EMERGENCY MEDICAL AUTHORIZATION

(State of Ohio Revised Code Section 3313.712)

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.

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone (_____)_____

Dentist _____ Phone (_____)_____

Medical Specialist _____ Phone (_____)_____

Local Hospital _____ Emergency Room Phone (_____)_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

Date _____ Signature of Parent/Guardian _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 the following action:

_____

_____

Date _____ Signature of Parent/Guardian _____

Please give any pertinent information regarding the health of this child:

EMERGENCY CARD
Department of Education
Diocese of Columbus

_____
School
School Year 20_____ - _____

Student's Name _____ Room _____

Address _____

_____ Zip _____

Phone _____ Birthdate _____

Father/Guardian's Name _____

_____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Place of Employment _____

Mother/Guardian's Name _____

Address _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Place of Employment _____

In the event this student becomes ill at school but does not need medical attention, name three people, i.e., relative, neighbor, child care provider, to be contacted if you cannot be reached.

1. _____ Relationship _____ Phone _____
2. _____ Relationship _____ Phone _____
3. _____ Relationship _____ Phone _____

FORM ES-17-2003

(See reverse side and inside of card.)

St. Mary Preschool

2026-2027 Tuition Rates

PRESCHOOL CLOVERS

3 Half Days	8:00 am – 11:00 am	Tuesday – Thursday	$1,900
3 Full Days	8:00 am – 4:00 pm	Tuesday – Thursday	$4,000
3 Early Drop Off-Starting @ 7:00 AM		Tuesday – Thursday	$700

PRESCHOOL SHAMROCKS

5 Half Days	8:00 am -11:00 am OR 12:00 pm-3:00 pm	Monday – Friday	$2,600
5 Full Days	8:00 am – 4:00 pm	Monday – Friday	$5,700
5 Early Drop Off- Starting @ 7:00 AM		Monday – Friday	$875

Families that have two or more children registered in the St. Mary Preschool will pay the full amount rate for their oldest child, and receive a 2% discount rate off the tuition rate for each additional child registered in the Preschool program.

Preschool Tuition Payments and Policies

All Preschool tuition payments must be made separately from a K-8 tuition payments. There is a $75.00 non-refundable registration fee due for each child enrolling.

Preschool tuition payments may be made in the following manner:

Full Payment: 3% discount off your tuition. Tuition must be paid in full for all students by July 1st, 2026.

OR

Monthly Payments: 10 equal payments. Payments due the 15th of each month August – May.

**** A $10.00 late fee will be charged for each late payment.**

Office Use Only:
Date Received:_____
Cash/Check:_____
Amount: _____

St. Mary Preschool Program
2026-2027 Tuition Agreement

($75 NON-REFUNDABLE Registration Fee Per Child is Required at Time of Registration)

NAME OF CHILD TO BE ENROLLED IN ST. MARY PRESCHOOL

_____D.O. B: _____
Gender: Male/Female Ethnicity: Hispanic/Non-Hispanic Race: _____
In what public school district do you reside? _____
Fathers Name: _____ Mothers Name: _____
Address: _____ Address: _____
City/Zip: _____ City/Zip: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Student resides with (circle): Mother/Father/Both/Other
Person responsible for tuition: _____
_____ We are a Parishioner of St. Mary – Lancaster

_____ We are a Parishioner of another Parish _____

_____ We are a non-participating Catholic or a member of another denomination

CHECK THE CLASS (es) THAT YOU WANT TO ENROLL YOUR CHILD IN:

_____ Clover 3 HALF days (Tuesday, Wednesday, Thursday)	_____ AM Session 8:00am-11:00am
	_____ PM Session 12:00pm-3:00pm
	_____ PM Extended Day 3:00-4:00pm
_____ Clover 3 FULL days (Tuesday, Wednesday, Thursday)	_____ 8:00am - 4:00pm
_____ Shamrock 5 HALF days (Monday – Friday)	_____ AM Session 8:00am-11:00am
_____ Shamrock 5 FULL days (Monday-Friday)	_____ 8:00 am – 4:00 pm
_____ Early Drop Off (Monday-Friday)	_____ Starting @ 7:00 AM
_____ Early Drop Off (Tuesday-Thursday)	_____ Starting @ 7:00 AM

I have read the 2026-2027 tuition schedule and I agree to meet my tuition obligation according to the following payment plan.

_____ **A.** Tuition paid in FULL by July 1, 2026 to receive a 3% discount.

Note: All preschool students in a family must be paid together in full to receive the 3% discount.

_____ B. TEN EQUAL PAYMENTS due by the 15th of the month with the first payment due August 15th 2026 and the final payment by **May 15th 2027.**

*** A $30 charge is assessed for a returned check.**

Parent/Guardian Signature: _____ Date: _____

PARENT PERMISSION FORM

2026-2027

☐ I DO give permission for photos featuring my child to be used by St. Mary Preschool in print or electronically for advertising or marketing purposes, for any classroom school activities, ClassDojo, for school fundraising events, activities, or projects and/or on the school website and Facebook Page. I understand that St. Mary Preschool will not identify my child in photos using their address, phone number, or any description of their personal characteristics.

☐ I DO NOT give permission for photos featuring my child to be used by St. Mary Preschool in print or electronically for advertising or marketing purposes, for any classroom or school activities, ClassDojo. for school fundraising events, activities, or projects, and/or on the school website and Facebook Page.

☐ If NO to the above, I DO give permission for my child's photo to be taken and used for ONLY ClassDojo and the school yearbook.

_____ _____

Signature of Legal Guardian Date

**Please contact the preschool director for clarification or questions

CHILD MEDICAL STATEMENT

Child's Name:_____ Date of Birth:_____

Height:_____ Weight:_____
Limitations or health condition (including allergies, medications, dietary restrictions

Immunizations: Please check one:

Complete for age: _____Yes _____No
In Process: _____Yes _____No

Exempt from Immunizations: Please check one:

Religious conviction: _____Yes No_____
Health concern: _____Yes No_____
Other:
_____

This child has been examined and is in suitable condition to participate in group care.

_____
Signature of examining (check one)
_____Physician _____Physician's Assistant _____Advanced Practice Nurse

Address:_____

Phone: _____**DATE OF EXAM:**_____

Assessments/Screenings Completed: Please check one

Vision: _____Yes _____No Date Completed:_____
Hearing: _____Yes _____No Date Completed:_____
Dental: _____Yes _____No Date Completed:_____
Lead: _____Yes _____No Date Completed:_____
Hemoglobin: _____Yes _____No Date Completed:_____
Reason not completed: (Check with applies)_____

St. Mary Preschool CHILD ENROLLMENT FORM

2026-2027 School Year

Childs Name: _____ DOB: _____

Preferred Name (if different from above) _____

Address: _____ City: _____

Zip Code_____

Mothers Name: _____

Address if different than above: _____ Cell #: _____

Employer: _____ Work #: _____

Email: _____

Fathers Name: _____

Address if different than above: _____ Cell #_____

Employer: _____ Work #_____

Email: _____

Please list at least 2 people to be contacted in the event of an emergency ***if the parent cannot be contacted:***

1. Name: _____ Cell #: _____

   Address: _____ Home #: _____

   Relationship to the Child: _____ Work #: _____

2. Name: _____ Cell #: _____

   Address: _____ Home #: _____

   Relationship to the Child: _____ Work #: _____

****Please complete the other side of the form****

Annual Class Roster

Each year we prepare a roster for each group of children in our program. This roster will not be given to any persons other than parents of children enrolled in his/her class.

I authorize the following to be listed on the parent roster:

Parents Name:	_____ Yes	_____ No
Address:	_____ Yes	_____ No
Home Number:	_____ Yes	_____ No
Cell Number:	_____ Yes	_____ No
Email:	_____ Yes	_____ No

Child Background:

Chronic Physical Problems: _____

_____

History of Hospitalization: _____

Diseases the Child has had: _____

Allergies and Treatment: _____

_____

Medications, Food Supplements, Modified Diet or Fluoride Supplements: _____

_____

List of people to whom this child **CAN BE** released to:

_____

_____

List of people **NOT PERMITTED** to pick up this child:

_____

_____

Restraint papers or Divorce Decree: YES or NO

Parent or Guardian Signature: _____