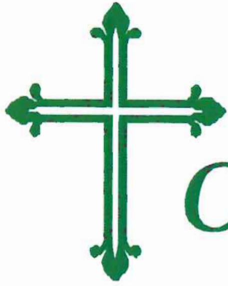

Our Lady of Perpetual Help

olphtoledo.org

2024-2025 Preschool Tuition

Registration fee–$150.00 (non-refundable)

Please choose a class

Preschool 3s ☐ Pre-Kindergarten 4s ☐

Please choose a schedule (days are listed on back)

5 full days - $5,000/yr. ☐ 5 half days - $2,970/yr. ☐

3 full days - $3,180/yr. ☐ 3 half days - $1,970/yr. ☐

2 full days - $2,270/yr. ☐ 2 half days - $1,575/yr. ☐

***Please note, our Preschool 3s class options are only available Tuesday, Wednesday, Thursday. For additional days please contact the school office with your request.**

Child's name ________________________________

Date of birth ______________________

Parent's name ______________________________

Email ____________________________________

Please complete the other side →

Please choose your days. Thank you 🙂

Preschool 3s	Tuesday	Wednesday	Thursday
3 Full Days	☐	☐	☐
2 Full Days	☐	☐	☐
3 Half Days	☐	☐	☐
2 Half Days	☐	☐	☐

Pre-K 4s	Monday	Tuesday	Wednesday	Thursday	Friday
5 Full Days	☐	☐	☐	☐	☐
3 Full Days	☐	☐	☐	☐	☐
2 Full Days	☐	☐	☐	☐	☐
5 Half Days	☐	☐	☐	☐	☐
3 Half Days	☐	☐	☐	☐	☐
2 Half Days	☐	☐	☐	☐	☐

email:

Office of Early Learning and School Readiness

Preschool Enrollment Form

Revised 11/30/18

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Student & Family Information

Child's Name ______________________ Date of Birth ______________

Family/Guardian Name ______________________

Please select 1, 2 or 3 to set call order of phone number used to reach you:

Home Address ______________________ Cell Phone ______________ Call Order ____

City ________ State ______ Zip ________ Home Phone ______________ Call Order ____

Employer Name ______________________ Work Phone ______________ Call Order ____

Employer Street Address ______________________ City ________ State ______ Zip ________

Alternate Family Information:

Please select 1, 2 or 3 to set call order of phone number used to reach you:

Family/Guardian Name ______________________ Cell Phone ______________ Call Order ____

Family Street Address ______________________ Home Phone ______________ Call Order ____

City ________ State ______ Zip ________ Work Phone ______________ Call Order ____

Employer Name ______________________

Employer Street Address ______________________ City ________ State ______ Zip ________

Section II - Authorization for Emergencies

List 2 Emergency Contacts for use ONLY if the parents cannot be contacted:

Name ______________________ Name ______________________

Street Address ______________________ Street Address ______________________

City ________ State ______ Zip ________ City ________ State ______ Zip ________

Please select 1, 2 or 3 to set call order of phone number used to reach emergency contact:

Home ______________ Call Order ____ Home ______________ Call Order ____

Cell ______________ Call Order ____ Cell ______________ Call Order ____

Work ______________ Call Order ____ Work ______________ Call Order ____

List Medical Contacts, In Case Of Emergency:

Physician ______________________ Dentist ______________________

Street Address ______________________ Street Address ______________________

City ________ State ______ Zip ________ City ________ State ______ Zip ________

Phone ______________________ Phone ______________________

Section III - Child's Health Information

Child's Chronic Medical/Health Needs

Please complete both pages of form

Child's History of Hospitalization:

Child's Disease History:

Child's Allergies/Treatment:

Child's Dietary Needs/Restrictions:

NOTE: A MEDICATION FORM MUST BE COMPLETED FOR EACH MEDICATION ADMINISTERED WHILE IN PROGRAM ATTENDANCE

Child's Medication/s:

Section V - Registration Authorizations

Annual Class Roster: Each year the program prepares a roster for each group of children. This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize the following to be listed on the parent roster:

My child's name ☐ Yes ☐ No

Family name ☐ Yes ☐ No

Phone numbers ☐ Yes ☐ No ☐ Cell ☐ Home ☐ Work

Exempt from immunizations because of religious conviction: ☐ Yes ☐ No

Child immunization records attached: ☐ Yes ☐ No

Date

Signature of Authorized Family Member/Guardian

Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 3/12/2018

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name ______________________________

Date of Birth ______________ Height ______ Weight ______

Immunizations:		**Exempt from Immunization:**	
Complete for Age	◯ Yes ◯ No	Religious Conviction	◯ Yes ◯ No
In Process	◯ Yes ◯ No	Health	◯ Yes ◯ No
		Other	______________

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name ______________________ Provider Address ______________________

Provider Phone Number ______________ Provider City ______________ Provider State ________ Provider Zip ________

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician Assistant
- ☐ Advanced Practice Registered Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional ______________________________ Date of Exam ______________

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

Office of Early Learning and School Readiness

Preschool and School Age Child Care Medication Form

This form meets Ohio Administrative Code. Programs may use this form or build their own including all required information.

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*A separate medication form is required for each prescription and non-prescription medication administered.

Student Name:________________________________ DOB:________________

Student address: ____

School ____________________________ Grade: ______ Class: ______________

To Be Completed by the Physician/Dentist:

Medication Name:_________________________________ Dose:______________

Dosage Time/s:______________ Reason for medication:___________________________

Start date: ______________________ Stop date: ____________________

Special Instructions: ____

Potential adverse reactions to be reported:

____

Physician/Dentist Signature:___________________________________ Date:____________

Physician/Dentist Phone Number:_________________________ Fax:_____________________

<u>Parent/Guardian:</u> I give permission for my child to receive this medication at school according to the school district policy and as instructed by my child's physician/dentist.

I agree and am responsible to:

- **Deliver my child's medicine to school in its original container**
- **Ensure prescription medication is labeled by a pharmacist or healthcare provider**
- **Ensure the medication is current within the past 12 months and provide new medication upon expiration**
- **Administer the first dose of any new medication, except in case of emergency**
- **Tell the school as soon as possible if there is a change in the use of my child's medicine**
- **Tell the school if my child gets a new healthcare provider**
- **Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes. I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.**

Parent/Guardian Signature_________________________________ **Date:** ______________

Parent/Guardian Phone: __________________ **Emergency Alternate Phone:** ______________

6/2020

Student Name:____ DOB:____________________

Grade: __________ Class: ___________________________________

Per ORC 3313.713 B (2) - Designated persons employed by the board are authorized to administer to a student a drug prescribed for the student. Effective July 1, 2011, only employees of the board who are licensed health professionals, or who have completed a drug administration training program conducted by a licensed health professional and considered appropriate by the board, may administer to a student a drug prescribed for the student. Except as otherwise provided by federal law, the board's policy may provide that certain drugs or types of drugs shall not be administered or that no employee shall use certain procedures, such as injection, to administer a drug to a student.

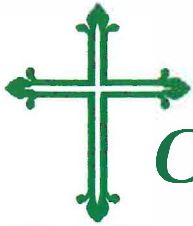
Staff Trained and Authorized to Administer Medication: ____________________________________

__________________________________ __________________________________

Drug Administration Training Date ___________________ Length of time _______________

Trained by ____

Date	Time	Dosage Amount	Reason Given/Comments	Signature of Person who Administered



Our Lady of Perpetual Help

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Spring 2024

Dear Parent(s)/Guardian(s),

Thank you for making the investment in your children's future by sending your them to OLPH. Tuition for the 2024-25 school year is $6,500/yr.

There is an additional, one time, Registration fee for each child. Fees are as follows:
1st student = $150
2nd student = $100
3rd student = $50
($300 max)
* ***Everyone*** is required to pay registration fees, these are **NOT** a part of tuition.

By signing this form you agree to pay any tuition and registration fees assessed for the 24/25 school year.

I/We agree that all payments owed under this agreement will be paid by the invoice due date. I understand and agree that, regardless of what payment option is selected, I am personally responsible for the payments and for ensuring that the tuition and fees are paid in full.

Student(s) Name(s)______________________ ______________________

______________________ ______________________

______________________ ______________________

Parent Name ____

Signature________________________________Date____________

Please sign and return to the school office with the non-refundable registration fee. If the registration fee is not paid in full by the first day of the 2024/2025 school year, your child will not be registered.

Thank you,
OLPH School
419-382-5696

Emergency Medical Authorization

Revised 5/6/2020

This form meets the requirement for Ohio Revised Code Section 3313.712. Programs may use this form or build their own.

Program Name ______________________________

Student Name ______________________ Phone ______________

Address ______________________________

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name ______________________ Daytime Phone ______________

Father's Name ______________________ Daytime Phone ______________

Other's Name ______________________ Daytime Phone ______________

Name of Relative or Childcare Provider ______________________

Relationship ______________ Daytime Phone ______________

Address ______________________________

Emergency Contact[1] #1 ______________________ Daytime Phone ______________

Address ______________________________

Emergency Contact #2 ______________________ Daytime Phone ______________

Address ______________________________

Emergency Contact #3 ______________________ Daytime Phone ______________

Address ______________________________

[1] Emergency contact information is required in accordance with Ohio Administrative Code Rule 3301-37-08 (for preschool programs) and Rule 3301-32-10 (for school aged child care programs).

Please complete both pages of the form

PART I *OR* II MUST BE COMPLETED:

PART I - *TO GRANT CONSENT* I hereby give consent for the following medical care providers and local hospital to be called:

Doctor ______________________________________Phone ____________________

Dentist ______________________________________Phone ____________________

Medical specialist ______________________________Phone ____________________

Local Hospital ___________________________Emergency Room Phone ______________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

____

____

____

Signature of Parent/Guardian ____________________________________ Date ______________

Address ____

PART II - *REFUSAL TO CONSENT* I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action (written instructions must be completed):

____

____

____

Signature of Parent/Guardian____________________________________ Date ____________

Address ____

Please complete both pages of the form

Media Release Form

Throughout the school year students will be photographed and/or videotaped participating in classroom, church, and other activities. Our Lady of Perpetual Help would like to use these in our publications, such as, but not limited to, the church bulletin, school newsletters, yearbooks, website, Facebook or other media outlets for the promotion of the School and Church.

This release will remain in effect during the time that your student attends Our Lady of Perpetual Help unless written communication requesting a change is submitted to the school.

I have read and understand the Media Release Form.

________________________ ________________________

Student Name/Grade | Student Name/Grade

________________________ ________________________

Student Name/Grade | Student Name/Grade

Please check one box:

☐ I grant consent for my child/ren to be photographed and/or video taped

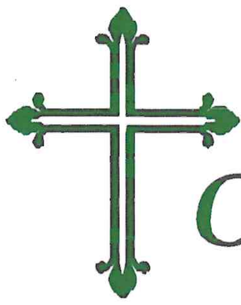
☐ I decline for my child/ren to be photographed and/or video taped

____

Parent Printed Name

________________________________ ____________________

Parent Signature | Date



Our Lady of Perpetual Help

olphtoledo.org

Release Authorization

Student Name: ______________________________ Grade: __________

Parent Name: ______________________________ Phone: ____________________

Parent Name: ______________________________ Phone: ____________________

Parent Name: ______________________________ Phone: ____________________

Parent Name: ______________________________ Phone: ____________________

In lieu of a parent listed above, my child may be released to the following individuals:

Name: ______________________________ Phone: ____________________

Name: ______________________________ Phone: ____________________

Name: ______________________________ Phone: ____________________

Name: ______________________________ Phone: ____________________

______________________________ ____________________

Parent Signature Date

Our Lady of Perpetual Help
2255 Central Grove, Toledo, OH 43614
Parish Office P: (419)382.5511 F: (419) 382.7360 E: olph@bex.net
School Office P: (419)382.5696 F: (419) 382.1745 E: vjagielski@olphtoledo.org