



JONATHAN R. PRIEBE
Senior Minister

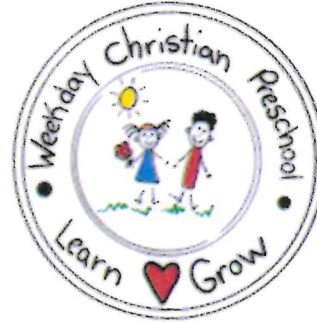
HOWARD N. PIPPIN, JR.
Associate Minister

MARVIN R. BROWN
Senior Minister
Emeritus

MARIE WILLIS GUARNERI
Director of Music &
Worship

DONNA CURFMAN
Director of
Children's Ministries

JENNIFER BROOKS
Director of Weekday
Christian Preschool



Weekday Christian Preschool

Dear Parents,

Welcome to Weekday Christian Preschool! Below you will find a synopsis of all of the required forms that must be completed in order for your child to attend this Fall (all are included). Please note carefully that the following required forms need to be completed and submitted no later than August 10th, at which point the September tuition payment is also due at enrollment in the form of direct withdrawal or cash/check.

COLOR

<u>LILAC</u>	REGISTRATION FORM	The bottom portion should be detached and presented or mailed with a \$70.00 non-refundable registration fee and is required for each child.
<u>BLUE</u>	CHILD MEDICAL STATEMENT	This form needs to be completed and signed by your child's physician by the first day of school.
<u>GREEN</u>	FAMILY INFORMATION	Please use this form to provide us with a thoughtful summary of your child and your expectations of your preschool experiences.
<u>YELLOW</u>	CHILD ENROLLMENT	One form, 3 pages. Please complete <u>all pages thoroughly.</u>
<u>WHITE</u>	PARENT REVIEW	Must be signed after you've reviewed handbook and policies.
<u>PINK</u>	PERSONS AUTHORIZED TO PICK UP	Please list all persons who will have your permission to pick-up your child.
<u>ORANGE</u>	PERMISSION	Indicate permission for use of Purell, use of Church property and Photo release.

Weekday Christian Preschool

Registration Information 2026/2027

The First United Methodist Church of Cuyahoga Falls offers a Christian preschool program for children who will be 3, 4 or 5 years old by September 30th, 2026. The program is state licensed and staffed with degreed lead teachers and trained teacher's assistants. We believe that learning takes place through discovery and play. Each classroom environment is child led and teacher facilitated. Our main objective is to foster a positive self-image in each child while nourishing their social, emotional, physical and intellectual growth.

Programs and Tuition Information

- M-W-F 3's, 4's and 5's a.m. session 9:00-11:30 - \$180.00 a month
- M-W-F 3's, 4's and 5's p.m. session 12:15-2:45 - \$180.00 a month
- T-Th 3's a.m. session 9:00-11:30 - \$120.00 a month
- M-W-F Full Day 3's or 4's - 9:00-2:45 - \$390.00 a month
- M-W-F Full Day 5's - 9:00-2:45 - \$390.00
 - Can add Tuesday for an extra \$110.00 a month.
- T-Th Enrichment - For children NOT in Full Day 5's
 - M-W-F + ½ A.M. Enrichment - \$100.00 a month
 - M-W-F + Full Day Enrichment - \$220.00 a month
- 10% discount for 2 children enrolled from the same household.
- A non-refundable registration fee of \$60.00 and September's Tuition for each child is required at the time of registration.

Registration starts January 13th, 2026. At enrollment we ask that you choose one of the below methods to pay 2026/27 tuition:

1. Fill out a direct withdrawal form that will run August 2026 through April 2027.
2. Pay monthly by Cash or Check. First month's tuition (August's tuition) due at registration.
3. Please turn in registration in an envelope with your child's name.

If you have any questions, please contact Jennifer Brooks by email at jbrooksfallsumc@gmail.com or by phone at 330-923-5243.

Weekday Christian Preschool

Registration Form 2026/2027

½ Day M-W-F- 3's 4's 5's I prefer the ____ A.M. ____ P.M.
 ____ I would like to add T/Th A.M. Enrichment
 A.M. T/Th- 3's
 Full Day M-W-F 3's 4's 5's ____ I would like to add T/Th Enrichment
 Full Day M-W-F 5's ____ I would like to add Tuesday Enrichment
 Needs to be attending Kindergarten Fall 2027 ____ I would like to add Thursday Enrichment

Before/After Care

- I am interested in Before Care - 8:30-9:00
 - \$10 for each day per month (example 3 days a week = \$30 per month)
 I am interested in Before Care - 8:00-9:00
 - \$20 for each day per month (example 3 days a week = \$60 per month)
 I am interested in After Care - 2:45-3:45
 - \$20 for each day per month (example 3 days a week = \$60 per month)

CHILD'S NAME: _____ BIRTHDATE: _____ AGE: _____
 First and Last Name Mo. Day Year On 9/30/26

ADDRESS: _____

MOTHER/GUARDIAN: _____ PHONE: _____
 First and Last Name Phone Number

EMAIL: _____
 Email

FATHER/GUARDIAN: _____ PHONE: _____
 First and Last Name Phone Number

EMAIL: _____
 Email

I will be paying 2026/27 tuition by (circle one below)

Direct Withdrawal Monthly by check/cash

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)	Date of Birth
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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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight _____	Hearing _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
BMI _____	Dental _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

Help Us Get to Know Your Child

Child's Name: _____ Nickname: _____ Birthdate: _____

People presently living in child's home:

Father/Guardian: _____ Mother/Guardian: _____

Brother's Name/Age:

Sister's Name/Age:

Does your child have a parent living outside the home? _____

If yes, how often do they see them? _____

Father's occupation: _____ Mother's occupation: _____

Does your child have any fears?

Are there any medical problems we should be aware of?

Any known allergies? _____

Favorite interests? _____

Favorite toys? _____

Favorite foods? _____

Ohio Department of Children and Youth
**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 <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> 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 DCY 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 DCY 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 DCY 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 DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 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 <u>Permission</u> to Transport		OR Do not sign both	Do Not Give <u>Permission</u> 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		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 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.

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.

Reset Form

Parent Review

Child's Name: _____

I _____ have received a copy of
Parent or Guardian's name (Please Print)
the preschool's **Parent Handbook** (can be found on the school website).

- The Parent Handbook has been reviewed with me by the administrator of the preschool.
_____ (parent/guardian's initials)

- I understand the policies and procedures to of the parent/guardian's handbook and will abide by its' content.
_____ (parent/guardian's initials)

Parent/Guardian's Signature _____ **Date** _____

Weekday Christian Preschool

Of
First United Methodist Church

Child's Name: _____

Please list the names/relationship below of those people who have your permission to pick up you child. We ask that you please either call or send a note in notifying the permission. Individuals on this list will need a valid picture ID in order to verify their identity. We can only release children to individuals age 16 and up.

Parent/Guardian's Name: _____

Parent/Guardian's Name: _____

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

Weekday Christian Preschool

Of

First United Methodist Church

Permissions

Child's Name _____

Purell

_____ I give my permission for the Weekday Christian Preschool to use Purell and/or other Hand Sanitizers occasionally with my child.

I understand that this does not take the place of all hand washing and will only be dispensed by the teachers.

Signature _____

Property Use

_____ I give my permission for my child to participate in school related activities on the whole of the First United Methodist Church property. Ex/ Chapel, Asbury Hall, Wesley Hall)

Signature _____

Photo

_____ Yes--- I give my permission for the use of my child's photo on materials to be used outside of the Preschool for the purpose of sharing information about our program. (Ex/ at a Preschool Fair at the Library, Facebook, preschool website....)

_____ No--- I do not want my child's photo used outside of the school or on any social media sites.

Signature _____