

SCIOTO COUNTY PRESCHOOL INTERVENTION PROGRAM

Peer Model Application

(R013122)

Student's Name _____ Resident School District _____

Date of Birth _____ Home Phone _____

Parents' Name _____ Work Phone _____

Center-Based Classrooms

Our classrooms are licensed for up to 8 students who have special needs with no more than 16 total students. We usually accept up to 4 peer models per classroom. Classes are in session four days a week, Monday through Thursday with times varying based on specific locations. The classrooms are located in various districts throughout the county. All students are provided developmentally appropriate practices and we strive to have students ready for achievement in kindergarten. All of our classrooms have a teacher and a teacher assistant, enabling the staff to accommodate the individualized needs of each child. Preschoolers in our program with special needs may receive speech therapy, physical therapy, occupational therapy, and related services as they may have documented disabilities in communication, motor, hearing, vision, social emotional/behavioral skills, adaptive skills and/or cognitive ability.

Peers serve as models of age-appropriate skills for children demonstrating delays in their development. For this reason, it is critical that peers demonstrate the skills listed below. If after a brief trial period, your child is not able to consistently demonstrate the criteria below within the preschool classroom; your child may not be able to continue to attend our preschool program as a peer model.

- Completely toilet trained
- Separates easily from parents
- Able to follow rules and routines
- Attends to adult-guided activities
- Plays with a variety of toys appropriately
- Is able to play beside and/or with other children while sharing the same toys
- Verbally interacts with peers in play situations
- Speech is clear and understandable by unfamiliar adults

Preference will be given to children who are age 4 and who are residents of the district to which they are applying.

PROCEDURES FOR PRESCHOOL ENROLLMENT

1. **Applications will be accepted starting January 1 for the following school year.** Applications will be reviewed by staff and, as part of the application process, a classroom visit will be arranged to meet the child and observe how he/she interacts with other children.
2. ***Parents will be notified of their child's acceptance or rejection before August 1.*** All students are accepted on a trial basis the first month. If the staff feels your child is not developmentally ready for a class of this type, they will discuss this with you.
3. The teacher will contact parents of children, who have completed the application process and been accepted, to schedule a home visit. During the visit the teacher will collect any forms and will discuss the parent handbook and the first day of class for the student.
4. Applications are valid for one school year. If a child is not accepted, application must be made again to be considered for the following year.

***The Ohio Department of Early Childhood sets the maximum number of children in the classroom. This classroom is licensed as a classroom for children with disabilities. Although rare, it may be necessary to remove a typically developing child from the classroom in order to provide for a student with disabilities.**

Locations of classrooms for children with special needs are listed below. Please indicate the classroom unit for which you are applying.

Bloom-Vernon

Northwest

Minford

New Boston

Valley

Portsmouth West

Application is for the school year beginning fall of _____.
year

If you have questions regarding the program, call 740-354-0223 and speak with Jodie Wheeler. Completed applications can be dropped off Monday-Friday 9:00 a.m. – 4:00 p.m., faxed to 740-353-0280 (please call to confirm receipt), scanned and emailed to jodie.wheeler@scoesc.org or mailed to:

**JODIE WHEELER
SCOESC
522 GLENWOOD AVE
NEW BOSTON OH 45662**

SCIOTO COUNTY INTERVENTION CLASSROOM AGREEMENT

1. Tuition is \$300.00 per month. (If any checks are returned, there will be a \$30 fee.)
2. If a child misses days during the month, a holiday occurs or a calamity results in school not being in session, the fee remains the same. Due to obligations, there may be occasions when the early intervention classes will be cancelled or a make-up day scheduled. This will not change the monthly fee. If a parent requests a leave of absence from the classroom, tuition must be paid during the absence to hold the spot in the classroom. If payment is not made on time, another child may be enrolled in that spot.
3. The fee must be paid monthly on the first school day of the month. It is essential that payments be made promptly to cut down on paper work and staff time. If special circumstances arise, the payment date can be discussed with the teacher. If payments fall more than a week behind, parents may be informed that their child will be withdrawn from the classroom.
4. If a parent withdraws the child during the month, the amount paid is non-refundable.
5. If the staff finds the child is not developmentally ready for the classroom setting, the tuition will be prorated and refunded.
6. **On rare occasions, circumstances may arise that would make it necessary for the Scioto County Intervention Program to terminate this contract. Every effort will be made to provide 30 days notice should this be necessary.**

I have read and understand the agreement and if my child is accepted as a student in the program, I _____ agree to pay the tuition due on the first school day of the month, for classroom services. I understand that if my payment is one week late without explanation that my child’s enrollment will be jeopardized and my child may be removed from the classroom.

(parent/guardian)

(signature of parent/guardian)

(date)

IDENTIFYING DATA

CHILD: _____
FIRST MIDDLE LAST

NICKNAME: _____

DOB: _____ SSN: _____

Male Female

SCHOOL DISTRICT OF RESIDENCE: _____

PARENT(S)/GUARDIAN(S) NAME: _____
(MOTHER) (FATHER)

ADDRESS: _____

PHONE: _____

WORK/CELL #: _____

DIRECTIONS TO HOME: _____

NAME(S) OF PERSON(S) COMPLETING FORM: _____

PLACE OF BIRTH: _____ MOTHER'S MAIDEN NAME: _____

Is the student of Hispanic/Latino origin? Yes No

Racial/Ethnic Group: White, Non-Hispanic Black or African American American Indian
 Asian Native Hawaiian or Other Pacific Islander
 Multiracial (if this category is chosen, the specific races must also be chosen)

ANNUAL INCOME \$ _____ or MONTHLY INCOME \$ _____ I PREFER NOT TO ANSWER

SOCIAL INFORMATION

FAMILY UNIT SIZE: _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ OTHER (how many)

LIST BELOW THE PERSONS LIVING IN THE HOME: (If more room is needed list on back of page.)

NAME	SEX	DOB	RELATIONSHIP	HEALTH

CHILD'S STATUS: _____ NATURAL _____ ADOPTED _____ FOSTER
CHILD'S STATUS IN FAMILY? _____ OLDEST _____ MIDDLE _____ YOUNGEST _____ ONLY

MOTHER'S EDUCATION: _____ FATHER'S EDUCATION: _____

MOTHER'S OCCUPATION: _____ FATHER'S OCCUPATION: _____

WHO IS THE PRIMARY CARETAKER OF THE CHILD? _____
_____ MOTHER _____ FATHER _____ GRANDPARENTS _____ OTHER (_____)

MEDICAL INFORMATION

HAS THE CHILD EVER HAD:

- | | | | |
|------------------------|-----------------------|------------------------|-----------------|
| _____ MEASLES (7 DAY) | _____ SCARLET FEVER | _____ BROKEN BONES | _____ ALLERGIES |
| _____ RUBELLA (3 DAY) | _____ RHEUMATIC FEVER | _____ OPERATION | _____ PNEUMONIA |
| _____ CHICKEN POX | _____ ASTHMA | _____ HEART PROBLEMS | _____ SEIZURES |
| _____ WHOOPING COUGH | _____ MUMPS | _____ HEARING PROBLEMS | _____ POISONING |
| _____ HOSPITALIZATIONS | _____ MENINGITIS | _____ VISUAL PROBLEMS | _____ ACCIDENTS |

OTHER/COMMENTS/EXPLANATIONS: _____

HEALTH

ATTENDING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

LAST EXAMINATION: _____ HEIGHT: _____ WEIGHT: _____

DOES CHRONIC CONDITION EXIST THAT REQUIRES MEDICATION? _____

DATE PRESCRIBED? _____ BY WHOM? _____

TYPE OF EVALUATION	DATE	TREATMENT	ADMINISTERING AGENCY/CONTACT PERSON

NUTRITIONAL INFORMATION

IS THE CHILD'S APPETITE NORMAL? _____ IF NOT, WHY? _____

WHAT ARE THE CHILD'S FAVORITE FOODS? _____

WHAT FOODS DOES THE CHILD REFUSE TO EAT? _____

IS THE CHILD ALLERGIC TO ANY FOODS? _____ IF YES, WHAT FOODS? _____

DOES THE CHILD FEED HIMSELF/HERSELF? _____

BEHAVIORAL INFORMATION

DOES THIS CHILD HAVE ANY OF THE FOLLOWING BEHAVIOR TRAITS?

- | | | |
|---|--|---|
| <input type="checkbox"/> NIGHTMARES | <input type="checkbox"/> THUMB SUCKING | <input type="checkbox"/> BITING |
| <input type="checkbox"/> TEMPER TANTRUMS | <input type="checkbox"/> STUTTERING | <input type="checkbox"/> NAIL BITING |
| <input type="checkbox"/> OVERACTIVE | <input type="checkbox"/> EYE BLINKING | <input type="checkbox"/> MOOD SWINGS |
| <input type="checkbox"/> ROCKING | <input type="checkbox"/> HEAD BANGING | <input type="checkbox"/> HITTING/PINCHING |
| <input type="checkbox"/> TOILET TRAINING PROBLEMS | | <input type="checkbox"/> EXTREMELY QUIET |

IS CHILD TOILET TRAINED? _____ DOES THE CHILD DRESS HIMSELF/HERSELF? _____

HOW DOES THE CHILD SPEND THE DAY? _____ NURSERY SCHOOL _____ DAY CARE
 SITTER _____ W/PARENT

DOES THE CHILD MAKE FRIENDS EASILY? _____ DOES THE CHILD SHARE TOYS? _____

DOES THE CHILD PLAY WITH OTHER CHILDREN DURING THE DAY? _____

- | | |
|---|---|
| <input type="checkbox"/> HAS LOTS OF FRIENDS | <input type="checkbox"/> PREFERS ONE OR TWO FRIENDS |
| <input type="checkbox"/> PLAYS WITH SIBLINGS ONLY | <input type="checkbox"/> PREFERS TO PLAY ALONE |

WHAT DOES THE CHILD LIKE TO PLAY WITH? _____

DOES THE CHILD PLAY WITH?

- PUZZLES CONSTRUCTION TOYS CRAYONS SCISSORS PENCILS

WHEN THE CHILD PLAYS:

- NEEDS SOMEONE PRESENT MUCH OF THE TIME OR GETS INTO TROUBLE
- OCCUPIES SELF BY FINDING AND DOING OWN ACTIVITY
- GETS BORED EASILY IN ANY ONE ACTIVITY
- NEEDS A LOT OF THINGS TO KEEP OCCUPIED

HOW DOES THE CHILD EXPRESS HIS NEEDS? _____

WHAT METHOD OF DISCIPLINE IS USED? BY MOTHER _____ BY FATHER _____

DOES THE CHILD SEPARATE FROM PARENT EASILY? _____

DOES THE CHILD HAVE ANY FEARS? _____

DESCRIBE YOUR CHILD:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> FRIENDLY | <input type="checkbox"/> INDEPENDENT | <input type="checkbox"/> QUIET |
| <input type="checkbox"/> SHY | <input type="checkbox"/> STUBBORN | <input type="checkbox"/> FEARFUL |
| <input type="checkbox"/> EASILY ANGERED | <input type="checkbox"/> DIFFICULT TO HANDLE | <input type="checkbox"/> COOPERATIVE |

ADDITIONAL COMMENTS: _____