



**Office of Teaching and Learning
Division of Early Childhood Education**

Central Enrollment Center
430 Cleveland Avenue
Columbus, OH 43215
Ph. 614.365.5822
Fax 614.365.5163

Mission: Each student is highly educated, prepared for leadership and service, and empowered for success as a citizen in a global community.

**Early Childhood Education
ENROLLMENT PAPERWORK**

Name of Student: _____ **Student #:** _____

Dear Parent/Guardian:

IF YOUR CHILD HAS ALREADY BEEN ASSIGNED TO AN EARLY CHILDHOOD CLASSROOM:

ASSIGNED SCHOOL: _____

In order to complete the enrollment process, the forms in this packet must be completed and returned to the Early Childhood Department before your child starts school. Please note that documentation of a current medical exam within the last 12 months is required prior to starting our program. A dental exam is highly encouraged.

The forms in this packet include:

**ECE Eligibility Screening Tool
ECE Family Information
ECE Transportation Arrangements Form
Developmental and Educational Goals for Step Up to Quality
Ready 4 Success
Medical Form: Completed by Physician
Dental Form: Completed by Dentist**

***Please return the completed paperwork to ecenrollment@columbus.k12.oh.us.**

All enrollment requirements must be met before your child is officially enrolled in the ECE Program and eligible to attend class. If you have questions, please contact the ECE office at 614-365-5822. You may also email questions to the ECE Enrollment email address.

I understand that all of the above registration requirements must be met BEFORE my child is officially enrolled in the Early Childhood Education Program and eligible to attend class.

Parent/Guardian

Date

By clicking the box, I am acknowledging that the name typed above is being used as an electronic signature.

The Columbus City School District does not discriminate because of race, color, national origin, religion, sex or handicap with regard to admission, access, treatment or employment. This policy is applicable in all district programs and activities.



**COLUMBUS
CITY SCHOOLS**

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FAMILY INFORMATION FORM

Child's Name
Who is in the child's family?
Who lives at home with your child?
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? _____Yes _____No Additional Details?
Are there any changes or transitions that your child has recently experienced or is experiencing? (divorce, new home, death of family member, friend or pet?) _____Yes _____No Additional Details?
Please indicate all of the words that best describe your child's personality and behavior: active adventurous affectionate anxious leader bright busy calm cautious cheerful content creative curious easily-upset emotional energetic excitable friendly follows directions happy hesitant likes structure/routines loud loving outgoing prefers adult attention quiet sensitive serious shares-well social spontaneous stubborn other: List of words:
Are there additional personality and behavior characteristics that would be useful to know about your child?

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Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?	
What causes your child to feel angry or frustrated?	
General education Pre-K students must be potty trained to attend the program. Is your child toilet trained? Yes No Does your child need assistance when using the toilet? Yes No If so, how?	
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?	
What you are you and/or child excited about as he/she starts in this program?	
What might you and/or child be anxious 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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DEPARTMENT OF EARLY CHILDHOOD EDUCATION
TRANSPORTATION ARRANGEMENTS

Please complete for all ECE students:

I understand that transportation is NOT provided for Early Childhood Education students unless my child has an Individualized Education Plan (IEP).

Parent/Guardian Signature

Date

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Transportation Arrangements: Please indicate below.

_____ Car Rider

_____ Daycare Van Rider

_____ Walker

_____ Bus Rider - option only available for students with Individualized Education Plans (IEP)

If a car rider or walker, please list the adult(s) that you authorize to drop off and/or pick up your child from school.

Name

Relationship

Phone #

Name

Relationship

Phone #

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DEVELOPMENTAL AND EDUCATIONAL GOALS FOR STEP UP TO QUALITY (SUTQ)

Parents - Please assist us in developing an educational goal for your child by completing the shaded portions of this form. We will review it together during our first meeting of the year.

Name of Child	
Date of Birth	
Developmental / Educational Goals *Please select at least two goals from the bank to the right or write in your own goal for your child	☐ I would like my child to expand their attention to a task or activities (non-electronic devices) ☐ I would like for my child to increase their problem solving and conflict resolution skills. ☐ I would like for my child to play with friends in the class and develop social-emotional skills, i.e. learning to manage their emotions, develop empathy for others and establish and maintaining positive relationships with others ☐ I would like for my child to improve their self-help skills and independence skills (i.e., getting dressed) ☐ I would like for my child to be able to count 1-10 ☐ I would like for my child to know the alphabet and the letters in their name ☐ I would like for my child to improve their "writing" or drawing for a variety of purposes ☐ I would like for my child to increase their ability to follow more complex directions ☐ Other: _____ _____
Action Steps	• Parent Completes "Family Information" form • Teacher reviews the form with the parent and asks clarifying questions • Teacher completes curriculum-based baseline assessment to gather additional data about potential goals • Parent and teacher agree upon 2 educational/developmental goals collaboratively • Progress towards goals are communicated at Parent/Teacher conferences and in student Report Cards
Person(s) Responsible	Classroom teacher, parent/guardian, outside agencies/community partners

Rev. 03.15.2019

Resources Needed	☐ Visual timers ☐ Additional language/literacy books, games, technology ☐ Wait time for independence ☐ Technology ☐ Social skills books and resources ☐ Repeated practice ☐ Multi-sensory approaches towards learning ☐ Other: _____
1 st Meeting Comments or Progress	
2 nd Meeting Comments or Progress	

1st Meeting Review:

Teacher Signature: _____ Date: _____

Parent Signature: _____ Date: _____

2nd Meeting Review:

Teacher Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Rev. 3.15.2019



Ready4Success
Parent Release for Child Information,
Early Reading and Early Math Screenings



Our preschool program is committed to supporting your child by providing early learning experiences that will help him or her be kindergarten ready. We are partnering with the Ohio State University's **Ready4Success** initiative and Early Start Columbus to receive assistance for early reading and math. By signing this **Permission Release**, your child's teacher will receive information that will help us plan lessons that will support your child's learning.

I hereby grant permission for _____
(Child's Legal Name)

be administered the Get Ready to Read and/or Preschool Early Numeracy Skills Test in the Fall of the current school year (pre-screening) and in the Spring of current school year (post screening). This information will be used by my teacher to identify instructional strategies that will help my child with early reading and early math development.

I give permission to Columbus City Schools
(Provider Name)

to share the screening results and basic information (e.g. date of birth, language and race) with Ready4Success, *FutureReady* Columbus, HMB, Early Start Columbus and/or the receiving school. I also permit the Crane Center for Early Childhood Research and Policy to obtain my child's Kindergarten Readiness Assessment information from the school district so that we may share these results with my child's preschool program for program improvement.

I understand that this information will be kept confidential and used only for improvement measures by the program. I understand that all personal information will be kept confidential.

Child's Legal Name (First, Middle, Last) (printed)

Child's Date of Birth

Parent/Guardian's Legal Name (printed)

Parent/Guardian's Signature

Date

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COLUMBUS CITY SCHOOLS HEALTH, FAMILY AND COMMUNITY SERVICES

Preschool Medical Form

NOTE: All Pre-Kindergarten children entering Columbus City Schools are required to have medical and dental examinations within the current calendar year. This information is confidential and becomes a part of the student's cumulative record.

Name _____ Address _____
School _____ Grade _____ Room _____ Date of Birth _____

HEALTH SCREENING:

Height _____ Weight _____ Visual Acuity: Right _____ Left _____
Hearing Acuity: Right _____ Left _____
Date of Exam _____ Strabismus: _____ Color vision _____

IMMUNIZATION REQUIREMENTS:

Section 3313.671 of the Ohio Revised Code requires children of school age to be immunized against diphtheria, whooping cough, tetanus, polio, rubeola, rubella, mumps and Hepatitis B.

DtaP, DPT, DT					
Polio					
MMR					
Hepatitis B					
Varicella					
Hib					
TB Test		Results			
Other					
Other					

PHYSICAL EXAMINATION:

Surgical History:

Medical History:

Current medical diagnosis:

Allergies:

Medications:

Head and Neck _____
BP _____
Orthopedic _____
Chest _____ Heart _____
Lungs _____ Abdomen _____
Hernia _____ Extremities _____
Neurological _____
Behavioral/Emotional _____

Urinalysis	
Hemoglobin	
Sickle Cell	
Serum Lead	
Other Labs	

Please indicate any physical activity restrictions or required adaptations to physical education program:

Based upon this child's medical history and physical condition at the time of examination, this child is free from apparent communicable disease and is in suitable condition for enrollment in an early childhood education program within Columbus City Schools.

Date of Exam _____ Health Care Provider Signature _____
Phone _____ Provider printed name or stamp _____

FAX Form to (614)365-8745

Rev. 03/2019

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**COLUMBUS CITY SCHOOLS
HEALTH, FAMILY AND COMMUNITY SERVICES**

**Dental Record
(To be completed by the dentist)**

SCHOOL _____

NAME _____

ADDRESS _____

PHONE # _____ BIRTHDATE _____

PARENT NAME _____

Child was examined on _____
(Date)

The following services have been performed: (*Please Check*)

Radiographs _____

Oral Prophylaxis _____

Fluoride Treatment _____

Restorations _____

The following statements are applicable: (*Please Check*)

All necessary services have been performed _____

No restorative services are required at this time _____

The child is in treatment and future
appointments have been arranged _____

_____, D.D.S.
Signature

Approved: Columbus Dental Society

**** Please fax completed form to the nurse at 614-365-8745 ****