Mary Queen of Peace School
4419 Pearl Road, Cleveland, OH 44109
Phone: (216) 741-3685 Fax: (216) 741-5534

Mrs. Jessica Robertson, Principal
Father Doug Brown, Pastor

Mary Queen of Peace Preschool

2021-2022

Child's Name: ____ Age: ____________

Please indicate your 1st and 2nd choice.

<u>Monthly Rate</u>

Parishioner	Non-Parishioner			
___ $300.00	___ $350.00	5 Full-Days	(7:45 am – 2:45 pm)	Mon - Fri
___ $255.00	___$300.00	3 Full-Days	(7:45 am – 2:45 pm)	Mon, Wed, Fri
___$215.00	___$250.00	2 Full-Days	(7:45 am – 2:45 pm)	Tues, Thurs
___$200.00	___$230.00	5 Half-Days	(7:45 am – 11:00 am)	Mon – Fri
___$155.00	___$180.00	3 Half-Days	(7:45 am – 11:00 am)	Mon, Wed, Fri
___$120.00	___$140.00	2 Half-Days	(7:45 am – 11:00 am)	Tues, Thurs

*To be eligible for enrollment for three-year-old class, the child must be three years old by September 1st.

*All children entering the preschool program must be toilet trained.
A $100 per child non-refundable registration fee is due at the time of registration. The registration fee will be refunded only if your child cannot be accepted into a class. The school reserves the right to cancel a program due to low enrollment.

<u>Tuition</u>

Tuition is paid in 9 monthly installments. The first payment is due September 1st and the last payment is due May 1st. Tuition payments are due on the first of every month. Failure to make tuition payments as scheduled will be interpreted as a withdrawal from our program.

Name of person(s) responsible for paying tuition:

Name: ______________________________ Signature: ______________________________

Name: ______________________________ Signature: ______________________________

"Empowering Our Students"

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Registration for Mary Queen of Peace Preschool Checklist 2021-2022

Child's Name: ____

The following must be turned in with registration packet:

- ☐ **Registration Packet – COMPLETED**
- ☐ **$100 Registration Fee – Cash, Check or Credit/Debit Card**
- ☐ **Copy of Birth Certificate**
- ☐ **Immunization Record**
- ☐ **Physical (ODJFS Child Medical Statement for Child Care)**

All registrations are not complete until the Registration Packet, Correct Documents, and Registration Fee is paid. Registration is on a "first come, first serve basis".

The child's Physical/Immunization record must be taken to your physician to be filled out. This form must be returned to the school before your child is available to attend.

Dear Parents/Guardians,

We are happy that you have chosen to enroll your child at Mary Queen of Peace Preschool. In this packet, you will find all the necessary papers to register your child for the school year. Please know that a completed Registration Packet will ensure a spot for your child for the school year. Mary Queen of Preschool works on a "first come, first serve basis".

Should you have any questions while completing this packet, please contact Brittiny Egan 216-741-3685 or brittiny.egan@maryqueenofpeaceschool.com.

Peace and Blessings,
Mrs. Brittiny Egan
Mary Queen of Peace Preschool Coordinator

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Mary Queen of Peace Preschool Information Form

Child's Name: ______________________________ Date of Birth: ____/____/____

Gender (circle): Male Female Student's Social Security Number: ______-______-______

Student's Home Address: ______________________ City: ____________ Zip: ______

Sex: M__________ F__________

Name of Mother/Step-Mother/Other: ______________________________

Name of Father/Step-Father/Other: ______________________________

Child lives with:
____ Both Parents ____ Mother Only ____ Father Only
____ Grandparent(s) ____ Other

Number of Brothers:

Name	Age	School	Grade
______________	______	______________	______
______________	______	______________	______
______________	______	______________	______

Number of Sisters:

Name	Age	School	Grade
______________	______	______________	______
______________	______	______________	______
______________	______	______________	______

Child's Place Among Siblings (youngest, oldest, middle): ______________________

Please Select One:
____ Catholic ____ Non-Catholic

If Catholic, are you a parishioner of Mary Queen of Peace Church? ____Yes ____No

Mother's Occupation: __________________ Email Address: ____________________

Work Phone: ______________ Home Phone: ______________ Cell ____________

Father's Occupation: __________________ Email Address: ____________________

Work Phone: ______________ Home Phone: ______________ Cell ____________

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Authorized Pick-Up List

For your child's protection, please fill out the names of the persons other than yourself authorized to pick up or bring your child to school. Notify us of any changes immediately. Inform persons on this list that they must be prepared to identify themselves to our staff. List parent other than the one signing this form if they are authorized to pick up.

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Carpool Arrangements: ____

____

Is there anyone whom you DO NOT wish to have your child released to?

____

Emergency Telephone Numbers

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Name: ______________________________ Relationship:______________________ Phone: ______________________

Parent/Guardian Signature: ____________________________________ Date: ______________

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Mary Queen of Peace School
Emergency Information Record

Student Last ________________________________Student First _____________________________________

Student Grade _______________ Student Date of Birth ________________________

Parent/Guardian Name(s) ____

Address ____

City _______________________________Zip ________________

Mother/Guardian Name:	Work Number:	Home/Cell Number:
Father/Guardian Name:	Work Number:	Home/Cell Number:

Mother/Guardian email address: ____

Father/Guardian email address: ____

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Part 1 or Part 2 must be completed

Part 1: Grant to Consent

In the event reasonable attempts to contact may have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by:

Dr. ______________________________ Phone #________________
(Preferred Physician)

Dr. ______________________________ Phone #________________
(Preferred Dentist)

or in the event the designated practitioner is not available, by another licensed physician or dentist and the transfer of the child to ____________________ or most easily accessible.
(preferred hospital)
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 before surgery is performed.

Facts concerning the child's medical history including allergies, medication being taken and any physical impairment to which a physician should be alerted.

Part 2: Refusal to Consent

Do not complete part 2 if you completed part 1

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 no action or to

____
(Briefly state acceptable actions for your child)

____________________________________ ____________________
Parent Signature Date

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Demographic Information

Student Name:______________________________________

Student's Date of Birth: ______________________________

____________Male ____________Female

Ethnicity:

____________Caucasian

____________African American

____________Hispanic

____________Asian/Pacific Islander

____________American Indian/Alaskan

____________Native American

____________Multi-Racial

Religion:

____________Catholic

____________Non-Catholic

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:

☐ 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):

Initials of Examining Health Care Practitioner

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 MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth
Special Health Conditions	
Symptoms to watch for and emergency action to be taken if the following symptoms occur	
Activities/foods/environmental conditions to avoid, if applicable	
Medical procedures to be followed and expected benefit of treatment, if applicable	
Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")* If yes, what medications?	
In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? ☐ Yes ☐ No	
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? ☐ Yes ☐ No	
Training Instructions *(Trainer must be a parent or certified professional)*	
Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No
Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Dietary Allowance Form

Please complete the form below if you would like your child to have a dietary restriction. If there is a medical reason please have your child's pediatrician sign and also fill out a medical form given to you by your child's teacher. Thank you

I (guardian's name)________________________________ would like to give

permission that (child's name)____________________________________does

not consume ________________________________.

Please add any additional notes you would like below

____

____

____

____

____

____

Please check the following as to why restrictions will be placed.

Medical__________ **Personal_________**

Signature:____

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	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/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. ☐ 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/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 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 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.

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 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** **Do not sign both**	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.			**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 and 5101:2-13-15. 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.

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Mary Queen of Peace Preschool
Child Profile/Social Experiences Form

Child's Name: ________________________ Date of Birth: __________

Has your child attended another preschool prior to this one? ______________

Where? ____

Was the experience enjoyable for your child? ______________________

Does your child have problems separating? ______________________

How does he/she deal with separation? __________________________

How does your child handle frustration? _________________________

How long can your child sit to read to? __________________________

Which T.V. shows does your child watch regularly? __________________

How does your child manage the toilet? __________________________

What terms are used? _______________________________________

Can your child dress him/her self?

____

Does your child have playmates his/her own age? ___________________

Does your child have hobbies or special interests?

____

Does your child have any physical problems that we should be aware of?

(hearing, speech, vision, etc.) ___________________________

Does your child have any allergies? ____________________________

Does he/she take medication on a regular basis? ___________________

Does your child have an imaginary friend? _______________________

What is your child's favorite indoor activity? ______________________

What are your goals for your child this year? ______________________

____

What are your expectations of me as your child's teacher? ______________

"Empowering Our Students"

Ohio Department of Job and Family Services

FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name *(Last)*	*(First)*	Nickname *(If any)*

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.
Who is in the child's immediate family?
Who lives at home with your child?
What is the primary language spoken in your child’s home?
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)
Do you have any pets at home? If so, what are they and what are their names?
Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)
My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)* How much and how often?
Does your child have any favorite foods?
Does your child dislike any foods?
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. *(Check the one that applies.)*

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.	
What might you and/or your child be anxious about as he/she starts in this program?	
What are you and/or your child excited about as he/she starts in this program?	
What are your expectations of this program?	
What other information would be helpful for the staff caring for your child to know?	
Parent/Guardian's Signature	Date

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Preschool Class Roster

Each year we prepare a class roster. It includes each child's name, address and telephone number. We need your written permission to include your child's name, address, phone number and parents name in this roster.

Please sign and return this form if you would like your child's name and information included on this roster. It will be distributed only to the children in the class.

Child's Name: ____

Parent(s)/Guardian Name (s):________________________________

Address:____

City, State, Zip:____

Telephone Number:_______________________________________

____ Yes, you may enter our child's name and information on the roster

Parent/Guardian Signature: ________________________ Date: __________

____ No, I do not want this information furnished to classmates.

Parent/Guardian Signature: ________________________ Date: __________

According to the Office of Early Learning and Readiness each child's file is to have a DENTIST listed. **This is Mandatory.**

Child's Name:____

Dentist Name:____

Address:____

Phone Number:____

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MEDIA RELEASE AND CONSENT FORM

We recognize the value of audio-visual and digital technologies in providing our child with an effective education and hereby grant permission for our child and/or his/her schoolwork projects to be photographed or recorded as part of an educational program produced by the school or a coalition of schools.

We grant permission for the photographs or recorded work to be used in media presentations that are made available to other educational institutions or through a cable television station or network. We further grant permission for photographs to be used in print media or on the school website including Edline and Facebook. We understand that our child's image, name, work product, school and grade may be revealed in the presentation(s), but that no other information about our child or his/her schoolwork will be revealed without prior consent.

Student Name ______________________________ Grade__________

Parent(s) Name ____

Parent(s) Signature____

Address____

City ____________________________State__________Zip Code_________

Phone ____
(Home) (Cell) (Work)

Date_________________

___________No, I do not wish to have my child's photo used in any public forum.