GREEN-OAK PRESCHOOL
1921 Woodman Dr.
Kettering, Ohio 45420
252-7840

I wish my child_____to be enrolled in Green-Oak Preschool, 2026-2027.
I/We agree to follow all rules and regulations of said school.

I/We agree to pay the fee of _____ ($175-3 days a week) or ($140-2 days a week)($300-5 days) , per month, monthly regardless if my child is present or not.

If my child has to be withdrawn from the school, I/We will give two weeks written notice. Failure to give two weeks written notice, I/We will be charged for the full month.

If written notice is given any fees paid beyond time of notice of withdrawal will then be refunded.

I/We agree to pay the $60 registration fee the day I/we enroll our child and fully understand this is NON REFUNDABLE. ($100 for two children or $150 for three children)

I/We understand that a $10 late charge will be enforced if monthly tuition is not paid by the tuition due date.
(This is usually the first Friday of each month.)

All Children must be fully potty trained. We do no diapering, which includes pull-ups.
All Children must meet the age requirements listed below.
By signing below, you agree to all rules and regulations stated in information packet and addendum.

Parents or Guardian:

_____ Date_____

Please circle the days and times that you would prefer for your child:

Pre-K 5 year old program (5 by Oct. 1, 2026)

Monday through Friday, 5 days 9:00- 11:30 AM

Pre-K 4-5 year old program (4 by Oct. 1, 2026)

Monday, Wednesday, Friday 9:00 – 11:30 AM
Tuesday, Thursday 9:00 - 11:30 AM

3-4 year old program (3 by Oct 1, 2026)

Monday, Wednesday, Friday 9:00 – 11:30 AM
Tuesday,Thursday 9:00 – 11:30 AM

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:	**Initials of 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):*	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):	**Signature of Parent**
☐ 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):	Date

JFS 01305 (Rev. 10/2021)

Ohio Department of Children and Youth

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

Child's Name	Date of Birth	First Day at Program
Address		
City	State	Zip Code

Parent #1 Name	Parent #1 Phone Number		
Parent #1 Address ☐Same as Child's	City	State	Zip Code
Parent #1 Email Address (if applicable)	Parent #1 Cell Phone (if applicable)		
Parent #1 Work/School Name (if applicable)	Parent #1 Work/School Phone Number (if applicable)		

Check here if Not Applicable ☐	Parent #2 Name	Parent #2 Phone Number		
Parent #2 Address ☐Same as Child's		City	State	Zip Code
Parent #2 Email Address (if applicable)		Parent #2 Cell Phone (if applicable)		
Parent #2 Work/School Name (if applicable)		Parent #2 Work/School Phone Number (if applicable)		

Primary Emergency Contact #1 Name (cannot be parent/guardian)	Check here if Not Applicable ☐	Optional Emergency Contact #2 Name (cannot be parent/guardian)
Primary Emergency Contact #1 Phone Number		Optional Emergency Contact #2 Phone Number
Primary Emergency Contact #1 Other number or email address for emergency contact *(if applicable)*		Optional Emergency Contact #2 Other number or email address for emergency contact *(if applicable)*
My child may be released to this emergency contact ☐ Yes ☐ No		Optional My child may be released to this emergency contact ☐ Yes ☐ No

Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication?

☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

Child's Name	Date of Birth

Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes
☐ No

Name of service provider(s) and frequency

☐ N/A

Emergency Transportation Authorization

☐ **The program 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.

☐ **The program 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:

SIGNATURE

This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.

Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures

By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures (parent handbook).

Parent Signature	Date

Program Acknowledgement of Completion

By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.

Program Administrator/Designee Signature			Date
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

CHILD'S NAME_____ NICKNAME_____ GENDER M F

(Circle one)

PLEASE LIST ALL OTHER MEMBERS OF YOUR HOUSEHOLD:

Name_____ Name_____ Name_____Name_____Name_____

Age_____ Age_____ Age_____ Age_____ Age_____

PICK-UP PERMISSION

I give permission for the following people to pick-up my child,_____at Green-Oak Preschool:

Name	Phone #	Relationship to Child

_____
Signature Date

HOW DID YOU FIND OUT ABOUT GREEN-OAK?

_____Friends or Family _____Newspaper Ad _____Phone Book _____Website _____Other