



Preschool Registration Enrollment 2026-2027

Supported by St. Peter in Chains and St. Julie Billiard Parishes

Preschool Registration - Please refer to the following guidelines:

Preschool

1. The following must be returned in order for your registration to be complete:

Items A-H (and fee) are due at time of registration to be considered a complete registration.

- A. Student Record Form with paid non-refundable registration fee: **Registration fees — \$50.00/student**
<https://payit.nelnet.net/form/LvOlewiV>
- B. Child Enrollment and Health Information For Child Care Form
- C. Health and History Record Form
- C. Family Information Form (For Step Up to Quality)
- D. Birth Certificate*
- E. Custody paperwork
- F. Student Sacrament Form and Baptismal Certificate (if applicable)
- G. Child Medical Statement For Child Care Form
- H. Student Immunization Record — *ALL students MUST be fully immunized to attend St. Peters.*

2. If a student is accepted, there will be a probationary period of nine weeks. The probationary period may continue for another nine weeks if deemed necessary by the Teacher and Principal. as well as a meeting with the teachers.

*Ohio Law, Section 3313.672 reads as follows:

“A pupil at the time of his initial entry to a public or non-public school shall present to the person in charge of admission any records given him by the elementary or secondary school he/she most recently attended and a certification of birth issued pursuant to section 3705.05 of the Revised Code or a comparable certificate or certification issued pursuant to the statues of another state, territory, possession, or nation.”



NEW Student Record 2026-2027

Supported by St. Peter in Chains and St. Julie Billiart Parishes

Please complete BOTH sides of form and pay the non-refundable registration fee on FACTS

NAME (First) (Middle) (Last) (Preferred Name)

ADDRESS (Street) (City) (Zip)

BIRTHDATE GRADE (2026-2027)

St. Peter in Chains School abides by the teachings and rules of the Catholic Church, and Faith is integrated into all aspects of the school's activities. According to the Catholic Faith, a person's sexual identity is rooted in one's biological identity as male or female. St. Peter in Chains School considers the gender of all students as being consistent with their biological sex, including participation in school athletics and teams, school-sponsored dances, dress and uniform policies, the use of changing facilities, showers, locker rooms, sleeping accommodations on trips, titles, names and pronouns, and school records. As an applicant/registrant and/or parent/guardian for admission to St. Peter in Chains School, I understand and agree to this policy. Please state your child's biological sex below:

Male Female

HOME PHONE PARISH/CHURCH AFFILIATION

YES/NO - Can we share your contact information with other families or in a school directory if one is printed?

FAMILY EMAIL

ETHNICITY (Requested for State Reporting Purposes)

African American American Indian/Native American Asian Caucasian Hispanic Multiracial* Native Hawaiian/Pacific Islander

Other *if choosing Multiracial, please choose all ethnicities that apply

HOW DID YOU HEAR ABOUT ST. PETERS?

PREVIOUS SCHOOL ATTENDED

PUBLIC SCHOOL DISTRICT OF RESIDENCE

PUBLIC SCHOOL BUILDING OF RESIDENCE (This is the public school your child would attend if they did not attend St. Peter's.)

HOME STATUS: Married Single* Divorced* Separated* *Legal custodial paperwork must be submitted and on file with the school office (even if a current family).

MAIL SHOULD BE ADDRESSED TO: Mr. and Mrs. Mrs. Mr. Ms.

FATHER'S NAME _____	RELIGION _____
EMAIL _____	
EMPLOYER _____	OCCUPATION _____
BUSINESS ADDRESS _____	
BUSINESS PHONE _____	CELL PHONE _____

MOTHER'S NAME _____	RELIGION _____
EMAIL ADDRESS _____	
EMPLOYER _____	OCCUPATION _____
BUSINESS ADDRESS _____	
BUSINESS PHONE _____	CELL PHONE _____

IF APPLICABLE	
STEP-FATHER'S NAME _____	RELIGION _____
EMAIL ADDRESS _____	
EMPLOYER _____	OCCUPATION _____
BUSINESS ADDRESS _____	
BUSINESS PHONE _____	CELL PHONE _____
STEP-MOTHER'S NAME _____	RELIGION _____
EMAIL ADDRESS _____	
EMPLOYER _____	OCCUPATION _____
BUSINESS ADDRESS _____	
BUSINESS PHONE _____	CELL PHONE _____

Ohio Department of Children and Youth
**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 <u>at least one person</u> 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 DCY 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 DCY 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 DCY 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 DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 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 <u>Permission</u> to Transport		<u>Do Not Give Permission</u> to Transport
Program or Home Name	OR Do not sign both	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 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.
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.

Reset Form

HEALTH CONDITIONS (Please answer yes or no):

Abnormal spinal curvature _____	Hemophilia (Von Willebrand Disease) _____
Allergies (please circle any that apply) _____	(excessive bleeding w/bloody nose _____)
medicines, foods, plants, animals _____	Injuries/Illness (please include child's age and if hospitalized) _____
emergency action if an allergic reaction is severe _____	_____
_____	_____
Anemia _____	Kidney disease or abnormality _____
Arthritis _____	Measles (10 day) _____
Asthma (last attack on _____) _____	Meningitis or encephalitis _____
Attention Deficit Disorder or Hyperactivity _____	Multiple ear infections (3 or more) _____
Behavior problems _____	Near-suffocation or drowning _____
Birth or congenital malformation _____	Physical activity restrictions _____
Cancer (type _____) _____	(be specific _____)
Chicken Pox (when _____) _____	Seizures or epilepsy _____
Chronic diarrhea or constipation _____	Sickle Cell Disease _____
Concussion (explain) _____	Substance Abuse _____
_____	Suicide Attempt _____
_____	Stool soiling during the day _____
Cystic Fibrosis _____	Toothaches or dental infections _____
Diabetes _____	Urinary Tract Infections _____
Difficulty sleeping _____	Wetting during the day _____
Easily fatigued _____	Vision problems _____
Eating disorders _____	(wears glasses _____ or contacts _____)
Eczema _____	(Lazy Eye _____)
Emotional problems _____	Other _____
Frequent headaches _____	_____
Hearing problems _____	_____
(wears hearing aid(s) _____)	_____
Heart disease (type _____) _____	_____

ADDITIONAL INFORMATION

Medications given daily and why: _____

Other medications given frequently and why: _____

Do you have other comments or concerns about this child's physical and emotional health, development, behavior, family or home life that you would like the school to be aware of? If so, please explain:

Please contact the school office if there are changes to the information provided or if any new medical condition(s) develop.

Completed by _____
(Please print name and relationship to child)

Signature _____ Date _____

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name <i>(Last)</i>	<i>(First)</i>	Nickname <i>(If any)</i>
<i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</i>		
Who is in the child's immediate family?		
Who lives at home with your child?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?		
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? <input type="checkbox"/> Yes or <input type="checkbox"/> No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice or <input type="checkbox"/> water. <i>(Check all that apply)</i> How much and how often?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)		

Please check all of the words that best describe your child's personality and behavior

- active adventurous affectionate anxious bossy bright busy calm cautious cheerful
 content creative curious easily-angered emotional energetic excitable friendly gives-in-easily
 happy hesitant insecure jealous likes structure/routines loud loving mellow outgoing
 prefers adult attention quiet sensitive serious shares-well social spontaneous stubborn tentative
 other:

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 routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a high chair, booster, child size chair or adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

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?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited 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



Supported by St. Peter in Chains and St. Julie Billiart Parishes

STUDENT NAME _____

BAPTISM (if baptized at a church other than St. Peter in Chains, please submit copy of baptismal certificate)

CHURCH _____

(City)

(State)

DATE _____

FIRST COMMUNION

CHURCH _____

(City)

(State)

DATE _____

CONFIRMATION

CHURCH _____

(City)

(State)

DATE _____

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

Child's Name (<i>print or type</i>)	Date of Birth
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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 _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lead _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight _____	Hearing _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemoglobin _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BMI _____	Dental _____	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

<p>Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:</p> <p><input type="checkbox"/> The above named child has been immunized against the diseases listed above.</p> <p><i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i></p>	<p>Initials of Examining Health Care Practitioner</p> <hr/> <p>Date</p>
<p>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</p> <p><input type="checkbox"/> 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):</p>	<p>Signature of Parent</p> <hr/> <p>Date</p>