



**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

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

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**Early Childhood Education  
ENROLLMENT PAPERWORK**

**Name of Student:** \_\_\_\_\_ **Student #:** \_\_\_\_\_

**Dear Parent/Guardian:**

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

**ASSIGNED SCHOOL:** \_\_\_\_\_

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

**The forms in this packet include:**

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

**\*Please return the completed paperwork to [ecenrollment@columbus.k12.oh.us](mailto:ecenrollment@columbus.k12.oh.us).**

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

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

\_\_\_\_\_  
**Parent/Guardian**

\_\_\_\_\_  
**Date**

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

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



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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.?<br>_____Yes      _____No<br>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?)<br>_____Yes      _____No<br>Additional Details?  |
| Please indicate all of the words that best describe your child's personality and behavior:<br>active adventurous affectionate anxious leader bright busy calm cautious cheerful content<br>creative curious easily-upset emotional energetic excitable friendly follows directions happy<br>hesitant likes structure/routines loud loving outgoing prefers adult attention quiet sensitive serious<br>shares-well social spontaneous stubborn other:<br>List of words: |
| Are there additional personality and behavior characteristics that would be useful to know about your child?   |

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|   |      |
|---|------|
| Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?  |      |
| What causes your child to feel angry or frustrated?   |      |
| General education Pre-K students must be potty trained to attend the program.<br>Is your child toilet trained?      Yes                  No<br>Does your child need assistance when using the toilet?      Yes                  No<br>If so, how? |      |
| What time does your child normally go to bed at night and wake up in the morning?   |      |
| What time(s) and for how long does your child usually nap?  |      |
| What 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<br><br><b>*Please select at least two goals from the bank to the right or write in your own goal for your child</b> | <input type="checkbox"/> I would like my child to expand their attention to a task or activities (non-electronic devices)<br><br><input type="checkbox"/> I would like for my child to increase their problem solving and conflict resolution skills.<br><br><input type="checkbox"/> 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<br><br><input type="checkbox"/> I would like for my child to improve their self-help skills and independence skills (i.e., getting dressed)<br><br><input type="checkbox"/> I would like for my child to be able to count 1-10<br><br><input type="checkbox"/> I would like for my child to know the alphabet and the letters in their name<br><br><input type="checkbox"/> I would like for my child to improve their “writing” or drawing for a variety of purposes<br><br><input type="checkbox"/> I would like for my child to increase their ability to follow more complex directions<br><br><input type="checkbox"/> Other: _____<br>_____ |
| Action Steps  | <ul style="list-style-type: none"> <li>• Parent Completes “Family Information” form</li> <li>• Teacher reviews the form with the parent and asks clarifying questions</li> <li>• Teacher completes curriculum-based baseline assessment to gather additional data about potential goals</li> <li>• Parent and teacher agree upon 2 educational/developmental goals collaboratively</li> <li>• Progress towards goals are communicated at Parent/Teacher conferences and in student Report Cards</li> </ul>   |
| Person(s) Responsible   | Classroom teacher, parent/guardian, outside agencies/community partners  |

Rev. 03.15.2019

|  |   |
|--|---|
| Resources Needed                             | <input type="checkbox"/> Visual timers<br><input type="checkbox"/> Additional language/literacy books, games, technology<br><input type="checkbox"/> Wait time for independence<br><input type="checkbox"/> Technology<br><input type="checkbox"/> Social skills books and resources<br><input type="checkbox"/> Repeated practice<br><input type="checkbox"/> Multi-sensory approaches towards learning<br><input type="checkbox"/> Other: _____ |
| 1 <sup>st</sup> Meeting Comments or Progress |   |
| 2 <sup>nd</sup> Meeting Comments or Progress |   |

1<sup>st</sup> Meeting Review:

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2<sup>nd</sup> Meeting Review:

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Rev. 3.15.2019



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



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

I hereby grant permission for \_\_\_\_\_  
 (Child’s Legal Name)

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

I give permission to Columbus City Schools  
 (Provider Name)

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

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

|  |                       |
|--|-----------------------|
| Child’s Legal Name (First, Middle, Last) (printed) | Child’s Date of Birth |
| Parent/Guardian’s Legal Name (printed)             |                       |
| Parent/Guardian’s Signature                        | Date                  |

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

**Preschool Medical Form**

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

Name \_\_\_\_\_ Address \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Room \_\_\_\_\_ Date of Birth \_\_\_\_\_

**HEALTH SCREENING:**

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

**IMMUNIZATION REQUIREMENTS:**

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

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

**PHYSICAL EXAMINATION:**

Surgical History: \_\_\_\_\_

Medical History: \_\_\_\_\_

Current medical diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

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

|             |  |
|-------------|--|
| Urinalysis  |  |
| Hemoglobin  |  |
| Sickle Cell |  |
| Serum Lead  |  |
| Other Labs  |  |

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

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

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

**FAX Form to (614)365-8745**

**Rev. 03/2019**

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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 \****