Bishop John King Mussio Central Elementary School
Preschool Registration Form

*3yo by Aug 1*_____ *4yo by Aug 1* _____

I am interested in a half day program _____

Student Name_____
(Last) (First) (Middle)

Address_____
(Street) (City) (State) (Zip Code)

Home Phone Number _____ Cell Number_____ E-Mail _____

Birthdate _____ Gender _____ Social Security Number _____

Religion _____ Student's Parish _____

Sacraments Received:

Baptism (church and date)_____ _____

First Communion (church and date)_____ _____

Confirmation (church and date)_____ _____

Public School **District** in which student resides_____

Name of Public School **Building** nearest student's home address_____

School Previously Attended _____Grade _____Date _____

Father's Name_____Occupation_____
(Last) (First) (Title)

Religion _____ Parish _____ Employer_____

Home Phone _____ Cell Phone _____ Email _____

Mother's Name_____Occupation_____
(Last) (First) (Title) (Maiden)

Religion_____ Parish _____ Employer_____

Home Phone_____ Cell Phone_____ Email_____

Whom does student live with? (Please circle): Mother & Father, Mother only, Mother and Stepfather, Father only, Father & Stepmother, Guardian

*Parent or Guardian Signature*_____ Date_____

Sibling Information (Please list all siblings in the family)

Name	School	Grade	Age

The following information must be provided if the student you are enrolling ***lives with*** a guardian or stepparent:

Stepparent Name_____
(Last) (First) (Title)

Home Phone_____ Cell Phone_____ Email _____

Guardian Name_____
(Last) (First) (Title)

Home Phone_____ Cell Phone_____ Email _____

Copies needed for complete registration:

_____ *Official* Birth Certificate
_____ Social Security Card
_____ Baptismal Certificate
_____ Immunization Record
_____ $50 Registration Fee for new BJKM Families

03/2026

Ohio | Department of Education

Office of Early Learning and School Readiness

Child Medical Statement

Revised 3/12/2018

This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Immunizations:		**Exempt from Immunization:**	
Complete for Age	○ Yes ○ No	Religious Conviction	○ Yes ○ No
In Process	○ Yes ○ No	Health	○ Yes ○ No
		Other	_____

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician Assistant
- ☐ Advanced Practice Registered Nurse

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

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type_____ Results_____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____

_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____

_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____

_____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06