CAMBRIDGE PRESCHOOL

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Follow us on Twitter @PrekBobcat and @Cambridge_CS
Follow us on Facebook at cambridge.preschool.790

We are very excited that you have selected Cambridge City Schools Preschool to begin your child's education. Cambridge City Schools Preschool operates preschool for students with disabilities and typically developing peer models ages 3 through 5.

Cambridge Preschool offers a tuition assistance program based upon household income. The maximum tuition payment could be $180 per month. The tuition is a flat rate and is not adjustable for absences, holidays or calamity days and is due the first day of every month.

Please complete the attached application. If you wish to be considered for tuition assistance, please complete all three pages of the attached JFS application and include one of the following proofs of income:

- Three most recent pay stubs, or
- A statement from the Dept. of Job & Family Services caseworker stating your poverty level, or
- A copy of your most recent tax return

Completed documents, including a copy of your child's birth certificate, can be mailed or dropped off at our preschool center.

Ohio's Early Learning and Development Standards are used to guide our preschool program. This along with a comprehensive curriculum provides developmentally appropriate processes, adult interaction and learning experiences to prepare your child for kindergarten. The curriculum used is responsive to individual development and interests.

If you have questions or need information, please call 740-439-7592.
Our staff is looking forward to working with you and your child as they grow and learn.

Sincerely,

Mrs. Edwards

Please complete the enclosed paperwork and check off these forms as you complete them **(please be sure that all forms are filled out completely):**

_____ Application (include custody papers, if applicable)
_____ Status of Custody Form
_____ Permission for Review
_____ Tuition Assistance Waiver (if you DO NOT wish to be considered for tuition assistance) **OR**
_____ Early Childhood Education Eligibility Screening Tool (if you wish to be considered for tuition assistance, fill out all three pages) This form **MUST** be accompanied by copies of three most recent consecutive pay stubs, or a current tax return (if you are still at the same job)). Proof of income must be turned in for each person in the household.
_____ Enrollment Form
_____ Program Authorization
_____ Emergency Medical Authorization Form (be sure to list emergency contacts as well as those who are authorized to pick up your child at school)
_____ Language Usage Survey
_____ Student Residency Questionnaire (2-sided)
_____ Household Information Survey (2-sided)
_____ Copy of your child's birth certificate

Any forms not completed in full will be returned and your child will not be put on a class list until forms are completed and turned in.

The following forms must be turned in at or before your child's screening appointment in August:
_____ Child Medical Statement (good for 12 months from date of appointment)
_____ Immunization Record
_____ Child Dental Exam Form (good for 12 months from date of appointment)

If your child has had a recent doctor or dentist appointment, have the doctor/dentist complete the forms and then turn them in to us with your other paperwork. If they have not had an appointment in the last 12 months, please schedule an appointment and call the preschool to let us know on what date the appointment is scheduled.

Cambridge City Schools Preschool

Application

Mail or Fax to: Cambridge City Schools Preschool
Attn: Cheryl Edwards
518 S 8th St
Cambridge, OH 43725

(phone) 740-439-7592
(fax) 740-432-2809

Child's Full Legal Name _____
First Middle Last

Date of Birth _____ Gender: ____Male ____Female

Place of Birth _____ Is this child Hispanic/Latino? _____ Yes _____ No
City and State

Primary Language Spoken at Home _____

Race/Ethnicity (check all that apply) _____ White _____Black/African American
_____Native Hawaiian/Other Pacific Island _____American Indian/Alaska native
_____Asian

Is the student a dependent of a member of active duty forces? Yes___ No___ Which Branch? (circle) Army, Navy, Air Force, Marines, Coast Guard

Is the student a dependent of an active member of the National Guard? Yes___ No___ Which Branch? (circle) Army, Air

Parents of this child: _____ Married _____ Single _____ Divorced _____ Separated _____ Live Together

**Are there custody papers? _____ Yes (please attach) _____ No
Is this child a foster child? _____ Yes _____ No

Child resides with (circle all that apply). Mother Father Stepmother Stepfather Guardian

Parent/Guardian Name(s) _____

Address _____
student address city state zip

Add mailing address, if different, including PO Box, if applicable _____

Phone Number (_____)_____ Email Address _____

Mother's Maiden Name _____

List any medications this child needs to take at school _____

List any allergies that we need to be aware of: _____

Do you reside in Cambridge City Schools _____ Yes _____ No, Please list the school district in which you RESIDE. _____

Does this child currently attend preschool? ___ Yes _____ No
Preschool Name & Location _____

Copies of the following need to be turned in with this application:

_____ Birth Certificate
_____ Custody Papers (if applicable)
_____ Tuition assistance form (if applicable) with proof of income attached

---

FOR OFFICE USE ONLY DATE RECEIVED _____ HS _____ EI _____

ETR/IEP _____ ECE_____ POV LEVEL _____ Age Aug. 1 _____ Oct. 1 _____

Date scanned to EMIS _____

START DATE _____ TEACHER _____ SCHEDULE _____ Tuition _____

Cambridge City Schools Preschool

Status of Custody Form

Student Name _____ Date of Birth _____

Name of Adult Completing Paperwork _____

Relationship to Student _____

Child lives with:

_____ Both Natural/Adoptive Parents

_____ Father Only

_____ Mother Only

_____ Other - Explain _____

_____ Grandparents(s)

_____ Aunt and/or Uncle

_____ Foster Family

If the child does not reside with both natural/adoptive parents, please check the parental status below.

_____ Divorced; current custody document is on file with this school

_____ Legally separated; current document is on file with this school

_____ Separated; custody not on file (both parents have equal rights regarding custody)

_____ Not married at time of birth

_____ Intent to gain custody paperwork is currently on file with this school

_____ Guardianship

_____ Temporary Protection Order (restraining order, or TPO) is currently on file with this school

_____ Parent deceased

I understand the rights of my child's other parent. If a legal separation, divorce or other custody change is initiated, I will furnish a copy of the custody document to the school.

_____ _____

Parent/Guardian Signature Date

Cambridge City Schools Preschool

Permission for Review

I give my permission for Cambridge City Schools Preschool to respond to a request for educational assistance for _____. In giving my permission, I understand that any or all of the following may occur:

1. Signed permission to release information educationally relevant medical information, obtained by HMG through physicians (e.g., medical diagnosis, concerns etc.);

2. Review of the following requested records:

Developmental Evaluations	Immunizations Records
Request for Assistance	Birth Certificate
Ohio School Health History	Custody Papers (if applicable)
Progress Reports (if applicable)	Child's Social Security Number
Hearing/Vision Screening Reports	Current IFSP
Referral for Evaluation (PR-04)	

3. Interviews with caregivers or myself;

4. Observations of my child;

5. Assessment (screening, curriculum based, and other appropriate measures to determine interventions); and/or

6. Other (please specify)

_____

I further understand and agree that the information collected by the school district representatives will then be reviewed and the team will develop an intervention plan and designate the resources needed to implement these interventions.

_____ _____

Parent Signature **Date**

Tuition Assistance Programs are available for those who qualify. Eligibility is determined by family household income below 200 percent of the federal poverty level (FPL).

United States Department of Health and Human Services

200% of Federal Poverty Level Income Chart

If your household income is BELOW the maximum on this chart, you may qualify for assistance.

Persons in Household	Annual Income
1	$27,180
2	$36,620
3	$46,060
4	$55,500
5	$64,940
6	$74,380
7	$83,820
8	$93,260

Add $9,080 for each additional person.

For your child to be considered for the tuition assistance program, you **must** complete the attached application (JFS 01121) and provide one of the following proofs of income along with the completed JFS form:

-Three most recent consecutive pay stubs **or**

-a copy of your most recent tax return

OR

If you do not wish to be considered for tuition assistance, please check, sign, and return this page with this application packet.

❑ I hereby waive my right to be considered for free or reduced tuition and agree to pay full tuition if accepted into the preschool program. I understand that this waiver neither hampers nor enhances the chance of my application being accepted. I understand that if my financial situation changes, I may request a review of my income determination and verification and if income eligible, qualify for tuition assistance.

_____ _____

Signature of Parent(s)/Guardian Date

Ohio Department of Job and Family Services
Ohio Department of Education

EARLY CHILDHOOD EDUCATION ELIGIBLITY SCREENING TOOL

Tell us about you (the applicant)

First Name	MI	Last Name	
Address			Today's Date
City	State	County	Zip Code
Phone Number ( )	Additional Phone Number ( )	E-mail Address	

Tell us about the people in your home

Name *(First, Middle, Last)*	Relationship to You *(spouse, son, friend, etc.)*	Race	Hispanic or Latino *Y or N*	Spoken Language	Date of Birth	Gender *M or F*	U.S. Citizen *Y or N*
	Self	☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					
		☐ African American ☐ Alaska Native/American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander					

Child 1	Provider Name and Address	What hours/days do you need services? (i.e. child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Child 2	Provider Name and Address	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Child 3	Provider Name and Address	What hours/days do you need services? (child care or preschool) *Check all that apply*
Name		☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Weekends
Child's Mother's Maiden Name		**What is the child's home school district?**
Child's City of Birth		

Special Needs

Is your child in need of special needs child care based on this definition?
"Special needs child care" means child care provided to a child who is less than eighteen years of age and either has one or more chronic health conditions or does not meet age appropriate expectations in one or more areas of development, including social, emotional, cognitive, communicative, perceptual, motor, physical, and behavioral development and that may include on a regular basis such services, adaptations, modifications, or adjustments needed to assist in the child's function or development.

☐ Yes ☐ No

Tell us about your finances

Will you or the people in your home receive income this month? ☐ Yes ☐ No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal/medical support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

Name	Type of Income	Amount of Income *(before taxes)*	How Often Received *(weekly, bi-weekly, etc)*	Date Last Received	Work or School Schedule *(please list times)*
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____
					☐ Sun ____ ☐ Mon ____ ☐ Tues ____ ☐ Wed ____ ☐ Thurs ____ ☐ Fri ____ ☐ Sat ____

Do you or anyone in your household pay Child or Spousal Support? ☐ Yes ☐ No

How Much?

Signature of Applicant	**Date**

Cambridge City Schools Preschool

Enrollment Form

Child's Name_____ Date of Birth _____
First Middle Last

Please list any **allergies** we should be aware of: _____

I'd like you to be aware of the following about my child's health, development, behavior, family or home life.

_____

Birth weight of child _____

Did the mother have any unusual physical/emotional illness during pregnancy? Yes No If yes, please explain.

_____

The child was (please circle) Full Term Early Late If applicable, how early/late? _____

Did the child have any sickness/problems? Yes No If yes, please explain: _____

Please indicate at what age the child began the following activities. Walked alone _____ Was toilet trained _____
Spoke in sentences _____ Dressed self _____

Please list any severe injuries, illnesses, surgeries.
Injury/Illness/Surgery Was the child hospitalized? Age at time of event?

1._____

2._____

Please describe any medications, food supplements, modified diet or fluoride supplements the child takes daily and/or frequency.
Medication/Supplement Reason taken? How often taken?

1._____

2._____

3._____

Please check any health conditions the child has or had.

- __ abnormal spinal curvature
- __ diabetes
- __ anemia
- __ emotional problems
- __ attention deficit disorder
- __ frequent sore throats
- __ birth/congenital malformation
- __ cancer - type _____
- __ chronic diarrhea/constipation
- __ wetting during day or night
- __ cystic fibrosis
- __ mumps
- __ asthma or wheezing
- __ nervous twitches/tics
- __ frequent headaches
- __ hyperactivity
- __ hepatitis
- __ speech difficulties
- __ chronic ear infections
- __ concern about relationships
- __ meningitis/encephalitis
- __ eczema/chronic skin condition
- __ poisoning
- __ measles
- __ rheumatic fever
- __ hemophilia
- __ heart disease - type _____
- __ chicken pox - date _____
- __ toothaches/dental problems
- __ allergies/hay fever
- __ near-drowning/near suffocation
- __ anaphylactic reaction
- __ eye problems or poor vision
- __ behavior problems
- __ seizure disorder/epilepsy
- __ sickle cell disease
- __ stool soiling
- __ urinary tract infections
- __ kidney disease-type _____

Please indicate if the family is involved with any of the following community services:

Speech Therapy _____ Yes _____ No If yes, where?
Head Start/Early Head Start _____ Yes _____ No Help Me Grow/Early Intervention _____ Yes _____ No
Occupational Therapy _____ Yes _____ No If yes, where? Physical Therapy _____ Yes _____ No If yes, where?
Job & Family Services _____ Yes _____ No If yes, Caseworker?
Preschool/Daycare _____ Yes _____ No If yes, where?
Child Protective Services _____ Yes _____ No If yes, Caseworker?
Mental Health/Individual/Family Counseling Services _____ Yes _____ No If yes, where?

Enrollment Form (page 2)

About My Child

My child's favorite color is: _____

My child's favorite book is: _____

My child's favorite food is: _____

My child's favorite toy is: _____

My child's other favorites are _____

Play and Social Experiences

Has your child attended a preschool setting previously? Yes No If yes, how long? _____

How did your child do there _____

How does your child get along with other children? _____

How does your child prefer to play? ____ alone ____ with others ____ both alone and with others

How does this child's development compare to other children (siblings or playmates)? (Please circle)

About the same as others Slower than others Faster than others

My child frequently exhibits the following behaviors.

__ hitting __ kicking __ biting __ scratching __ fighting __ name calling
__ shy __ outgoing __ withdrawn __ friendly __ tattling __ tantrums

My child likes to…

__ listen to stories
__ play with other children
__ play alone
__ play quiet games
__ other _____

__ draw and color
__ play outside
__ play inside
__ play pretend/make-believe
__ other _____

My child doesn't like to: _____

What concerns do you currently have regarding your child? _____

_____

What goals do you have for your child?

Goal #1 _____

Goal #2 _____

Goal #3 _____

What do you expect your child to learn from being in our program? _____

Do you exclude celebrating holidays? _____ Yes _____ No

****List holidays not celebrated** _____

Cambridge City Schools Preschool
Program Authorization

Authorization for School District Transportation. Please check the appropriate line below.

_____ Yes, I grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate. Furthermore, I grant permission for my child to participate in walking field trips that are close to my child's school.

_____ No, I DO NOT grant permission for my child to be transported to/from school and/or field trips by the school district bus/van, if appropriate. Furthermore, I DO NOT grant permission for my child to participate in walking field trips that are close to my child's school.

Authorization for Annual Class Roster. Each year we prepare a roster for each group of children in our program. This roster will not be shared with any person other than the parents of children enrolled in our program. I authorize the following information to be listed on the Class Roster (please circle yes or no for each).

My child's name. Yes No Parent/Guardian name. Yes No Parent/Guardian home phone number. Yes No Parent/Guardian cell phone number. Yes No

Authorization for Picture Publication. *Please circle YES to grant permission or NO to revoke permission.*

My child's picture can be taken and used for possible publication (Twitter, Facebook, newspaper, brochure, website, etc.). **YES NO**

My child's picture and name may appear together in possible publication (Twitter, Facebook, newspaper, brochure, website, etc.). **YES NO**

My child may be videotaped and I understand that it may be used for professional development and/or advertising purposes. **YES NO**

Authorization for Participation and Release of Information.

- My child has permission to participate in any health/developmental/academic screenings and assessments (which may include, but are not limited to physical, dental, vision, hearing, speech, mental health, lead, iron, height, weight, developmental, etc.) that are conducted through Cambridge Preschool and other community agencies.
- Cambridge Preschool has my permission to conduct assessments as required by the Ohio Department of Education (which may include, but are not limited to the Early Learning Assessment, Child Outcomes Summary Process, etc.). I understand that my child's teacher/specialist will provide feedback regarding the assessment to myself and other staff members working with my child. Additionally, I grant permission for the preschool administration to report the results of these assessments electronically, as required by law, the the Ohio Department of Education.
- I understand that there may be some screenings/assessments that are not able to be conducted at my child's preschool setting and that I may need to obtain these screenings/assessments through my child's physician, dentist, local health department or other community agency. I also understand that it may be necessary to obtain follow-up care for my child based on the results of the health/developmental assessments performed and that it will be my responsibility to do so.

As the parent/guardian of _____, I authorize Cambridge Preschool to release all medical, developmental, educational and psychological information concerning my child to the appropriate agencies, as noted above. By signing, I am verifying that I have read, understand, agree and authorize the information as listed above.

_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Date

Cambridge City Schools Preschool
Cambridge, Ohio

EMERGENCY MEDICAL AUTHORIZATION FORM
O.R.C. 3313.712

Class _____

Male _____ Female _____ Weight_____ Student Name_____

DOB_____ Age_____ Student Address_____

_____

Student resides with (circle all that apply). **Mother** **Father** **Stepmother** **Stepfather** **Guardian**

Name and phone number of parent(s):

Parent _____ Please circle: Mother or Guardian

Home or Cell Phone_____ Place of Work _____ Work Phone _____

Parent _____ Please circle: Father or Guardian

Home or Cell Phone_____ Place of Work _____ Work Phone _____

Name and phone number of two persons to contact in an emergency if the parent cannot be located.

Em. Contact #1 _____ Daytime Phone (_____) _____

Em. Contact #2 _____ Daytime Phone (_____) _____

Name of persons to whom the child can be released.

_____ _____ _____ _____

PART 1: CONSENT FOR TREATMENT

I hereby give consent for the following medical care providers and local hospital to be called.

Physician _____ Phone (_____) _____

Dentist _____ Phone (_____) _____

Medical Specialist _____ Phone (_____) _____

Local Hospital _____ Phone (_____) _____

In the event reasonable attempts to contact me or other emergency contacts have been unsuccessful, I hereby give my consent for any treatment deemed necessary by the preferred doctor indicated, or by another licensed physician or dentist, and the transfer of my child to any hospital reasonably accessible.

Parent/Guardian Signature_____ Date_____

PART 2: REFUSAL CONSENT

I do not give my consent for EMERGENCY MEDICAL TREATMENT of my child in the event of illness or injury requiring emergency treatment at the hospital. I wish the following action:

_____

_____

Parent/Guardian Signature_____ Date_____

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medications being taken at home and school, and any physical impairment of which a physician and/or school personnel should be alerted to:_____

_____

_____

Cambridge City Schools Preschool

518 S 8th St
Cambridge, OH 43725

(phone) 740-439-7592
(fax) 740-432-2809

Child Medical Statement

PARENT, PLEASE COMPLETE RED BOXED AREA THEN GIVE TO PHYSICIAN.

Child's Name _____ DOB _____

By signing below, I authorize my physician, _____, to release the completed medical statement and any communicable disease diagnosis during this school year to Cambridge Preschool.

_____

Parent/Guardian Signature Date

Required for ALL children enrolled in Preschool Special Education and Early Childhood Education Grant Programs.

Date of exam _____

Height _____ Weight _____ Allergies _____ History _____

	Normal	Abnormal		Normal	Abnormal
General Appearance			Glands (Lymphatic?Thyroid)		
Posture, Gait			Nose, Mouth Pharynx		
Speech			Teeth, Gums		
Head			Heart		
Skin			Lungs		
Eyes			Abdomen		
*symmetrical light reflex			Genitalia		
*external aspects			Bones, Joints, Muscles		
Development			Extremities		
Ears			Muscular Coordination		
Social/Emotional			Neurological (gross, fine, sensory, motor)		

Assessments/Screening	Completed (please circle one)	Date	Assessments/Screening	Completed (please circle one)	Date
Lead	Yes No		Vision screen	Yes No	
Hemoglobin	Yes No		Hearing screen	Yes No	

Medications_____

Limitations or health conditions (including food supplements/modified diets, activity restrictions, health services needed at school)

_____

_____

Immunization record (Required by Section 3313.671 of the Revised Code and for attendance in a preschool program) **Please attach a copy.**

*Exempt from immunizations: _____ Religious conviction _____ Health concern _____ Other

I have examined this child and found that he/she is in suitable condition for participation in group care.

_____

Signature Physician/Physician's Assistant/Advanced Practice Nurse Printed Name Date

_____ Address

Telephone Fax

Cambridge City Schools Preschool

518 S 8th St
Cambridge, OH 43725

(phone) 740-439-7592
(fax) 740-432-2809

Child Dental Exam Form

PARENT, COMPLETE AREA IN THIS BOX THEN GIVE TO DENTIST.

Child's Name_____ Date of Birth_____

Parent's Name_____ Preschool: CAMBRIDGE PRESCHOOL

Is the child now receiving any of the following?

(If yes, include length of time receiving fluoride)

Topical fluoride application: _____ No _____ Unknown _____ Yes _____

Fluoridated water: _____ No _____ Unknown _____ Yes _____

Fluoride supplement diet: _____ No _____ Unknown _____ Yes _____

_____ Tablets _____ Liquid

Does the child have any trouble with teeth, gums or mouth? _____ Yes _____ No

If so, what kind?_____

Has the child previously seen a dentist? _____ Yes _____ No

Dentist Name _____ Date of last visit _____

Is child under physician's care? _____ Yes _____ No

Physician Name _____

Is child receiving medication? _____ Yes _____ No

Date of Exam_____ **Services provided this visit:**

Tooth Number	Description of work
_____	_____
_____	_____
_____	_____

Is follow-up required? _____ Yes _____ No

(If yes, see section below)

Name of Dentist	Telephone Number ( )
Street Address	City, State, Zip

Dentist Signature	Date Signed

PLEASE COMPLETE THIS SECTION FOR FOLLOW-UP REQUIREMENTS

Please provide a written summary of the following services required:

* For the relief of pain or infection
* Restoration and/or pulp therapy of decayed permanent teeth
* Extraction prophylaxis & instructions in self-care oral hygiene procedures

Recommended follow-up dental needs (check all that apply):

( ) A. Treatment (restoration, pulp therapy, extraction)
( ) B. Cleaning
( ) C. Fluoride
( ) D. Other (please specify below)

_____

Approximate number of visits need to be complete care _____

Has a follow-up appointment been scheduled? ____ Yes ____ Date _____

Ohio | Department of Education

Cambridge City Schools

Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

Student Name: *(First Name and Last Name)*	**Student Date of Birth:** *(mm/dd/yyyy)*

Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.	1. In what language(s) would your family prefer to communicate with the school? _____
Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	2. What language did your child learn first? _____ 3. What language does your child use the most at home? _____ 4. What languages are used in your home? _____
Prior Education Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.	5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? ☐ Yes ☐ No If yes, how many years/months? _____ If yes, what was the language of instruction? _____ 7. Has your child attended school in the United States? ☐ Yes ☐ No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month Day Year
Additional Information Please share additional information to help us understand your child's language experiences and educational background.	

Parent/Guardian First Name: _____ Parent/Guardian Last Name: _____

Parent/Guardian Signature: _____ Today's Date: *(mm/dd/yyyy)* _____

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: https://www2.ed.gov/about/offices/list/ocr/ellresources.html

(Appendix A, continued)

COMPLETED BY SCHOOL EMPLOYEE

1. **Check.** Confirm the following statements related to the administration of Ohio's language usage survey:

   - ☐ The district or school presented the language usage survey, to the extent practicable, in a language and form that the parent or guardian understood.
   - ☐ The district or school informed the parent(s) or guardian(s) of the form's purpose. The language usage survey only is used to understand students' linguistic experiences and educational background.
   - ☐ The district or school reports information from the language usage survey in the appropriate Educational Management Information System (EMIS) records.
   - ☐ For students enrolling from other U.S. schools and districts, school officials request previous language survey data and refer to the information when identifying English learners.
   - ☐ Results of the language usage survey are kept with the student's cumulative records and follow the student if he/she transfers to another district or school.

2. **Note.** Record additional information to assist the review of the language usage survey.

3. **Record.** Indicate responses from the language usage survey in the table below. Refer to the Language Usage Survey Annotations on page 2 for item-specific guidance.

Student's native language See Language Usage Survey Question 2. Report for all students in EMIS.	_____
Student's home language See Language Usage Survey Question 3. Report only for English learners in EMIS.	_____
Potential English learner See Language Usage Survey Questions 2-4.	☐ Yes. Assess the student's English proficiency. ☐ No. Do not assess the student's English proficiency.
Immigrant student status See Language Usage Survey Questions 5-7. Report for all students in EMIS.	☐ Yes, the student is an immigrant child. ☐ No, the child is not an immigrant child.

4. **Validate.** Complete the information below.

_____ Signature of validating school employee

_____ Date (mm/dd/yyyy)

_____ Printed name of validating school employee

_____ Name of school or school district

Student Residency Questionnaire

**** Form to be completed by Parent, Guardian, Caregiver or Student *(if living independently)***

The information requested below will be used to help identify eligibility under the McKinney-Vento Homeless Assistance Act, as amended by the Every Student Succeeds Act of 2015 (ESSA). **Please complete and return this form ASAP** to the student's school office or during the new student registration process.

Name of Student: _____ Gender: ☐ Male ☐ Female
Last *First* *Middle*

Birth Date: ____/____/____ Grade: _____ Student Attends: ☐ Primary (K-2) ☐ CMS ☐ Intermediate (3-5) ☐ CHS ☐ Preschool ☐ Other
Month *Day* *Year*

Check the box that best describes with whom the student resides. (***Please note:*** *legal guardianship may be granted only by a court. Students living on their own or with friends or relatives who do not have legal guardianship are allowed to enroll in and attend school.)*

- ☐ Parent(s)
- ☐ Legal Guardians(s)
- ☐ Caregiver(s) who are not legal guardian(s) *(Examples: friends, relatives, parents of friends, etc.)*
- ☐ On my Own, or Other (explain) _____

Name of person with whom student resides: _____

Address: _____

City: _____ ZIP: _____

Home Phone #: _____ Cell Phone #: _____ Other Emergency #: _____

Length of Time at Present Address: _____ Length of Time at Previous Address: _____

Last District Attended: _____ Last School Attended: _____

Please check <u>at least one box</u> that describes your family living situation *(please check <u>all that apply</u>)*:

- ☐ We rent or own our own home or apartment.
- ☐ Student lives with parent(s), legal guardian(s), or caregiver(s).
- ☐ We live in the home of a friend or relative in a **Long-term**, cooperative living arrangement between each other.
- ☐ We **Temporarily** share the home of a friend or relative due to the loss of our own housing – **CODE C**
  (i.e., economic hardship, eviction, divorce, domestic violence, kicked out, fire, flood, military deployment, parent in jail, etc.)
- ☐ We live in a **temporary** shelter or **transitional** housing because we do not have permanent housing – **CODE A**
  (i.e., Transitional housing is only for a short period of time & is provided as a step to permanent housing - family, youth, or domestic violence shelter.)
- ☐ Our home or apartment has no electricity – **CODE B**
- ☐ Our home or apartment has no running water – **CODE B**
- ☐ We live in a car, abandoned building, a public park, on the streets, in public spaces not ordinarily used for regular sleeping accommodations, or other unsheltered locations – **CODE B**
- ☐ We live in a hotel, motel, or camping grounds – **CODE I**
  (i.e., economic hardship, eviction, unable to get deposits for permanent home, flood, fire, tornado, etc.)
- ☐ Student is independent and is on his/her own without parent(s), legal guardian(s), or caregivers(s) – **CODE U/A**
- ☐ None of the above describes my present living situation.

  Briefly describe your situation: _____

Continued on Back

If applicable, check any of the following factors contributing to the family living situation you indicated on the front of this form *(check none or any that apply)*:

- ☐ Military Service: *(Army, Navy, Air Force, Marines, Coast Guard)*
  - ☐ Student is a dependent of a member of active duty forces – Which Branch: _____
  - ☐ Student is a dependent of an active member of the National Guard – Which Branch: _____
  - ☐ Student is a dependent of a member of military Reserves – Which Branch: _____
- ☐ Economic hardship:
  - ☐ Loss of job resulting in inability to pay rent or mortgage
  - ☐ Income from part-time or low-paying job does not cover the cost of housing in the area
  - ☐ Loss of mortgage, including loss of landlord's mortgage if family is renting
  - ☐ Eviction record and/or inability to produce deposits for rent or utilities
- ☐ "Family" Issues such as divorce, domestic violence, kicked out by parents, student left due to family conflict, etc.
- ☐ "House" Issues such as lack of electricity, water, heat, adequate home repair due to lack of funds, overcrowding, mold, etc. List specific "House" Issue: _____
- ☐ Incarceration of parent/guardian
- ☐ Incapacitation of parent or guardian due to health, mental health, drugs/alcohol, or other factors
- ☐ House fire that is NOT DUE to a Natural Disaster due to *faulty equipment, appliances, wiring, furnace, stove, fireplace, etc.*
- ☐ Natural Disaster
  - ☐ Fire: forest, grass, lightning strike, etc.
  - ☐ Tornado, storm, flood, etc.
- ☐ Other
  - ☐ High medical bills that leave little or no money for housing
  - ☐ Lack of affordable housing in the area
  - ☐ Minor student unable to afford housing on my own
- ☐ None of the above describes the main reasons for my present family living situation.

Briefly explain the contributing factors: _____

Please provide the following information for school-age and pre-school brothers and/or sisters of the student:

Name	Grade Level	School	District

I realize that falsifying records is an offense, and enrollment of the child under false documents subjects the person to liability under the Criminal Code.

_____ _____

Signature of Parent / Legal Guardian / Caregiver / Student (if living independently) Date

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For School Use Only

I certify the above-named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Homeless Assistance Act.

_____ _____

McKinney-Vento Liaison Signature Date

Cambridge City SD
518 S 8th St
Cambridge, Oh 43725
740-439-3508

HOUSEHOLD INFORMATION SURVEY

Cambridge City SD will participate in the Community Eligibility Provision (CEP) under the National School Lunch Program (NSLP). Under this option, all children in the school receive a breakfast/lunch at no charge regardless if they complete this form. However, to determine eligibility for various additional state and federal program benefits that your child's school may qualify for, please complete, sign and return this application to your school building if your income falls within or below the guidelines listed in the following chart.

INCOME GUIDELINES – 185%
Guidelines to be effective from July 1, 2022 through June 30, 2023

Number of persons in family or household size	Annual	Monthly	Twice per month	Every two weeks	Weekly
1	$25,142	$2,096	$1,048	$967	$484
2	33,874	2,823	1,412	1,303	652
3	42,606	3,551	1,776	1,639	820
4	51,338	4,279	2,140	1,975	988
5	60,070	5,006	2,503	2,311	1,156
6	68,802	5,734	2,867	2,647	1,324
7	77,534	6,462	3,231	2,983	1,492
8	86,266	7,189	3,595	3,318	1,659
Each additional member add	+8,732	+728	+364	+336	+168

If any member of your household receives Supplemental Nutrition Assistance Program (SNAP) (formerly food stamps) or Ohio Works First (OWF) benefits, provide the name and 7 -digit case number for the person who receives the benefits then proceed to Section 4. If no one receives these benefits, start with Section 1.

Name: _____ 7-digit Case Number: _____

INSTRUCTIONS: Complete this survey and return to your child's school or mail to the following address: Cambridge City SD,518 S 8th St Cambridge, Oh 43725.

The following selections must be completed by the Head of Household or Designee:

1. **SIZE OF FAMILY** - Indicate the total number of individuals living in your household, including all adults and children:

2. **STUDENT INFORMATION** - Complete for each student Pre-K through grade 12.

Last Name	First Name	Birth Date MM-DD-YY	School	Identify: H = Homeless M = Migrant R = Runaway F = Foster
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

For additional lines, please attach a second sheet to this survey or attach a copy of this survey clearly marked as Page 2.

3. **TOTAL MONTHLY HOUSEHOLD INCOME** – Report income for all members of household excluding foster children. If you have reported a case number above, please do not complete this section. Proceed to section 4.

Type of Income	Income	Circle if No Income
1. Gross Monthly Earnings: Wages, Salary, Commissions	$	None
2. Monthly Welfare Payments, Child Support, Alimony	$	None
3. Monthly Payments from Pensions, Retirement, Social Security	$	None
4. Monthly Dividends or Interest on Savings	$	None
5. Monthly Worker's Compensation, Unemployment, Strike Benefit	$	None
6. Other Monthly Income (SSI, VA, Disability, Farm, other)	$	None
Total Monthly Household Income (Add lines 1-6)	$	

4. **SIGNATURE** - If income section is completed, the adult signing the form must also list the last four (4) digits of his or her Social Security number or check the "I do not have a Social Security number" box below.

I certify (promise) that all information on this application is true and that all income is reported. I understand the school will be eligible for certain federal and/or state funds based on the information I give. I understand that the school officials may verify (check) the information. I understand that if I purposely give false information, my child may lose benefits and I may be prosecuted.

Sign Here: X_____ Print Name:_____

Date_____

Last Four (4) Digits of Social Security Number: XXX-XX-_____ ☐ I do not have a Social Security Number

Address	City	Zip Code

Home Phone	Work Phone	Email Address
		By providing your email address, you may be contact via email by the district.

For Internal Office Use Only:

Please circle one option.

QUALIFIES DOES NOT QUALIFY