

# Save my Spot

## ST. MARY SCHOOL

Early Childhood - Preschool Daycare

515 Beall Avenue  
Wooster, OH 44691  
330-262-2752  
330-262-0967 FAX

[www.stmarywooster.org](http://www.stmarywooster.org)  
[stmarydaycarepreschool@gmail.com](mailto:stmarydaycarepreschool@gmail.com)

Thank you for your interest in the Early Childhood program at St. Mary School. A brief description of our program follows to familiarize you with our services. Your child must be 3 and potty trained to attend our program.

Our Early Childhood program is designed to offer the proper discipline and curriculum to prepare your child for school and to assist you as a parent in raising a positive and resilient child. Our curriculum is based on The Creative Curriculum System® for Preschool and includes; Spanish, Language and Literacy, Math, Science, Social Studies, Social and Emotional Development, Physical Well-being and Motor Development with gym class twice a week, development of attention, engagement and persistence.

CHOOSE FROM ONE OF THE FOLLOWING TWO OPTIONS:

OPTION 1)

\_\_\_\_\_ St. Mary Preschool with extended care - This program is open from 7:00 am to 5:30 pm each weekday during the school year. You may choose from a half day (8:30am -1:30pm) or full day (when pick up is after 1:30) and between 2-5 days per week to fit your schedule

\_\_\_\_\_ Full Days - list approximate drop off and pick up time \_\_\_\_\_  
\_\_\_\_\_ Half Days - 8:30 - 1:30

Circle Days of the week needed: M T W TH F

OPTION 2)

\_\_\_\_\_ St. Mary 2 ½ hour Preschool 8:30am - 12 noon M T W TH F

Parent/Guardian(s)

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Email Address: \_\_\_\_\_

Drop off or mail this Registration Form with \$35.00 fee to: St. Mary, ATTN: Preschool, 515 Beall Avenue, Wooster OH 44691. How did you hear about our program? \_\_\_\_\_

Is your family Catholic? \_\_\_\_\_

St. Mary Daycare and Preschool

Child's first name as you would like us to teach them to write it:
My Child is 3 or over:
Who is in the child's immediate family?(Include family members' names and ages)
Who lives at home with your child? Please include names and relationships.
What is the primary language spoken in your child's home? How many languages are spoken?
Are there any special family arrangements, such as shared parenting, living in two homes, etc?
Are there any changes or transitions that your child has experienced recently?
Are there any cultural or religious practices we should be aware of? (Dietary restrictions, etc)?
Please list person(s) to pick up your child other than parent or guardian: (they must have picture ID)
My Child had permission to walk to Church and on the Church grounds for occassional trips to these areas. ( There is no water 18inches or more in depth.)
Please list email address(es) to be used for school communications:
Do you give permission for your child to use hand lotion - we use Cereve and Cereve Baby and baby Aveeno Eczema relief?
Do you give permission for your child to use alcohol based wipes (like Purell)?
Parent/Guardian Signature and DATE of permission (valid for one year)

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Early Childhood - Preschool Daycare

[www.stmarywooster.org](http://www.stmarywooster.org)

[stmarydaycarepreschool@gmail.com](mailto:stmarydaycarepreschool@gmail.com)

Child Name

Parent Name

Date

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Please list out two educational goals for us to work on for your child. An example of an Educational Goal: Fine Motor Coordination: Tool and Object Manipulation - Provide multiple fine motor opportunities ie... play doh, legos, chopsticks for snack and art; painting, markers, crayons, pencils.

1) \_\_\_\_\_

2) \_\_\_\_\_

Signature: \_\_\_\_\_

These goals will be discussed during parent meetings.

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Staff Concerns/goals \_\_\_\_\_

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Parent Signature

St. Mary Catholic School  
515 Beall Avenue  
Wooster, OH 44691

MEDIA RELEASE AND CONSENT FORM

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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 to 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 and school social media. We understand that our child's image, 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.

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Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Family Internet Address: \_\_\_\_\_

Date: \_\_\_\_\_

No, I do not wish to have my child's photo used in any public forum.

**OWL: Observe, Wonder, Lead**  
Early Childhood Mental Health Consultation  
Annette M. Fisher, LSW, ECMHC  
Catholic Charities 215 S. Walnut St., Wooster, OH 44691  
330-204-3687

We are excited that our early childhood program has decided to participate in the Whole Child Matters Collaborative. As part of this opportunity, classrooms will be implementing the Devereux Early Childhood Assessment (DECA) Preschool Program. The DECA Preschool Program promotes resilience “the ability to bounce back from difficulty” in children ages 3 to 5 years old. Through the program, teachers and families learn specific ways to support young children’s social and emotional development.

Teachers will use the DECA Preschool Program to help children be more successful in school. In addition, teachers will share information about activities that you can do at home to foster resilience in your child.

Teachers will complete an assessment of all children in the classroom. This assessment will help us learn about the way each child gets along with others, shares how they feel, explores and learns. We will use this information to better plan for all children in the program, building on individual childrens’ strengths.

If you have any questions regarding this opportunity, or if you would like your child to be exempt from the DECA Preschool Program process, please feel free to contact Annette Fisher at 330-204-3687 with Catholic Charities. Annette will provide support and training to our staff in the areas of social/emotional development and behavior management. She is also a great resource for parents with any questions or concerns regarding a child’s social/emotional development or behavioral concerns.

I \_\_\_\_\_(parent/guardian) grant permission for the DECA-P2  
assessment to be completed on my child \_\_\_\_\_(name) while  
he/she is in care of St. Mary Preschool/Daycare (center).

\_\_\_\_\_  
Parent/Guardian 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 #1			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip		
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip		
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
<b>Emergency Contacts:</b> Parents <b>cannot be listed</b> as emergency contacts. List the name of <b>at least one person</b> 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 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		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 Medical Foods**

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 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/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 to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

- No  
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or 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 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

- No  
 Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

- No  
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

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 file.  
 N/A - program does not provide meals or snacks to the child.

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.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Child's Name \_\_\_\_\_

**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**

<b>Give <u>Permission</u> to Transport</b>		<b>OR</b>  <b>Do not sign both</b>	<b><u>Do Not Give Permission</u> to Transport</b>	
Program or Home Name			Program or Home Name	
<b>has permission</b> 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.			<b>does not have permission</b> 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, 5101:2-13-15, and 5101:2-14-04. 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.

**CHILD**

**MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE**

separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition

Does this health condition require medication or medical food?  Yes (If Yes, complete Part II)  No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid?  Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

**Part II: Conditions Requiring Medication or Medical Food**

**Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

**(If no medications or medical foods are required for the condition, skip Part II).**

**If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.**

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name	Date of Birth	Weight (if needed to determine dosage)
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Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date

Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature
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**Part III: Administration of Medication or Medical Food Training Authorization**

**Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)**

**Part III must be completed**

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? (Check all that apply)

<input type="checkbox"/> Medication	<input type="checkbox"/> Supplies	<input type="checkbox"/> Assistance	<input type="checkbox"/> N/A
<b>Parent Provided Training AND grants permission to perform the procedure</b>	<b>Complete Only One Section</b>	<b>Certified Professional Training AND parent grants permission to perform the procedure</b>	
<i>My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>		<i>My signature indicates I have provided instructions for care and/or training for the medical procedure</i>	
Parent Signature		Certified Professional's Name (please print)	
Date of Signature		Certified Professional's Signature	
		Date of Signature	Phone Number
		<i>My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>	
		Parent Signature	
		Date of Signature	
Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the procedure for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.			
Printed Name	Signature	Date	
Printed Name	Signature	Date	
Printed Name	Signature	Date	
Printed Name	Signature	Date	
Printed Name	Signature	Date	
<i>My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.</i>	Administrator/Provider Signature	Date of Signature	
This 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, a new form must be completed.			
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
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review



Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT FOR CHILD CARE**

Child's Name ( <i>print or type</i> )		Date of Birth
FAX: 330 262 0967		
<input checked="" type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. <input checked="" type="checkbox"/> This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).		
Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered 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**

**Exceptions to Immunization requirements pursuant to 5104.014 ORC** (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature
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<b>Optional Recommended Assessments/Screenings</b>			
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
<b>Measurements</b>		<b>Notes</b>	
Height			
Weight			
BMI			