בס״ד

בית חינוך הרב דסלר· קליבלנד
Hebrew Academy of Cleveland

HEBREW ACADEMY

EARLY CHILDHOOD DIVISION

Dear Parents,

Welcome to our Hebrew Academy Preschool family! Our mission is to offer your child a home away from home in a fun and loving Torah atmosphere. We will be working collaboratively with you to ensure that your child learns and grows in a nurturing and exciting environment while he/she is setting the foundation for a life-long love of learning.

Our school day begins at 9:00 a.m. An early drop-off option at 8:20 a.m. is available (for an additional fee.)

- Our two and three-year-olds have three dismissal options: 12:20 p.m. 1:45 p.m. and 3:15 p.m.
- Our four-year-olds have two choices for dismissal: 1:45 p.m. and 3:15 p.m.
- All children entering our three-year-old program **must be toilet trained to attend school**.

Registration for the upcoming school year, 2024-2025, is now open.

NEW Families to HAC
To secure a slot for your child, please meet with Rabbi Simcha Dessler, menahel first and then complete the following three steps:

1. Use this link to complete the online portal application: https://portal.admirepro.com/hac/apply
2. Print out and complete the attached preschool registration forms 1-5 **very clearly**. Each line with a red arrow needs to be filled in. **Illegible forms will not be accepted. All signatures must be handwritten.**
3. Bring or email the hard copy to our preschool office. (Medical and immunization records must be included.)

NEW Children of Current Families
To secure a slot for your child, please complete the following three steps:

1. Use this link to complete the online portal application: https://portal.admirepro.com/hac/apply
2. Print out and complete the attached preschool registration forms 1-5 **very clearly**. Each line with a red arrow needs to be filled in. **Illegible forms will not be accepted. All signatures must be handwritten.**
3. Bring or email the hard copy to our preschool office. (Medical and immunization records must be included.)

Current Families
To maintain the slot for your child, please complete the following:
Students will be auto-enrolled in April. Details to follow by email to review the online portal information.

1. Print out and complete the attached preschool registration forms 1-5 **very clearly**. Each line with a red arrow needs to be filled in. **Illegible forms will not be accepted. All signatures must be handwritten.**
2. Bring or mail the hard copy to our preschool office. (Medical and immunization records must be included.)

Children new to our program will need to come in for a short interview before being accepted. *Please call or email for an appointment.*

Only children with complete registration will be allowed to attend school.

Please feel free to call us with any questions or concerns!

We look forward to a fabulous year of fun, learning, and growth!

Mrs. Rivky Wolf
Administrator

Mrs. Rochel Garfinkel
Assistant Administrator

1800 Warrensville Center Road • Cleveland, Ohio 44121

PHONE: (216)382-3300 EXT. 270 **EMAIL:** wolfra@hac1.org

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בית חינוך הרב דסלר-קליבלנד
Hebrew Academy of Cleveland

APPLICATION

Child's legal name (last and first) _____
First name that you want your child to be called in school _____
Spelling in Hebrew _____
Male _____ Female _____ Date of birth _____ Does your child have an IEP? _____
If the answer is yes, the IEP needs to be attached.

ARRIVAL AND DISMISSAL TIMES

Arrival:

□ 9:00

□ 8:20-Early Drop-Off. (For an additional fee) Please note that slots are filled on a first come, first serve basis and there are very limited slots available.

Dismissal:

□ 12:20 (2 and 3 year olds only)

□ 1:45

□ 3:15

FRIEND REQUEST

One or two friends that you would like your child to be with. We will try our best to accommodate.

_____

PHOTO RELEASE

□ I allow my child's photographs to be published.

□ I don't allow my child's photographs to be published.

ANY ADDITIONAL INFORMATION FOR US TO BE AWARE OF

_____
_____
_____
_____

□ **I have completed the online portal registration.**

Parent's Signature _____

Administrator's notes _____
_____
_____

2A

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 9/4/2024
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

2B

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 JFS 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 JFS 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 JFS 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 JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 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.

2C

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 2 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			**OR** Do not sign both	***Do Not Give Permission* to Transport**	
Program or Home Name Taylor Road Nursery Hebrew Academy Preschool				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 to be taken:	
Parent's Signature	Date 8/21/24			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 8/21/24
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 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. 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.

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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

4A

Ohio Department of Job and Family Services

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information

Routine Trip Destination(s)

Walks around the neighborhood

Date of Permission *(valid for one year)*

8/22/24 - 6/25/25

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

4B

Ohio Department of Job and Family Services

DEVELOPMENTAL AND EDUCATIONAL GOALS FOR STEP UP TO QUALITY (SUTQ)

Name of Child	Date of Birth

For Three to Five-Star Rated programs, the program must work with families to develop goals for children. These goals must be updated at least annually.

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Lead Teacher's Name	Signature	Date

Parent/Guardian's Signature	Date
	8/21/24

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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

According to Ohio State Law, All early childhood students must have an-up-to date medical exam every calendar year.

The attached child medical statement form should be submitted to the preschool office upon completing your child's yearly well visit.

Please bring it with you to your child's appointment, have it filled out and sent to us asap.

If you are unsure when your child is due for a well visit, please contact your pediatrician or Brocha Schiff at 216-382-3300 x 275 to clarify.

If your child's medical statement has expired, please let us know the date of your upcoming well visit.

As a reminder, last-minute well visits are usually very challenging to accommodate, please schedule them in a timely fashion.

Additionally, please ensure that your child's immunizations are up to date and submit a copy of the latest immunization records with the medical statement.

Thank you!