Guidelines for Forms to attend Good Hope Christian Preschool

The following forms are needed to secure enrollment:

1. Registration Form (blue paper)
2. Non-refundable Registration Fee- $60.00

Please send a check, money order, or have exact change.

****The following forms and September tuition of $130.00 are needed by 4:30 pm Wednesday, August 5, 2026. ** (Please do not turn in before June 1, 2026)**

3. Medical Statement (yellow) -A licensed physician or certified nurse practitioner MUST complete this form.
*Include an up-to-date copy of immunizations.

4. Child Enrollment and Health Information
On page 4, please ensure there are no blank areas. (**If there is nothing to add, please mark the box-not applicable**)

You will receive a copy of our Parent Handbook during the Parent Orientation Meeting.

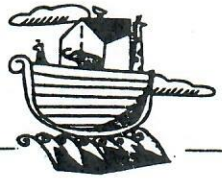
5. Authorized Pick-up -Please **include parents**.

6. Getting to Know Your Child & Facebook Permission

7. Routine Trip Permission for Child Care

8. Child Medical/Physical Plan
This form should be completed **only** if your child has special health concerns or conditions. Examples of conditions are as follows (but not limited to): asthma, juvenile arthritis, food allergies, insect allergies, etc…

GOOD HOPE CHRISTIAN PRESCHOOL



129 West Charles Street
Bucyrus, Ohio 44820

Phone: 419-562-0286
Fax: 419-562-2704

2026-2027 Registration Information

Thank you for your interest in the Good Hope Christian Preschool Program for the 2026-2027 school year. We are very excited about beginning our 26th year of offering preschool classes for three-, four- and five-year-old children. The program is sponsored by Good Hope Lutheran Church and is licensed by the Ohio Department of Children and Youth. Below is a list of important preschool registration guidelines:

Age requirement: Students must be 3 years old no later than August 1, 2026, to enter our 3-year-old Program.
Students must be 4 years old no later than August 1, 2026, to enter our 4/5-year-old Program.
All students must be potty-trained; no pull-ups or diapers shall be worn.

Registration Dates: **January 26-February 5, 2026, for** Current Preschool Families and Good Hope Lutheran Church members' children shall be given priority regarding class choice. Please keep in mind that a completed registration form and the non-refundable registration fee must be given to the preschool director to ensure your child's enrollment in a class.

Sunday, February 8, 2026
Registration shall be open to everyone. A completed registration form and the non-refundable registration fee must be given to the preschool director to ensure enrollment in a class.

Registration Open House- On **Sunday, February 8, 2026,** from 1:00 pm-2:30 pm, there will be a Registration Open House. During the Open House, you can meet our teachers, tour the classrooms, submit the registration form/fee, and learn more about the preschool.

How to enroll a student: 1. Complete the registration form, and give it to the preschool director or the church office.
2. Pay **non-refundable** registration fee, paid once per school year: $60.00

Preschool Classes: 3-year-old Class: Monday, Tuesday, Wednesday, Thursday 8:30-11:30 am
4/5-year-old Class: Monday, Tuesday, Wednesday, Thursday 8:30-11:30 am

Preschool Tuition: $130.00 a month ($1,170.00 for the year)
September tuition is due by **Wednesday, August 5, 2026.**
October tuition is due September 30, 2026.
Please pay with a check, money order, or exact change. All tuition payments need to be paid in the church office.

Preschool Snacks: Snacks/drinks shall be provided by parents on a rotating basis.

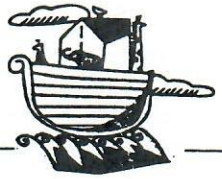
Teachers: Each class will have a teacher and an assistant teacher.

Parent Orientation: Parents Only: Thursday, August 27. 2026, 6:30 pm-7:00 pm (church sanctuary)

Preschool Open House: Preschoolers & Parents: Friday, August 28, 2026, 8:30 am-9:30 am (classrooms)
First day of class: Monday, August 31, 2026, 8:30 am-11:30 am

"But Jesus called for them and said, "Let the little children come to me, and do not stop them; for it is to such as these that the kingdom of God belongs." Luke 18:16

GOOD HOPE CHRISTIAN PRESCHOOL



2026-2027 Registration Form

129 West Charles Street
Bucyrus, Ohio 44820

Phone: 419-562-0286
Fax: 419-562-2704

Child's Name _____

Child's Birthday_____

Child's Address _____
Street address City zip code

Mother's Name _____

Mother's Address _____
Street address City zip code

Mother's Home Phone Number _____

Father's Name _____

Father's Address _____
Street address City zip code

Father's Phone Number _____

Preschool Class Preferred

Please mark your preferred class choice. Please keep in mind that a preschool child **MUST be 3 years old by August 1, 2026,** to be registered in our 3-year-old class. A preschool child **MUST be 4 years old by August 1, 2026,** to be registered in our 4/5-year-old class.

3-year-old students: _____Mon. Tues. Wed. Thurs. 8:30 am-11:30 am

4/5-year-old students: _____Mon. Tues. Wed. Thurs. 8:30 am-11:30 am

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Office Use Only

Reg Fee____ Current ___ Church ___ Public ___ Date & Time _____

"But Jesus called for them and said, "Let the little children come to me, and do not stop them; for it is to such as these that the kingdom of God belongs." Luke 18:16

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): ☐ 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):	**Signature of Parent** Date

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 ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ 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

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 *Permission* to Transport			**Do Not Give *Permission* to Transport**	
Program or Home Name			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.		**OR** **Do not sign both**	**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

Authorized Pick up List

These persons are given permission to pick my child up from the Good Hope Christian Preschool. No other person will be allowed to take my child from school without written and dated permission from me. **(Please include parents)**

Child's Name _____

1. _____ Phone# _____ Relationship _____

Address _____

2. _____ Phone# _____ Relationship _____

Address _____

3. _____ Phone# _____ Relationship _____

Address _____

4. _____ Phone# _____ Relationship _____

Address _____

5. _____ Phone# _____ Relationship _____

Address _____

6. _____ Phone# _____ Relationship _____

Address _____

Good Hope Christian Preschool

Getting to Know Your Child & Facebook Permission Form

Some of the following information may be useful to us when we want to start conversations with your child and will help us all feel more comfortable with each other.

Child's Full Name_____Birth Date_____

What name do you prefer your child learn to write? _____

Father's Name_____

Occupation_____Special Interests_____

Mother's Name_____

Occupation_____Special Interests_____

Marital Status_____

Whom does child live with? _____

Describe any custody or visiting arrangements_____

Brothers and Sisters:
Name_____Age____Name_____Age____

Name_____Age____Name_____Age____

Other members of household: (include relationship and age) _____

Are you a member of a church and where?

Mother:_____Father:_____

Has your child attended: Preschool_____

Daycare_____

Sunday School_____

Do you have pets? What kind? _____

Does your child have any known fears? (cats, dogs, the dark, etc…)_____

_____

Is your child right or left-handed? _____

Please describe your child's personality. _____

_____

_____

What would you like your child to learn/experience at Good Hope Christian Preschool?

_____

_____

How did you hear about Good Hope Christian Preschool?

_____

_____

In which school district do you live? _____

*Good Hope Christian Preschool has a Facebook page. It contains preschool special events and other happenings within the preschool. We would also like to add photographs of students. **No picture will include any student's name**. We may also submit photographs to Crawford County Now, Bucyrus Telegraph Forum, New Washington Herald, and the Good Hope Lutheran Church Facebook Page.

_____ Yes, permission granted to add my child's picture to the Good Hope Christian Preschool's Facebook page or local media

_____ No, permission not granted to add my child's photograph to the Good Hope Christian Preschool's Facebook page or local media.

Ohio Department of Children and Youth

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information	
Routine Trip Destination(s)	Anywhere on Good Hope Lutheran Church Property
Date of Permission *(valid for one year)*	August 24, 2026
Mode of Transportation (*walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*	walking
During this trip children will have access to water that is 18 inches or more in depth. ☐ Yes ☒ No	
Are water activities planned in water that is 18 inches or more in depth? ☐ Yes ☒ No (if yes, a swimming permission slip is required)	
Child's Information	
Child's Name	
My child is ☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 8 years and/or over 4' 9"	
Signature	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date

Reset Form

*Please do not sign and turn in until after May 2026.

Ohio Department of Children and Youth

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a DCY 01217 is not required.

Child's Name

Special Health Condition

Does this health condition require medication or medical food? ☐ Yes (If Yes, complete Part II) ☐ No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid? ☐ Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

Part II: Conditions Requiring Medication or Medical Food

Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

(If no medications or medical foods are required for the condition, skip Part II).

If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name	Date of Birth	Weight *(if needed to determine dosage)*

Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date

☐ **Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature

Part III: Administration of Medication or Medical Food Training Authorization

Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)

Part III must be completed

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure	**Complete Only One Section**	**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided instructions for care and/or training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the proced for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.	Administrator/Provider Signature	Date of Signature

This 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, a new form must be completed.

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
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Part IV: Documentation of Administration of Medication or Medical Food

Completed by child care staff member, family child care provider or in-home aide for the child listed on this form

All medication or medical food must be documented when administered. Document each medication or medical food on its own page. Incomplete information elevates the level of risk to children. If more than one medication or medical food is needed, make a copy of this page for each medication or medical food.

This medication or medical food is not to be administered until after the child has received the first dose or application at least once prior to the program administering a dose to avoid unexpected reactions. Emergency medications for the child are exempt from this requirement.

Child's Name	Name of medication/medical food

Date	Time	Dosage	Signature of designated person administering medication