בית חינוך הרב דסלר•קליבלנד
Hebrew Academy of Cleveland

בס"ד

HEBREW ACADEMY

EARLY CHILDHOOD DIVISION

Dear Parents,

Welcome to the Hebrew Academy Preschool family!

Registration for the upcoming school year 2025-26, is now open.

Our mission is to provide your child with a nurturing, Torah-based "home away from home" fostering a lifelong love of learning in a fun and supportive environment.

Program Details:

Start time:
9:00 a.m. *(Early drop-off available at 8:20 a.m. for an additional fee.)*
Dismissal Options:
Two and three-year-olds 12:30 p.m. 1:45 p.m. and 3:15 p.m.
Four-year-olds 1:45 p.m. or 3:15 p.m.

New Families:
Please meet with Rabbi Simcha Dessler (DesslerS@hac1.org) and then complete the following three steps:

1. Use this link to complete the online HAC portal application: https://portal.admirepro.com/hac/apply
2. Select "New Family-Initial Application"
3. Print out and complete the attached preschool registration forms 1-5 **clearly**, ensuring all red-arrowed lines and signatures are completed.
4. Submit the forms with Medical and immunization records to the preschool office. Out of town families may email the forms as an attachment to an email addressed to schiffb@hac1.org

New Children of Current Families

Please complete the following three steps:

1. Use this link to complete the online portal application: https://portal.admirepro.com/hac/apply
2. Select "New Additional Student Application"
3. Print out and complete the attached preschool registration forms 1-5 **clearly**, ensuring **all** red-arrowed lines and signatures are completed, and all medical and immunization records are included.
4. Submit the forms to our preschool office.

Current Enrolled Students

The portal forms should be completed now and Preschool papers handed in after April 1.

Important Notes:

Children entering our three-year-old program **must be toilet trained**.

Only children with complete registrations will be admitted.

We look forward to an amazing year of growth, learning and fun. Please feel free to contact us with any questions

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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APPLICATION

Child's 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 8/28/25
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			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 8/27/25		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 8/27/25
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.

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

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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)*
8/27/2025-6/25/26

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
	8/27/25

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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 are required to have an-up-to date medical exam and immunization records on file.

Please submit the attached Child Medical Statement along with your child's immunization records, to the preschool office upon completing your child's registration.