COLUMBUS CITY SCHOOLS

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 eceenrollment@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.

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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?

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 got 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:_____
1st Meeting Comments or Progress	
2nd 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, *Future*Ready 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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www.ccsoh.us/earlychildhoodeducation

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Medical Reminder

According to state licensing guidelines, every preschool student is required to have documentation of a well child exam or yearly physical done within the last 12 months and an up-to-date immunization record on file before starting school. The medical form must be completed by a licensed healthcare provider in addition to the immunization record.

If your child needs a well child exam or immunizations, please contact their healthcare provider or Nationwide Children's Hospital School Based Health Services at 614-355-2590 as soon as possible to schedule an appointment. If a student has been seen by Nationwide Children's Hospital within the last year for a well child exam, the parent/guardian can access this information online through MyChart.

You can email documentation of a well child exam/yearly physical including an immunization record to ECEnurses@columbus.k12.oh.us, fax it to 614-365-8745, or return it to your classroom teacher. We can accept the attached CCS Medical form, ODJFS Medical form, or any official documentation from a healthcare provider of a well child visit or yearly physical within the last 12 months.

We must have documentation of a yearly physical or well child exam on file BEFORE your student can start attending school.

Revised 10/23/25

COLUMBUS CITY SCHOOLS

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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_____

Date of Exam _____

Visual Acuity: Right_____ Left_____
Hearing Acuity: Right_____ Left_____
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

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 ****