



LAKEVIEW PRESCHOOL CENTER REGISTRATION PACKET

Sharing Jesus, teaching children,
And supporting families since 1986.

(2023-2024)

Serving families in the
Amherst, Lorain, Firelands, and Vermilion
School districts.

Like us on:



***Developmentally appropriate curriculum for
children's first school experience and
preparation for kindergarten.***

***Please complete and return with the \$100 deposit to reserve
you child.***

Tuition Payment Schedule for 2023-2024 School Year

Three Year Old Class
(3 hrs.) 5 days per week
9-month payment plan **\$250 per month**
Starting Sept. 5th – May 20th

Four Year Old Class
(3hrs.) 5 days per week
9-month payment plan **\$250 per month**
Starting Sept. 5th – May 20th

If paid in full option by October 2nd (with no exceptions) you will receive a 5% percent discount.

There is a non-refundable registration fee of **\$100** for the first child and **\$50** for the second child enrolled. This fee will reserve a spot for your preschooler. By not paying this fee, it does not guarantee an enrollment.

*Payments are due the 1st of every month. If received after the 1st week of the month; a **\$25** late fee will be added. Failure to pay for 2 months will result in withdrawal of your child.

Please see director for other plans. **All tuition must be paid in full by May 13th.**

Lakeview Preschool Center

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Amherst, Lorain, Firelands, and Vermilion School Districts,

School Year 2023-2024

I wish to Enroll: Son or Daughter 9:00-12:00

Name: _____

Address: _____

Child's Birthday is _____ 20_____

Three year old class meets Monday through Friday from 9:00-12:00

Annual Tuition \$2,250 5% discount available if paid in full by Oct. 2nd

Four year old class meets Monday through Friday from 9:00-12:00

Annual Tuition \$2,250 5% discount available if paid in full by Oct. 2nd

Please enclose a non-refundable registration fee for **\$100** for the first child and **\$50** for the 2nd child. This fee will reserve a spot for your preschooler. By not paying, this fee it does not guarantee an enrollment.

I understand that this is a tuition program with discounts and payment options. I also understand that this 9-month program tuition will be paid accordingly to the contract. You are still obligated to pay even if we are closed due to snow days, pandemic related closures, or any other acts of God. (Ex. Tornado, fire, flooding, etc.) I also realize that the school requires a two week notice to withdraw my child from your program.

I have read and hereby agree to these terms and conditions specified as above.

Parents/Guardian Signature

Date

Address

Phone Number

Lakeview Preschool Center

Photo Release

Dear Parents,

From time to time, we like to post photos of the children participating in various activities on our Facebook Page and /or website. In addition, photos are occasionally submitted to the Vermilion Photo Journal or other local media for publishing. Children will be identified as students of Lakeview Preschool Center and class, not by individual names.

By signing this form, you give permission for your child's photo to be published.

Teresa Krause
Director

Print Child's Name

Parent Signature

Date

Personal Information Sheet

Child's name used during school _____

Who does the child live with? Ages of siblings

How does your child get along with family members?

Favorite playmate? _____

Involved with other play groups/sports or activities?

Attend church? _____ Where? _____

Pets? _____, Favorite toy? _____

Child's personality _____

Does anything upset your child?

Any assistance needed with restroom/or outside clothes?

Is there anything else that we may need to be aware of?

How did you hear about our school?

Lakeview Preschool Center

Pick Up and Drop Off list for your child

Names and Phone numbers of person(s) that will be picking up or dropping off your child, while your child is in the program.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

***If staff is not familiar with this person, they will be asked for an I.D. or driver's license to verify who they are.**

Annual routine field trip permission form

Destination: Family life center, ball field, fellowship hall.

Mode of Transportation: Walking

The child will not have access to water that is two feet or more in depth.

No water activities planned in water that is two feet or more in depth.

Please check:

My child is over 4 and 40 lbs _____ is NOT over 4 years AND/OR 40lbs _____

Child's Name _____

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

Parent/guardian signature

Date

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 <input type="checkbox"/> Same as Child's | | | Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email | | | | | |
| Where can you be reached while your child is in this program/home? | | | | | |
| Parent/Guardian Name #2 | | | Relationship to Child | | |
| Home Address <input type="checkbox"/> Same as Child's | | | Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> 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

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

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

| | | |
|---|--|---------------------|
| Child's Name (<i>print or type</i>) | | Date of Birth |
| <input checked="" type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. <input checked="" type="checkbox"/> This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below). | | |
| Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner | | Date of Examination |
| Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner | | Telephone Number |
| Street Address | | |
| City, State and Zip Code | | |

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

| | | | |
|--|--|-------------------|--|
| Signature of Parent | | Date of Signature | |
| Optional Recommended Assessments/Screenings | | | |
| Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lead | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemoglobin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dental | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | |
| Measurements | | Notes | |
| Height | | | |
| Weight | | | |
| BMI | | | |