The Silver Lake Preschool
Tuition Policy
2024-2025

The Silver Lake Preschool tuition policy requires that the first tuition payment be paid by August 1st. Failure to pay this tuition by August 1st will result in your child losing his/her position in the preschool. The remaining tuition payments will be due no later than the 15th of each month, September through April. The final payment will be due by April 15th. Tuition may be paid in advance. Refunds will be granted on advance payments if the withdrawal policy is followed. There will be no refunds for absences due to illness, vacations or canceled days due to weather conditions or emergency repairs to the preschool building such as heating, water, etc. Tuition is non-refundable.

Payments received after the 15th of each month will incur a late fee of $25.00. If the tuition and late fee are not received by the last school day of the month, your child may not return to school until payment is received.

All parents must provide a two week notice before withdrawing a student from the program. Failure to do so will result in forfeiture of the current month's tuition.

No refund of tuition will be made after April 15th.

If your child is not toilet trained by August 15th, you will need to either withdraw your child from preschool or pay the tuition until your child is toilet trained. As long as tuition is paid, we will hold your child's spot at the preschool. We will not hold any spot without payment of tuition. There will be no refunds made for students not toilet trained in time for the opening of school.

PLEASE RETURN THIS FORM ALONG WITH YOUR AUGUST 15th PAYMENT.

Make check payable to: **Silver Lake Preschool**
2951 Kent Road
Silver Lake, Ohio 44224

I have read the above Tuition Policy. I agree to pay $200.00 for the 3's class, $250.00 for the 4's class, and $450.00 for the 5's All Day class per month.

_____ _____

Parents Signature Date

Reset Form

Ohio Department of Job and Family Services

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information

Routine Trip Destination(s)

Hiking on Bike Trail

Date of Permission *(valid for one year)*

8/1/2024

Mode of Transportation (*walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*

Walking

During this trip children will have access to water that is 18 inches or more in depth.

☐ Yes ☐ No

Are water activities planned in water that is 18 inches or more in depth? ☐ Yes ☐ No

(if yes, a swimming permission slip is required)

Child's Information

Child's Name

My child is

☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 8 years and/or over 4' 9"

Signature

I grant permission for my child to participate in the routine trips described above.

Parent's Signature	Date

Reset Form

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

Reset Form

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 ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information 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 #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information 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 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 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

Give *Permission* to Transport			**OR** **Do not sign both**	***Do Not Give Permission* to Transport**	
Program or Home Name				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, 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.

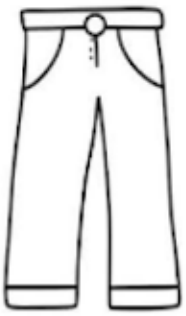
CHANGE OF CLOTHING

Dear Parents,

Sometimes, small children do not make it to the restroom on time. Please send a complete change of clothing inside this Ziploc® bag. Write your child's name on the bag so that we can find it quickly. I will keep his/her clothes at school in case that they are needed.

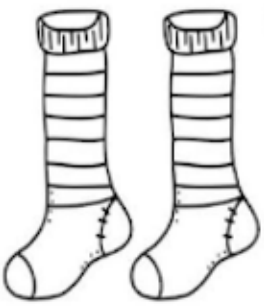
Your child needs:

a shirt



pants

under pants



socks

Thank you,

The Church in Silver Lake Preschool
2951 Kent Road
Silver Lake, Ohio 44224
Morghan Weekly, Director
330-945-7864

ALL ABOUT ME

Child's Name _____

Name you wish your child to be called at school _____

Please list other children in the family

Name **Ages** **Birth Date**

_____

_____

_____

Has your child attended preschool previously? _____

Does your child have any habits such as thumb sucking, nail biting, or stuttering?

_____

Is your child timid? _____ **Afraid of new experiences?**_____

Jealous? _____ **Over-dependent of adults?** _____

What are your child's favorite interests? _____

_____

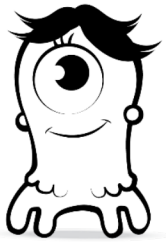
Does your child have any problems toward school which school cooperation might help?

_____

_____

How did you hear about The Church in Silver Lake Preschool?_____

_____



Hi Parents/Guardians,

This year we will be using Class Dojo in our classroom. This will be our classroom management tracker for the year. Class Dojo is an awesome tool to encourage working together, responsibility, and being prepared. It is an easy way to instantly see your student's behavior in class. Students will be rewarded points for displaying their awesome behavior. You will also be able to see the skills they need to work on.

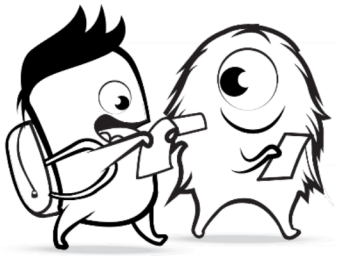
I would like all families to join our classroom community and sign up for Class Dojo! Once I have your e-mail address, I will send an invite. You can then confirm and set up an account.

It is very simple:
Download the free mobile app for iOS and Android, and you can view from any computer at www.classdojo.com. For more information go to www.classdojo.com/LearnMore.

Please provide the information below and we can get started with Class Dojo! Feel free to ask any questions.

Thank you for your support!

Student Name_____
Parent/Guardian Name(s)_____
Parent/Guardian e-mail:_____



Permission to Photograph

I, _____, give permission for The Church in Silver Lake Preschool to
(Parent or Guardian name)

photograph my child, _____, for the following purposes:
(Child's name)

Type of Use:	(Please check one) Grant Permission	Decline Permission
Still Photographs:		
Display in my personal scrapbook	☐	☐
Give photographs possibly containing your child to current clients	☐	☐
Display in facility's scrapbook or bulletin boards, shown to current and prospective clients	☐	☐
Display still photos on child care website*	☐	☐
Post photos on child care's Facebook page	☐	☐
Other:	☐	☐
Videos:		
Give video to current parents	☐	☐
YouTube™ promotional video	☐	☐
Other:	☐	☐
Other (please list):		
	☐	☐
	☐	☐
	☐	☐
	☐	☐

*Only first names and possibly last initials (in the event of two or more children with the same first name) will be displayed on the facility website.

I understand that it is my responsibility to update this form in the event that I no longer wish to authorize one or more of the above uses. I agree that this form will remain in effect during the term of my child's enrollment.

Signed:

_____ _____
(Parent or Guardian signature) (Date)