MONTESSORI
GOOD SHEPHERD PRESCHOOL

508 Center Street
Ashland, Ohio 44805
Phone: 567-261-0670
Fax: 419-289-1381
Email: montessori@trinityashland.org
www.trinityashland.org

Registration

2025-2026

A $50 non-refundable fee by cash or check is required at the time of application. All forms except the medical form, need to be completed and returned within 14 days. If forms are not returned within 14 days, we cannot guarantee placement. Please complete one application for each child.

Circle days requested: M (am) M (pm) Tu (am) Tu (pm) W (am) W (pm) Th (am) Th (pm)

Start date: _____

Child's name: _____

Address:_____
Street *City* *Zip Code*

Age: _____ **Date of birth:** _____ **Male:** _____**Female:** _____

Past Educational Experience:

_____
(*Child care or preschool)*

Current Activities:

_____

Anticipated Education: Home School _____ Public Kindergarten _____

Private School _____ Other: _____

Parent/Guardian Information

Mother/Guardian	Father/Guardian
Name:	Name:
Address:	Address:
Phone number:	Phone number:
Email:	Email:
Workplace:	Workplace:
Work Address:	Work Address:
Work Phone:	Work Phone:

Contact person preference: _____ Mother/Guardian _____ Father/Guardian

Siblings

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Helpful Information

Please describe some of the activities your child enjoys:

_____

My child communicates: In English _____ Other Language: _____

Are there any special circumstances regarding your child? No _____ Yes _____

If yes, please explain:

_____

_____

Are you aware of any areas where we might give your child special encouragement?_____

_____

How did you hear about our program or who were you referred by? _____

_____

Application Terms

I understand that the $50 application fee due with submission of this application is non-refundable. With this application, my child will be enrolled pending placement procedures.
A signature of both parents is required on this form if both parents reside in the same household.

Signature of Mother/Guardian: _____**Date:** _____

Signature of Father/Guardian: _____ **Date:** _____

For Office Use

MONTESSORI
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508 Center Street
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Fax: 419-289-1381
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www.trinityashland.org

Montessori Good Shepherd Preschool

of Trinity Lutheran Church

Tuition

2025-2026

3 Mornings	$140.00
4 Mornings	$180.00
4 Mornings + 2 afternoons	$305.00
3 Full days	$305.00
4 Full days	$360.00

Our school operates Monday - Thursday, closed on Fridays. Mornings are from 8:30 am - 11:30 am. All day is from 8:30 am–3:00 pm.

If children attend all day they bring a packed lunch.

Tuition is paid on a 10-month schedule (August – May) and made through automatic bank payments.

Payments are withdrawn on the 1st of every month. Each month a tuition payment is returned a $30.00 fee will be charged.

Each additional sibling receives a 10% discount

OR

Trinity members receive a 10% discount

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Direct Debit Program for Tuition Payments

Authorization Agreement
2025-2026

This tuition program enables you to use a payment process called Direct Debit to make your tuition payment to Montessori Good Shepherd Preschool. You authorize your bank to withdraw a specific amount of money from your checking or savings account on a monthly basis. This amount is automatically deposited into Montessori Good Shepherd Preschool's account. *To participate, simply follow these instructions:*

- Complete this authorization agreement
- Remember to designate your account number and account type
- Indicate the dollar amount per withdrawal
- Include a voided check to ensure accuracy of bank numbers
- Sign the authorization form and return via mail to Montessori Good Shepherd Preschool or drop it off at the church office

Name (as shown on your account): _____

Your Address:

_____

Your Phone Number: _____

Financial Institution:

_____

Financial Institution Phone Number: _____

Account Type: _____ Checking Account *(please attach voided check)*
_____ Savings Account

Bank Routing Number (ABA): _____ *(call your bank if unsure)*

Bank Account Number: _____

Amount of Monthly Tuition: _____

Tuition will be withdrawn from your account on the 1st of the month.

I (we) hereby authorize Montessori Good Shepherd Program of Trinity Lutheran Church to deduct my (our) payment from the account indicated above. This authorization is to remain in full force and effect until the end of the school year and all tuition has been paid for the current school year. If for some reason the child is withdrawn during the school year, Montessori Good Shepherd Preschool must receive your request in writing for termination of withdrawals and reasonable time is to be given for the school and bank to act on it.

Signature: _____Date: _____

Signature: _____Date: _____
(If joint account)

Child's Name: _____

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Authorization for Pick-up

2025-2026

Child's Name: _____

Persons authorized to pick up child (including yourself):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Comments _____

Signature _____ Date _____

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Directory Sharing Information

2025-2026

Please indicate the information that can be shared with other families in your child's class. If you choose not to share any information please indicate below.

I, _____ agree to share:

_____ All directory information

_____ Family name

_____ Phone number

_____ Email address

_____ Address

_____ None

Signature _____ Date _____

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Photo and Videography Release Form

2025-2026

Photos and videos may be taken of the children throughout the year as they participate in Montessori programs and activities. These photos and videos may be displayed in the classroom or publically (example: in the hallway, family newsletter, in the newspaper, on social media, etc.) for others to see some of the great opportunities that children have by attending Montessori Good Shepherd Preschool of Trinity Lutheran Church.

Please choose **ONE** of the following statements and sign accordingly:

_____**YES**, I give permission for photos and videos to be taken of my child, _____, and understand that they may be displayed.

I release Montessori Good Shepherd Preschool and Trinity Lutheran church assigns, licensees, and successors from any claims that may arise regarding the use of my child's image, including any claims of defamation, invasion of privacy, or infringement of moral rights, rights of publicity, or copyright. I waive the right to inspect or approve any images used for publication or the written copy that may be used in connection with the images.

_____**NO**, I do not give permission for photos and videos to be taken of my child, _____.

Signature _____

Date _____

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
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 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.

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 Montessori Good Shepherd Preschool		**OR** **Do not sign both**	Program or Home Name Montessori Good Shepherd Preschool	
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 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.

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: Chickenpox, 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: ☐ 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):*	**Initials of Examining Health Care Practitioner**
	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