Dear Parent(s)/Guardian(s),

It is that time of year to register your preschool child for the 2020-2021 school year. Our preschool schedule for the 2020-2021 school year will continue to be 4-day AM or PM preschool, Monday through Thursday. The morning program will run from 8:00 am to 10:45 am, and the afternoon program will run from 12:00 pm to 2:45 pm. Children who are three years old before August 1, 2020, are eligible to attend Bear Cub Academy.

Completed packets will be accepted at the Hilfiker Elementary School beginning on Friday, April 24 at 8:00 am. Enrollment is on a limited basis, so fully completed applications will be accepted in the order they are turned in with all required paperwork including all health forms. Packets, when accepted, will be marked with the date and time received and whether complete. A student will not be placed on a preschool roster until all paperwork has been turned in. A student will not be allowed to start preschool without all of the necessary paperwork turned in.

At registration, turn in the forms from the registration packet, which include:

**Current Bear Cub Student**
- Preschool Application
- Emergency Medical Form (EMF) (front & back)
- Oral Assessment
- Physical Examination Form
- Family Information (SUTQ)
- Student Internet Agreement
- $10 Registration Fee

**New Bear Cub Academy Student**
- all forms listed above
- New Student Registration Form
- Health History
- Child Medical Statement
- Authorization to Disclose Immunization Information
- Immunization Records
- Child’s Birth Certificate
- Custody records (if applicable)
- $10 Registration Fee

Incomplete forms or paperwork will only delay your child’s enrollment process. If you need any help in completing any of the forms, assistance can be obtained by calling 419-637-7249.

Tuition for preschool will be $160 per month. Tuition is collected from the 1st thru the 15th of month. If you think you may qualify for financial assistance, also complete the Free and Reduced Price Meals Family Application along with the Application for Waiver or Reduction of Fees and a valid Food Stamp/QSF number OR a copy of your W-2 Tax Forms. When completing an address, please be sure to include the street name and number, as well as the name of the city. All of these forms must be turned in at the time of registration for consideration and processing.

If any child is not placed due to limited openings, his/her name will be placed on a waiting list. If an opening occurs, parents will be contacted.

If you have any questions, please contact the Hilfiker Elementary office at 637-7249.

Sincerely,

Emily M. Sisco  
Co-Preschool Director  
Elementary Principal

Mrs. Emily Sisco  
Co-Preschool Director  
Special Education Director
Preschool Checklist

It is MANDATORY for ALL documents listed below to be turned into the office BEFORE the student can become eligible to attend preschool.

___ Registration Fee ($10.00)
___ Preschool Application
___ Emergency Medical Form
___ Student Internet Agreement
___ Family Information (SUTQ)
___ Waiver for Reduction of Fees (if applicable)
___ Child Medical Statement
___ Ohio School Health History (green)
___ Oral Assessment (orange)
___ Physical Examination (purple)
___ Hemoglobin & Lead Screening
___ Authorization to Disclose Immunization Information
___ Immunization Records
___ *New Student Registration (blue)
___ *Custody Paperwork (if applicable)
___ *Birth Certificate

*Only NEW STUDENTS unless information has changed
Gibsonburg Exempted Village Schools
NEW STUDENT REGISTRATION FORM

Please complete ALL sections

<table>
<thead>
<tr>
<th>Legal Last Name</th>
<th>First</th>
<th>Middle</th>
<th>Suffix</th>
<th>Grade</th>
<th>Entry Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>Zip</td>
<td>Phone Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County of Residence</td>
<td>Gender</td>
<td>Date of Birth</td>
<td>City of Birth</td>
<td>Citizenship (ex. U.S.)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity/Race</td>
<td>1. Ethnicity of child: Hispanic/Latino</td>
<td>Yes</td>
<td>No (please check one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>Asian</td>
<td>Black/African American</td>
<td>Native Hawaiian/Oth.Pacific Islander</td>
<td>White/Non-Hispanic</td>
<td></td>
</tr>
</tbody>
</table>

Has this student previously attended Gibsonburg Schools?  No  Yes

If Yes, grade level at withdrawal:

Is your child on an IEP?  

Primary Language Spoken at Home | English | Other |

Has this student presently under expulsion or suspension?  No  Yes

If Yes, please provide copies of paperwork

Previous School Address/City/State/Zip

Previous School District/Building Attended

Student resides with  
- Biological/Adoptive Parents
- Mother/Stepfather*
- Father/Stepmother*
- Foster Family**
- Other

Marital Status of Parents  
- Single
- Married
- Separated
- Divorced
- Remarried
- Widowed

Biological/Adoptive Parent Information (required)

Mother’s Last Name  
First Name  
Middle  
Address (if different from above)  
City/State Zip  
Mother’s Birth City/State  
Last Grade Completed  
Place of Employment  
Spouse’s Name (if applicable)  
Maiden

Father’s Last Name  
First Name  
Middle  
Address (if different from above)  
City/State Zip  
Father’s Birth City/State  
Last Grade Completed  
Place of Employment  
Spouse’s Name (if applicable)  

Non-Custodial/Non-Residential Parent Information (if applicable) *
Name  
Address  

If the student is NOT living with both parents, is there a temporary or permanent custody order/decrement allocating parental rights and responsibilities?  Yes  No  
If yes, you must provide a certified copy of the custody order yearly.

Would the non-custodial/non-residential parent like to receive school correspondence?  Yes  No

Legal Guardian/Foster Parent/Grandparent/Other Information (if applicable) **
Name  
Relationship  
Name  
Relationship  

If the student is placed with a legal guardian/foster parent or residing with a grandparent(s), legal documents which declare placement must be provided to the school yearly.

Please complete back of form, including signature and date.
Please list all siblings.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

To the best of my knowledge, all of the above information is correct and may be filed with my child’s school records.

Signature of Person Enrolling Student ______________________ Relationship to Student ___________ Date __________

_Race Descriptions:_

I American Indian or Alaskan Native
Persons having origins in any of the original peoples of North and South America (including Mexico and Central America) and who maintain tribal affiliation or community attachment.

A Asian
Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Phillipine Islands, Thailand, and Vietnam.

B Black or African American
Persons having origins in any of the black racial groups in Africa.

P Native Hawaiian or Other Pacific Islander
Persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

W White
People who have origins in any of the original peoples of Europe, North Africa, or the Middle East.
PRESCHOOL APPLICATION

Date of Enrollment__________________ (to be completed by school)

Name of Child_________________________ Date of Birth________________
Address_____________________________ Phone #________________

Mother’s Name (natural, step, foster)_____________________________________
Address_____________________________ Phone #________________
Place of Employment____________________ Phone #________________
Address_____________________________

Father’s Name (natural, step, foster)_____________________________________
Address_____________________________ Phone #________________
Place of Employment____________________ Phone #________________
Address_____________________________

Names of persons to whom your child can be released and/or contacted in the event of
an emergency (if parent(s) cannot be reached).

**your child will NOT be released to any other person NOT listed here**

1. Name_________________________ Relationship________________
   Address_______________________ Phone #________________

2. Name_________________________ Relationship________________
   Address_______________________ Phone #________________

3. Name_________________________ Relationship________________
   Address_______________________ Relationship________________

*If parents are divorced or currently involved in a parent/custody court action, does a
non-custodial parent have the right to pick up your child from school? YES___ NO___

*To meet licensing regulations, a class roster must be posted and available to the parent(s) upon
request. The name of the child’s parents and phone number will appear on the roster.
I grant permission to appear on list___ I deny permission to appear on list___

Signature__________________________________________

$10.00 Registration Fee____
Health Service Information

Welcome to Bear Cub Academy! What an exciting time for you and your child as you begin this voyage. It is my goal as the school nurse to help ensure your child’s safety during their time in school. In order to do this, several guidelines and rules must be followed. Here is a list of health topics to insure that all the students will be as healthy as possible.

State Requirements: Each student is to have the following completed in order to enroll your child in preschool: Physical exam, oral exam, immunization record, Child Medical Statement, lead screening, hemoglobin screening, copy of birth certificate, and copy of custodial paperwork (if applicable). Failure to have ANY of these completed prior to preschool entry may result in your child being excluded. A physical exam, oral exam, and hemoglobin testing must be completed each year your child is enrolled in preschool. A physical exam meets state requirements for 13 months before another is needed. Lead testing need only be done once upon initial entry, depending on the results. Your physician should conduct/order the lead testing, hemoglobin testing, hearing screening, and vision screening, and they are all to be completed on the Physical Assessment form. Your physician is also to complete the Child Medical Statement form.

Revised 2/2020
**Immunizations:** It is state law that every student's immunizations are up to date and an immunization record is on file at school. **If the appropriate immunizations were not received by the second week of school, that student is to be excluded until all immunizations are completed.** Needless to say, it is VERY important that your child receives his/her immunizations, and that the school is provided with a copy of his/her record. Failure to do so will result in your child’s exclusion from school. If you have any questions regarding which immunizations are mandatory for enrollment, please contact Sandusky County Health Department at 419-334-6377, or you may contact the school nurse, Sarah Halbeisen RN, MSN, LSN at 419-637-7249.

**Immunizations may be received at:**

- Sandusky County Health Department (Fremont) 419-334-6377
- St. Michael's Catholic Church (Gibsonburg) by SCHD on the second Wednesday each month
- Bellevue Health Department 419-483-3404
- Community Health Services (Fremont) 419-334-3869
- Wood County Health Department (Bowling Green) 419-698-1384
- Possibly your healthcare provider

Revised 2/2020
Required Immunizations for Preschool:

**Diphtheria, Tetanus, Pertussis (DTaP/DT):** 4 doses

**POLIO:** 3 doses of OPV or IPV or any combination of OPV or IPV

**Measles, Mumps, Rubella (MMR):** 1 dose on or after the first birthday

**Haemophilus Influenzae Type b (Hib):** 3-4 doses depending on the vaccine type, the age when the child began the 1st dose and the last dose must be after 12 months –or– One (1) dose if given on or after 15 months of age.

**Hepatitis B (Hep B):** 3 doses. The second dose must have been administered 28 or more days after first, and the third at least three months after the second.

**Varicella (VAR):** 1 dose

**Influenza:** annual

**Hepatitis A (Hep A):** one dose

**Pneumococcal:** 4 doses

**Rotavirus:** 3 doses completed by 6 months of age. If child has not been immunized by 7 months then not age appropriate to receive vaccination.

Revised 2/2020
**Emergency Medical Form:** Please complete ALL areas of the Emergency Medical Form, front and back. List the phone numbers of people to contact in case your child becomes ill and we are unable to contact a parent. Be sure to keep all phone numbers updated and to note if there are any restrictions to who can or cannot pick up your child. For child safety purposes, we will only release your child to the persons listed on the card. Keep in mind that children get ill at the most inopportune times, so make sure you have prior arrangements for daycare or babysitters in the event your child becomes ill in school if you are unable to miss work.

**Health Clinic:** The health clinic is an excellent resource for providing basic first aid for injuries and illness during the school day. Unfortunately, it is not a substitute for your own physician or health care provider as they can diagnose and prescribe appropriate treatment. If you do not have a healthcare provider and/or are having financial difficulties, care is available through Community Health Services in Fremont. Fees are on a sliding scale. Call 419-334-3869 for an appointment. Also, your child may be eligible for free healthcare through Children’s Health Insurance Plan (CHIPs) program. Call 1-800-324-8680 for an application.

**Medication:** A form must be completed for ALL over the counter and prescription medications administered at school, which includes cough drops. These forms are available at the front office and on our website at www.gibsonburg.k12.oh.us under District Health Services. If you know you are going to the doctor’s office, please take a form with you just in case. A physician must sign and provide the needed information in order for prescription medication to be administered at school. A physician’s signature for non-prescription medication is not necessary. However, a parent signature is mandatory. A hand written note is not sufficient for your child to receive medication at school. Also, prescribed medication is to come to school in its original container with the prescription label. Prescribed medication will not be accepted otherwise. Over the counter medications are to be provided in the original, unopened container.

Revised 2/2020
**Illness:** If your child has fever, vomiting, diarrhea, unexplained rash, or red eyes, please keep him/her at home. You can return your child to school when he or she has been fever free WITHOUT medication for 24 hours. If your child has a contagious disease, such as strep throat or conjunctivitis (pinkeye), he/she must stay home for at least 24 hours on appropriate medication before returning to school. In the case of head lice, your child must be nit free and examined by the school nurse BEFORE returning to school.

**Injury:** Please call the school at 419-637-7249 if your child has an illness or received an injury that the school is to be aware of, such as head injury, stitches, fracture, sprain, or surgery. **A physician’s note is necessary to inform us of any activity restrictions for physical education class or recess,** so that the child will not be further injured. A note from the doctor is needed if the parent requests that a student not go out to recess for more than one day.

**Absences:** If your child is absent from school, please call the school in the morning and notify us of your child's illness and if it is contagious. This is especially important in the case of head lice. Please do not be embarrassed to report it. In the case of head lice, letters are sent home as a means to prevent the further spread of infection. The name of the child is never identified in the letter. Be sure to write a note explaining the absence when the child returns to school to excuse your child's absence.

Thank you so much for your cooperation. Please do your best to turn in all the appropriate paperwork at Preschool Registration. I hope your child has a happy, healthy year!

Sincerely,

Sarah Halbeisen RN, MSN, LSN

Director of Health Services

Revised 2/2020
Preschool Paperwork Checklist

*Failure to provide ANY of the below mandatory documents, may result in your child’s exclusion from preschool.

✓ Custody Papers (if applicable)
✓ Hemoglobin Testing (on physical form)
✓ Lead Testing (on physical form)
✓ Authorization to Disclose Immunization Information
✓ Physical Exam
✓ Oral Exam
✓ Immunization Record
✓ Child Medical Statement
✓ Health History
✓ Birth Certificate
✓ Emergency Medical Form
Authorization to Disclose Immunization Information

Name of Child ___________________________________________ Date of Birth ________________________

I, ____________________________________________, as the parent of guardian of the above named child,
hereby authorize (Name of Provider[s])

to disclose the specific and individually identifiable immunization records of the above named child to (Name of School):

for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that
the above named child has been immunized by a method of immunization approved by the department of
health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section
3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that
I may revoke this authorization, in writing, at any time and that I may be asked to sign the Revocation Section
on the back of this form. I further understand that any action taken by the above named Provider(s) or School
in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information
unless otherwise provided for by state or federal law. Please note: medical records provided to schools that
receive federal funding are protected by the Family Educational Rights and Privacy Act (FERPA).

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my
ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is
requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health
information (e.g., physical exam), service may be denied if authorization is not given.

I also understand that my refusal to sign this authorization may prevent the school from verifying that the
above named child has been immunized. I further understand that if the school cannot verify and I cannot
provide satisfactory written evidence that the above named child has been immunized, the child may be
excluded from school pursuant to section 3313.671 of the Ohio Revised Code.

I further understand that I may request a copy of this signed authorization.

(Signature of Personal Representative) (Date) (Relationship / Authority)

************

NOTE: This Authorization was revoked on: (Date) (Signature of Staff)

Last reviewed: December 2014
REVOCATION SECTION

I do hereby request that this authorization to disclose immunization information of ________________________
(Name of Child/Patient)
signed by ______________________________ on __________________________ be rescinded,
(Enter Name of Person Who Signed Authorization) (Enter Date of Signature)
effective ________________________.
(Date)

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the revocation date is legal and binding.

________________________ (Signature of Client/ Patient) __________________________ (Signature of Witness) __________________________ (Date) (Date)

________________________ (Signature of Personal Representative) __________________________ (Date) (Relationship/ Authority)
**Preschool Program**

**CHILD PHYSICAL EXAMINATION RECORD**

**** All Sections Must Be Completed ****

<table>
<thead>
<tr>
<th>CHILD’S NAME</th>
<th>BIRTHDATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Weight</td>
</tr>
<tr>
<td>Hematocrit or Hemoglobin REQUIRED ANNUALLY</td>
<td>If Hgb&lt;11.0 or Hct&lt;34%, has treatment been prescribed: YES / NO If yes, please describe treatment:</td>
</tr>
<tr>
<td>LEAD SCREEN RESULTS (please give number)** <em>Child must have one passing lead screening. Screenings of 10 or greater must be repeated.</em>*</td>
<td></td>
</tr>
<tr>
<td>DATE OF SCREENING</td>
<td>Lead screening done by: Health Department / Other (Annual lead screening is not required.)</td>
</tr>
<tr>
<td>ALLERGIES (Includes allergies to Medications, Foods and Others.)</td>
<td></td>
</tr>
<tr>
<td>SIGNIFICANT MEDICAL HISTORY</td>
<td></td>
</tr>
<tr>
<td>Is child currently taking Medication? Yes / No If yes, What Medication(s)?</td>
<td></td>
</tr>
</tbody>
</table>

### IMMUNIZATIONS

<table>
<thead>
<tr>
<th>DPT / OPT / DTeP</th>
<th>diopheria / tetanus / pertussis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polio (OPV / IPV)</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>measles / mumps / rubella</td>
</tr>
<tr>
<td>HIB</td>
<td>hemophillus B influenza</td>
</tr>
<tr>
<td>Hep B or HBV</td>
<td>hepatitis B vaccine</td>
</tr>
<tr>
<td>Varicella (Varivax)</td>
<td>chicken pox vaccine</td>
</tr>
<tr>
<td>Pneumonia (Prevnar)</td>
<td></td>
</tr>
<tr>
<td>Other immunizations</td>
<td>Give name of immunization and date(s) given</td>
</tr>
<tr>
<td>TB test (tuberculosis test)</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**IMMUNIZATIONS**

Two (2) MMR Immunizations are now required for kindergarten.

Hep B series required for Kindergarten

If not given, has child had Chicken Pox? Yes / No Date: (please circle one)

Give name of immunization and date(s) given

### SCREENINGS

***CHIld ONLY NEEDS TO BE SCREENED. THEY DO NOT NEED TO BE TESTED***

<table>
<thead>
<tr>
<th>VISION SCREENING</th>
<th>NORMAL/ABNORMAL (please circle one)</th>
<th>CORRECTED / UNCORRECTED (please circle one)</th>
<th>ACUITY R L</th>
</tr>
</thead>
</table>

Does the child need to be seen by an Eye Doctor? Yes / No

Is the child currently under the care of an Eye Doctor: Yes / No

Vision Comments:

<table>
<thead>
<tr>
<th>HEARING SCREENING</th>
<th>Pass</th>
<th>Fail</th>
</tr>
</thead>
</table>

Hearing Comments:

<table>
<thead>
<tr>
<th>SPEECH SCREENING</th>
<th>Pass</th>
<th>Fail</th>
</tr>
</thead>
</table>

Speech Comments:

### PHYSICAL EVALUATION

<table>
<thead>
<tr>
<th>PHYSICAL EVALUATION</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMENTS</td>
<td>(explain all abnormal observations)</td>
<td></td>
</tr>
</tbody>
</table>

1. GENERAL APPEARANCE

2. EARS:
   a. canals
   b. TM

3. NOSE:
   a. septum or obstruction
   b. discharge
<table>
<thead>
<tr>
<th>PHYSICAL EVALUATION CONT.</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>COMMENTS (explain all abnormal observations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. DENTAL / MOUTH:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. teeth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. pharynx</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. tonsils</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. LUNGS / THORAX:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. contour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. breath sounds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. HEART</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. rate</td>
<td></td>
<td></td>
<td>(Please thoroughly explain all murmurs.)</td>
</tr>
<tr>
<td>b. rhythm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. murmur</td>
<td>(no)</td>
<td>(yes)</td>
<td>If a hear murmur is present, does child have activity restrictions? Yes / No</td>
</tr>
<tr>
<td>7. LYMPH NODES:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. ABDOMEN (include hernia):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. SPINE:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. EXTREMITIES:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. GENITALIA:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. strength</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. NEUROLOGICAL:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. speech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. strength</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. MENTAL STATUS:</td>
<td></td>
<td></td>
<td>(Please thoroughly explain inappropriate behavior.)</td>
</tr>
<tr>
<td>14. BEHAVIOR:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate</td>
<td>Inappropriate</td>
<td></td>
</tr>
</tbody>
</table>

ARE THERE ANY RESTRICTIONS ON THIS CHILD'S ACTIVITIES?  List any restrictions or health conditions

YES __________  NO __________

DOES THIS CHILD NEED ANY MEDICAL FOLLOW-UP CARE?  If yes, what care is indicated?

YES __________  NO __________

Date of appointment for follow-up:

Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care. As required by Rules 5101:2-12-37 and 5101-13-37, Ohio Department of Job and Family Services Child Care Licensing. Children enrolled in a licensed child care program are required to have a physical every 13 months.

Signature ___________________________  Date of Physical ___________________________

Address ___________________________  Phone ___________________________

Fax ___________________________  (may use office stamp for address)
Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (print or type)  Date of Birth

☐ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner  Date of Examination

Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner  Telephone Number

Street Address

City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Diseases for Immunization</th>
<th>Immunized</th>
<th>In Process of Immunization</th>
<th>Medically Contraindicated/ Not Age Appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken pox</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenza type b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Seasonal Vaccine Not Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pertussis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.

Signature of Parent  Date of Signature

Recommended Assessments/Screenings

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Yes</th>
<th>No</th>
<th>Lead</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Yes</th>
<th>No</th>
<th>Hemoglobin</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Yes</th>
<th>No</th>
<th>Other</th>
</tr>
</thead>
</table>

Measurements:  Notes:

Height

Weight

BMI

JFS 01305 (Rev. 6/2015)
# Ohio Department of Health • School and Adolescent Health
## Oral Assessment

<table>
<thead>
<tr>
<th>Student's name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### The following services have been performed (please check all that apply)

<table>
<thead>
<tr>
<th>Examination</th>
<th>Fluoride application</th>
<th>Oral prophylaxis (cleaning)</th>
<th>Prescription for fluoride supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic assessment</td>
<td>Radiographs</td>
<td>Dental sealant</td>
<td>Treatment (restoration, pulp therapy)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### The following oral hygiene instruction was provided (please check all that apply)

<table>
<thead>
<tr>
<th>Toothbrushing</th>
<th>Flossing</th>
<th>Dietary counseling</th>
<th>Use of fluoride mouthrinse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### The following statements are applicable (please check all that apply)

| All necessary preventive services have been performed, (Fluoride treatment, prophylaxis) |
| No restorative services are required at this time. |
| Further treatment is indicated  (See comments) |
| Further appointments have been arranged, (Orthodontic, restorative) |
| Routine recall visits recommended. |

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dentist's signature</th>
<th>Print name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(     )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>
Ohio Department of Health • School and Adolescent Health
Health History

<table>
<thead>
<tr>
<th>Student's name</th>
<th>Sex</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.
Father
Mother
Brothers and Sisters

Birth and Developmental History □ No unusual birth or developmental history

<table>
<thead>
<tr>
<th>Did the mother have any unusual physical or emotional illness during this pregnancy?</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was infant born full term? □ Yes □ No</td>
<td>Did the infant have any sickness or problems? □ Yes □ No</td>
</tr>
</tbody>
</table>
Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?
□ About the same □ Delayed □ Advanced

Student Health Conditions

□ YES, my child receives regular medical/health care for the following conditions: □ NO medical conditions

□ Allergies □ Diabetes □ Seizure disorder
□ Asthma □ Depression □ Sickle cell anemia
□ ADD/ADHD □ Ear problem/hearing difficulty □ Skin conditions
□ Autism □ Emotional concerns □ Speech problems
□ Behavior concerns □ Headaches □ Traumatic brain injury
□ Birth/congenital malformations □ Heart problems □ Vision problems (glasses, contacts)
□ Bone/muscle/joint problems □ Hemophilia □ Other
□ Blood problems □ Juvenile arthritis □ Other
□ Bowel/bladder problems □ Lead poisoning □ Other
□ Cancer □ Migraines □ Other
□ Cystic fibrosis □ Neuromuscular disorder □ Other

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

<table>
<thead>
<tr>
<th>Allergy type</th>
<th>Reaction</th>
<th>School restrictions or recommended actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Bee/Insect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HEA 4240  8/06
Health History  continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

<table>
<thead>
<tr>
<th>Medication and dose</th>
<th>Time</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?
- [ ] Yes  [ ] No  If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?
- [ ] Yes  [ ] No  If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Form completed by

Relationship to student

Date  /  /
Parent email address: __________________________

Domestic Data Collection: The ODE requires schools to note students who are homeless, living in a shelter or living with other family members. Please mark None of the above on one or more of the following relationships. Please check the applicable relationship(s): Not applicable

If Active Duty Force of National Guard, please check the applicable relationship(s). Not applicable

Active Duty Force of National Guard

Mother

Father

Legal Guardian

Parent/Guardian Signature:

In the event of an unplanned EMERGENCY OR EARLY DISMISSAL, I request that my child:

---

Parent/Guardian Signature:

EMERGENCY MEDICAL FORM

Physical impairment to which a physician should be alerted:

---

This authorization does not cover major surgery unless the medical opinion of two (2) other licensed physicians or dentists, concluding in the necessarily for such surgery, are obtained prior to the performance of such surgery. Please concerning the child's medical history including allergies, medications being taken and any EMERGENCY MEDICAL FORM
GIBSONBURG SCHOOLS EMERGENCY MEDICAL FORM

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.

Student Name ___________________________ Grade _______ Date of Birth ________

Address ___________________________________________ Home/Cell Phone ________

Natural Mother ___________________________ Address ___________________________ Home/Cell Phone ________ Work Phone ________

Natural Father ___________________________ Address ___________________________ Home/Cell Phone ________ Work Phone ________

Step Mother ___________________________ Address ___________________________ Home/Cell Phone ________ Work Phone ________

Step Father ___________________________ Address ___________________________ Home/Cell Phone ________ Work Phone ________

Guardian ___________________________ Address ___________________________ Home/Cell Phone ________ Work Phone ________

List two relatives or LOCAL persons who will assume temporary care of your child if you cannot be reached

1) Name ___________________________ Relationship ___________________________ Home/Cell Phone ________ Work Phone ________

2) Name ___________________________ Relationship ___________________________ Home/Cell Phone ________ Work Phone ________

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT
In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for: (1) the administration of any treatment deemed necessary by

Dr. ___________________________ Phone ___________________________

Preferred Physician

Dr ___________________________ Phone ___________________________

Preferred Dentist

Preferred Hospital

Parent/Guardian Signature ___________________________ Date ___________________________

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 no action or to

______________________________

______________________________

______________________________

______________________________

Parent/Guardian Signature ___________________________ Date ___________________________

DO NOT COMPLETE PART II IF YOU COMPLETE PART I
STUDENT NETWORK AND INTERNET ACCEPTABLE USE AND SAFETY AGREEMENT

To access electronic mail, hereafter referred to as email, and/or the Internet at school, students under the age of eighteen (18) must obtain parental consent AND must sign and return this form. Students eighteen (18) and over may sign their own forms.

Use of the Internet is a privilege, not a right. The Board of Education’s Internet connection is provided for educational purposes only. Unauthorized and/or inappropriate use will result in a cancellation of this privilege.

The Board has implemented the use of a Technology Protection Measure which is a specific technology that will protect against (e.g., block/filter) Internet access to visual displays that are obscene, child pornography or harmful to minors. The Board also monitors online activity of students in an effort to restrict access to child pornography and other material that is obscene, objectionable, inappropriate and/or harmful to minors. Nevertheless, parents/guardians are advised that determined users may be able to gain access to information, communication and/or services on the Internet which the Board has not authorized for educational purposes and/or which they and/or their parents/guardians may find inappropriate, offensive, objectionable or controversial. Parents/Guardians assume this risk by consenting to allow their students to participate in the use of the Internet. Students accessing the Internet through the school’s devices assume personal responsibility and liability, both civil and criminal, for the unauthorized or inappropriate use of the Internet.

The Board has the right to monitor, review and inspect any directories, files and/or messages residing on or sent using the Board’s devices/networks. Messages relating to or in support of illegal activities will be reported to the appropriate authorities.

Administrators are responsible for determining what is unauthorized or inappropriate use. The administrator may deny, revoke or suspend access to the Internet/Network to individuals who violate the Board’s Student Network and Internet Acceptable Use and Safety Policy and related Guidelines, and take such other disciplinary action as is appropriate pursuant to the Student Code of Conduct.
Parent/Guardian

As the parent/guardian of this student, I have read the Student Network and Internet Acceptable Use and Safety Policy and Guidelines, and have discussed them with my child. I understand that student access to the Internet is designed for educational purposes and that the Board has taken available precautions to restrict and/or control student access to material on the Internet that is obscene, objectionable, inappropriate and/or harmful to minors. However, I recognize that it is impossible for the Board to restrict access to all objectionable and/or controversial materials that may be found on the Internet. I will not hold the Board (or any of its employees, administrators or officers) responsible for materials my child may acquire or come in contact with while on the Internet. Additionally, I accept responsibility for communicating to my child guidance concerning his/her acceptable use of the Internet (ex. Setting and conveying standards for my son/daughter to follow when selecting, sharing and exploring information and resources on the Internet). I further understand that individuals and families may be liable for violations. To the extent that proprietary rights in the design of a website hosted on the Board's servers would vest in my child upon creation, I agree to assign those rights to the Board.

Please check each that applies:

_____ I give permission for my child to use and access the Internet at school AND for the Board to issue an Internet/email account for my child.

*Each child is given a username and password that they are required to enter each time they use a school device. Accounts are required to access web based learning programs.

*Internet usage is strictly monitored.

*Elementary Internet usage is generally limited to specific sites selected for projects assigned by teachers.

*No email accounts are given to elementary students below the third (3rd) grade level.

_____ I give permission for my child's image (photograph) to be published online. Photographs may identify individual children by first name.

_____ I give permission for the Board to transmit "live" images of my child (as part of a group) over the Internet via a web cam. (ex. Virtual visits to locations, group discussion with experts or another group of students for educational purposes.)

_____ I authorize and license the Board to post my child's work on the Internet without infringing upon any copyright my child may own with respect to such class work. I understand my child's first name may accompany such class work. (ex. Photograph of artwork/project)

Please note that the safety of all children is our first priority in making decisions to do any of the above.

Parent/Guardian's Signature: ___________________________________________ Date: __________________

Parent/Guardian's Name (please print): __________________________________________

Student

I have read and agree to abide by the Student Network and Internet Acceptable Use and Safety Policy and Guidelines. I understand that any violation of the terms and conditions as set forth in the Policy and Guidelines is inappropriate and may constitute a criminal offense. As a user of the Board's devices/networks and the Internet, I agree to communicate over the Internet and the Networks in an appropriate manner, honoring all relevant laws, restrictions, and guidelines. I understand that my breaking this agreement may be grounds to lose my privilege and may result in consequences as outlined in the Student Code of Conduct.

Student's Signature: ___________________________________________ Date: __________________

Student User's Full Name (please print): __________________________________________

School: ___________________________ Grade: ___________________________
<table>
<thead>
<tr>
<th>Child's Name (Last)</th>
<th>(First)</th>
<th>Nickname (If any)</th>
</tr>
</thead>
</table>

*By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.*

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*

How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? *(Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)*
Please check all of the words that best describe your child's personality and behavior:

- active
- adventurous
- affectionate
- anxious
- bossy
- bright
- busy
- calm
- cautious
- cheerful
- content
- creative
- curious
- easily-angered
- emotional
- energetic
- excitable
- friendly
- gives-in-easily
- happy
- hesitant
- insecure
- jealous
- likes structure/routines
- loud
- loving
- mellow
- outgoing
- prefers adult attention
- quiet
- sensitive
- serious
- shares-well
- social
- spontaneous
- stubborn
- tentative
- other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a
- high chair
- booster
- child size chair
- adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?
Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature

Date
APPLICATION FOR WAIVER or REDUCTION OF FEES

Student Name ____________________________________________

School Name ____________________________________________

Your student may be eligible for a waiver or reduction of fees, if your family meets one of the following guidelines:

1. Your child is eligible for a Food Assistance program and has a VALID SNAP or OWF case number. All numbers are verified through Job and Family Services before waivers are granted.

OR

2. Your family must meet income guidelines by submitting this application with copies of current pay stubs (including retirement, alimony, child support, etc.) or current tax returns for all individuals in the household.

Your signature is required, if you wish to give the school district permission to use your child’s eligibility of free or reduced meals for placement on the sliding-fee scale to attend Bear Cub Academy Preschool. Please make sure to complete the backside of this page in addition to this signature page.

Signing this waiver is not an additional requirement or prerequisite for participation in the preschool's program. Gibsonburg Exempted Schools will not in any way indicate that a household is eligible for SNAP or AFDC.

________________________________________________________

I have read the above information and give my permission to use my child’s free and reduced eligibility for the placement on the sliding-fee scale for Bear Cub Academy.

________________________________________________________

SIGNATURE OF PARENT OR GUARDIAN

________________________________________________________

DATE

REVISED 8/2019
**Part 1. ALL HOUSEHOLD MEMBERS**

<table>
<thead>
<tr>
<th>Names of all household members (First, Middle Initial, Last)</th>
<th>Name of school and grade level for each</th>
<th>Check if a foster child (legal responsibility of welfare agency or court)</th>
<th>Check if No Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>School</td>
<td>*If all children listed below are foster children, skip to Part 5 to sign this form.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grade</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Part 2. BENEFITS:** If any member of your household receives Supplemental Nutrition Assistance Program (SNAP) or Ohio Works First (OWF) benefits, provide the name and 7 or 10-digit case number for the person who receives benefits and skip to Part 5. If no one receives these benefits, skip to Part 3.

**NAME:**

7 or 10-DIGIT CASE NUMBER:

**Part 3.** If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Mr. Tim Murray at tmurray@gibsonburgschools.org or 419-637-2479.

- Homeless [ ]
- Migrant [ ]
- Runaway [ ]

**Part 4. TOTAL HOUSEHOLD GROSS INCOME** (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once.

<table>
<thead>
<tr>
<th>2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NAME (List all household members with income)</td>
</tr>
<tr>
<td>Earnings from work before deductions</td>
</tr>
<tr>
<td>Weekly</td>
</tr>
<tr>
<td>Example: Jane Smith</td>
</tr>
</tbody>
</table>

**Part 5. SCHOOL INSTRUCTIONAL FEE WAIVER ADULT CONSENT:** Your child(ren) may qualify for a waiver of their school instructional fees. Your permission is required to share your meal application information with school officials to determine if your child(ren) qualifies for a fee waiver. Answering this question will not change whether your children will receive free or reduced-price meals.

- Yes, I agree to have my meal application used to determine if my child(ren) qualifies for a fee waiver. [ ]
- No, I do not agree to have my meal application used to determine if my child(ren) qualifies for a fee waiver. [ ]

Signature of Parent/Guardian: __________________________ Date: ________________

**Part 6. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)**

An adult household member must sign the application. If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will receive federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that deliberate misrepresentation of the information may cause my children to lose meal benefits and I may be subject to prosecution under state and federal statutes.

Sign here: X __________________________ Print name: __________________________ Date: ________________

Address: __________________________ Phone Number: __________________________

Last four digits of your Social Security Number: _______ _______ _______ [ ] I do not have a Social Security Number

**Part 7. Children's ethnic and racial identities:** We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children’s eligibility for free or reduced price meals.

<table>
<thead>
<tr>
<th>Choose one ethnicity:</th>
<th>Choose one or more (regardless of ethnicity):</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Hispanic/Latino</td>
<td>[ ] Asian</td>
</tr>
<tr>
<td>[ ] Not Hispanic/Latino</td>
<td>[ ] American Indian or Alaska Native</td>
</tr>
<tr>
<td></td>
<td>[ ] Black or African American</td>
</tr>
<tr>
<td></td>
<td>[ ] White</td>
</tr>
<tr>
<td></td>
<td>[ ] Native Hawaiian or other Pacific Islander</td>
</tr>
</tbody>
</table>