ ] Valid driver's license or state ID
- [ ] Guardianship/custody documents (if applicable)

Additional Required Documents (depending on program)

- [ ] Child's health insurance card
- [ ] Proof of income, attending a training program or school schedule
- [ ] Child's social security card
- [ ] Social security cards for all individuals in the household
- [ ] If receiving WIC, some programs would like to see the WIC book
- [ ] Child's doctor and dentist contact information
- [ ] Emergency contacts (2 people)
- [ ] Allergen or special needs information

PRE4CLE

How to obtain a **Birth Certificate**

INFORMATION NEEDED

- [ ] Full name as listed on the birth certificate*
- [ ] Sex (male or female)
- [ ] Date of birth*
- [ ] Mother's maiden name (her name prior to first marriage)
- [ ] Father's full name (if available)
- [ ] Hospital of birth
- [ ] City of birth
- [ ] Record of legal name change (if applicable)

*Required Documents

	PLACE OF BIRTH	WHERE TO GO	PAYMENT	TIME
ONLINE	Ohio and other states	www.vitalchek.com/birth-certificates	credit card (fee applies)	3-10 business days
MAIL	Ohio only	Mail items above along with contact name, phone number and a self-addressed, stamped envelope to: Office of Vital Records 601 Lakeside Avenue Room 122 Cleveland, OH 44114	check or money order	2-4 weeks
PHONE	Ohio and other states	Vitalcheck 866.691.1914	credit card (fee applies)	3-10 business days
IN-PERSON	Ohio only	601 Lakeside Avenue (Cleveland City Hall) Room 122 8:00 a.m.-4:00 p.m. M-F Note: Photo ID required to enter building, but accommodations can be made.	$25 cash, check, money order, or credit card (fee applies)	immediate

For more information about obtaining birth certificates, visit clevelandhealth.org

PRE4CLE

How to obtain a **Social Security Card**

U.S. BORN CITIZEN

	ORIGINAL	REPLACEMENT
CITIZENSHIP	Proof of U.S. citizenship through either a U.S. birth certificate or U.S. passport	If you have not already established the child's U.S. citizenship, you will need to supply proof of U.S. citizenship. Accepted documents include a U.S. birth certificate or U.S. passport.
AGE	If your child has or can obtain a U.S.-State-Issued birth certificate that recorded his or her birth before age 5, you must submit it. If not, other documents will be considered, such as your child's passport, to prove his or her age.	N/A
IDENTITY	• State-issued non-driver's identification card • Adoption decree • Doctor, clinic or hospital record • Religious record • School daycare center record • School identification card • US Passport	• State Issued non-drivers identification card • Adoption decree • Doctor, clinic or hospital record; • Religious record • School daycare center record; or • School identification card
GUARDIANSHIP	• U.S. driver's license • State-issued non-driver identification card • U.S. passport • I-551 Permanent Resident Card • I-94 Arrival/Departure Record with unexpired foreign passport or admission stamp in the unexpired foreign passport • I-766 Employment Authorization Document, (EAD, work permit) from DHS	

PRE4CLE

How to obtain a **Social Security Card**

FOREIGN BORN U.S. CITIZEN

	ORIGINAL	REPLACEMENT
CITIZENSHIP	• Certification of Report of Birth (DS-1350) • Consular Report of Birth Abroad (FS-240) • U.S. passport • Certificate of Citizenship (N-560/N-561) • Certificate of Naturalization (N-550/N-570)	• Certification of Report of Birth (DS-1350) • Consular Report of Birth Abroad (FS-240, CRBA) • U.S. passport • Certificate of Citizenship (N-560/N-561)
AGE	Anyone age 12 or older must appear in person for an interview. You will be asked for evidence to ensure that a Social Security card has not already been issued to your child. Here are examples of documents that you may be asked for: If your child lived outside the United States for an extended period, a current or previous passport, school and/or employment records, and any other record that would show long-term residence outside the United States. If your child has lived in the United States information about the schools your child attended, and copies of tax records.	N/A
IDENTITY	• State-issued non-driver's identification card • Adoption decree • Doctor, clinic or hospital record • Religious record • School daycare center record • School identification card	
GUARDIANSHIP	• U.S. driver's license or State-issued non-driver identification card* • U.S. passport* • School identification card • Health insurance card (not a Medicare card) • U.S. military identification card **If you do not have one of these specific documents: Employee identification card*	

Reset Form

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE CENTERS AND TYPE A HOMES

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 Center
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. ☐ Yes ☐ No

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

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

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. ☐ Yes ☐ No

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

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

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 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.

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 type A 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 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.

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.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

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 center/type A home'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	
Center or Type A Home Name			Center or Type A 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.		**OR** 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 center's or type A 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. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.

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 centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

The Learning Coalition

FAX: 216.432.7250

Physical / Well Child Exam

Child's Name: _____ **Sex:** _____ **Date of Birth:** _____ **Race:** _____

Section II IMMUNIZATIONS (May also provide immunization record)		These screenings are required for the Medicaid EPSDT Program				
		Vision Test	Hearing Test	Blood Pressure	Length or Height	Weight
VACCINE	DATE	Date:	Date:	Date:	Date:	Date:
DTP	1.	Acuity:	dB:	Reading:	Reading:	Reading:
	2.	Strabismus:	Hz:	Sickle Cell Disease? YES ☐ NO ☐		Sickle Cell Trait? YES ☐ NO ☐
	3.	Hemoglobin	Hematocrit	Lead Screening	Sickle Cell Test	TB Test or Questionaire
	4.	Date:	Date:	Date:	Date:	Date:
	5.	Gm:	%:	Pb:	Results:	Results:
POLIO	1.	NEONATAL HEARING	Responds to voice/noise/noisemaker YES ☐ NO ☐		Allergies:	
	2.	NEONATAL VISION	Looks at faces/Fixes and follows YES ☐ NO ☐		Medications:	
	3.	EXAMINATIONS and/or INSPECTIONS				
	4.		Normal	Abnormal	Referred	Essential findings deviating from normal and/or recommendations
VARICELLA	1.	Eyes				
	2.	Ears, Nose, Throat				
HBV	1.	Teeth				
	2.	Thyroid				
	3.	Lymphatic System				
MMR	1.	Heart-Vascular Syst.				
	2.	Lungs				
HIB	1.	Breasts				
	2.	Abdomen				
	3.	Genitalia				
	4.	Neurological Syst.				
PNE	1.	Skin				
	2.	Extremities				
	3.	Spine				
ROTA	1.	Speech/Language				
	2.	**Is this child is in suitable condition for enrollment?** YES ☐ NO ☐				
	3.					

Physician or Examiner's Name: _____ Todays Date: _____

Physician or Examiner's Signature: _____ **Date of Examination:** _____

Clinic Address: _____ Telephone: _____

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

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

☐ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

Signature of Examining Physician/Physician's Assistant/Advanced Practice 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

	PHYSICIAN /PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER COMPLETES *check all that apply for each disease*		
Diseases for Immunization	**Immunized**	**In Process of Immunization**	**Medically Contraindicated/ Not Age Appropriate**
Chicken pox	☐	☐	☐
Diphtheria	☐	☐	☐
Haemophilus influenzae type b	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B	☐	☐	☐
Influenza ☐ Seasonal Vaccine Not Available	☐	☐	☐
Measles	☐	☐	☐
Mumps	☐	☐	☐
Pertussis	☐	☐	☐
Pneumococcal disease	☐	☐	☐
Poliomyelitis	☐	☐	☐
Rotavirus	☐	☐	☐
Rubella	☐	☐	☐
Tetanus	☐	☐	☐

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.

Signature of Parent	Date of Signature

Recommended Assessments/Screenings			
Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements:		**Notes:**
Height		
Weight		
BMI		

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

CHILD'S NAME:_____ **SEX:**_____ **BIRTHDATE:**_____

HEAD START CENTER:_____ **PHONE:**_____

ADDRESS:_____

PART I. TO BE COMPLETED BY HEAD START STAFF (COMPLETE AT INTERVIEW)

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No_____Unknown_____Yes_____
   - Fluoridated water? No_____Unknown_____Yes_____
   - Fluoride Supplement diet? (tablets_____, liquid_____) No_____Unknown_____Yes_____

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name_____Date last visit_____

4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name_____

5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION.
   Type_____

6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

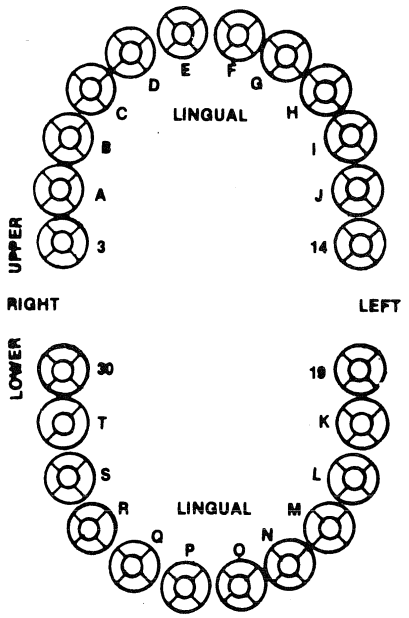
	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider_____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)_____

8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (▨), or filled (■); indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

Approximate number of visits_____. Approximate cost_____.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
All planned treatment (___is, ___is not) complete. If not, explain here, as well as items checked.

_____

_____

- ☐ a. Routine recall visits
- ☐ b. Special home emphasis, oral hygiene
- ☐ c. Dietary problem(s)
- ☐ d. Developmental problem(s)
- ☐ e. Harmful oral habits
- ☐ f. Needs fluoride supplement

I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

Signature_____ Date_____

INTERVIEWER: GO TO FORM 6

CEOGC

HEAD START
HEALTH APPRAISAL SUMMARY

Child's Name: _____ **Gender:** _____ **Birthdate:** _____

Physical Exams / Assessments

TEST	DATE	RESULTS
PRESENT AGE		____ Yrs ____ Mos.
HEIGHT		
WEIGHT		
BMI		
BLOOD PRESSURE		
HEARING		
VISION		
LEAD (required) *age 12 & 24 months or once after age 2		
HEMOGLOBIN OR HEMATOCRIT (required) *once after the age of 2		
TB (if at risk)		
SICKLE CELL (newborn screen)		

Physical Exam/ Assessment	Normal For Age	Abnormal	Not Evaluated
General Appearance			
Posture/Gait			
Speech			
Muscular Coordination			
Skin			
Eyes			
Ears			
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen			
Genitalia			
Bones, Joints, Muscles			
Neurological			
Social			
Glands (*Lymphatic/Thyroid*)			
OTHER			

- **The above named child has been examined and is in suitable condition for participation in group care.**
- **Child is up-to-date according to EPSDT guidelines.**
- **Attach copy of child's immunization record with dates of doses of all immunizations.**

Immunizations: To be completed by physician/physician assistant/advanced practice nurse/certified nurse practitioner

Disease	In process/ Complete	Medically Contra-indicated	Not Medically Appropriate	*Parent Declined
Chicken Pox	☐	☐	☐	☐
Diptheria	☐	☐	☐	☐
Haemophilus Influenza B	☐	☐	☐	☐
Hepatitis A	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐
Influenza ☐ Seasonal Vac. Not Avail	☐	☐	☐	☐
Measles	☐	☐	☐	☐
Mumps	☐	☐	☐	☐
Pertussis	☐	☐	☐	☐
Pneumococcal Disease	☐	☐	☐	☐
Poliomyelitis	☐	☐	☐	☐
Rotavirus	☐	☐	☐	☐
Rubella	☐	☐	☐	☐
Tetanus	☐	☐	☐	☐

PARENT STATEMENT

☐ **I have declined to have my child immunized against one or more of the diseases listed above for reasons of conscience, including religious convictions.**

_____

Signature/Date

Are there any limitations or health conditions including allergies, daily medications or dietary restrictions?

If yes, please list:

_____

_____

If there are any abnormal findings; please list and include any recommended follow-up.

Finding: _____

Recommended Follow-up: _____

_____

Finding: _____

Recommended Follow-up: _____

_____

Signature of examiner	***Date:***
Name/Title of examiner	
Office Name (if applicable)	
Address	
Telephone	

Notice to Parent/Guardian

- This completed form is **required within 30 days** of your child's first day of attendance and annually.
- When completed, this form must be returned to the Head Start Center where your child is attending.
- Failure to return this completed form, within 30 days of your child's first day of attendance, may result in suspension of program participation.
- Any medical statement signed on/after 3/19/15 **MUST** be completed using this revised form.

Notice to Health Care Provider

- **Requirement for Attendance** - Head Start Standards require children receive specific screenings in association with their physical examination (Immunization, Lead, Hemoglobin/Hematocrit). ***The initial physical needs to be completed within 30 days of the child's first day of school and repeated on an annual basis.***
- **Immunization Verification – CHECK ALL APPLICABLE BOXES** to inform of current immunized status (See front of Form).
- **Recommendations/Abnormal Findings-** Indicate any abnormal findings, recommendations, immunizations given and laboratory results on the attached form.
- **Form Submission** - With parental permission, this form can be faxed to (___)_____.
- **Questions/Clarification** – Contact _____.

New Immunization Requirements (Effective 3/19/2015):

- Memo issued March 27, 2015; Ohio Department of Job and Family Services- Additional diseases that children must be immunized against to be enrolled in child care (**Hepatitis A, Influenza, Pneumococcal disease, Rotavirus**).
- Medical statement must contain a record of the immunizations that the child has had, specifying the month, day, and year of each immunization; this record may be attached to the medical statement.
- A statement from the Physician, Physician Assistant, Advanced Practice Nurse, or Certified Nurse Practitioner that the child has been immunized or is in the processes of being immunized against the diseases required by section 5104.014 ORC.