



WELCOME TO

THREE RIVERS ELEMENTARY

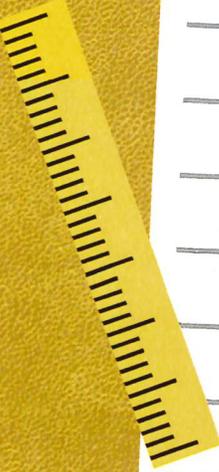
2026-2027 KINDERGARTEN REGISTRATION

THREE RIVERS USES AN ONLINE
REGISTRATION PROCESS.

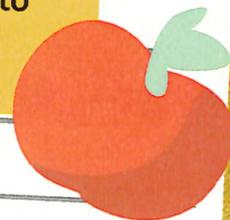
WWW.TAYLOR-OH.FINALFORMS.COM/STUDENTS



This packet includes all the forms that need to be completed in order for your child to be enrolled for the 2026-2027 school year. In addition to this packet, parents/guardians are required to present their photo ID, custody documentation (if applicable) and the student's original birth certificate.



When all online and paper forms are completed, please call our school office @ (513) 467-3210 to schedule an appointment to enroll your child.



Three Rivers Elementary
Kindergarten Enrollment Checklist
2026 - 2027

Students are required to be 5 years old by August 17th, 2026 in order to enroll in KG for the 2026-2027 school year

**** ALL ONLINE FORMS AND ALL OTHER REQUIRED DOCUMENTS MUST BE RECEIVED BEFORE A STUDENT IS ELIGIBLE FOR ENROLLMENT**

Student Name: _____

Grade: _____

Student ID: _____

- **Final Forms Completed**
Yes No
- **Original Birth Certificate**
- **Parent Photo ID**
- **Custody Documents - if applicable**
- **Affidavit of Current Residence - will need to be notarized**
- **Affidavit of Landlord (if renting or currently in residence not owned) - will need to be notarized**
- **Affidavit of Prior Residence (if residence has changed in the last 12 months) - will need to be notarized**
- **Proof of Residence - utility bill, tax bill, lease/rental agreement with name and current address**
- **Immunization Record**
- **Health History**



THREE RIVERS LOCAL SCHOOL DISTRICT

Tim Sies, Superintendent

401 N. Miami Avneue • Cleves, Ohio 45002
513-941-6400 Fax 513-941-1102

AFFIDAVIT OF CURRENT RESIDENCY

(Must be signed by parent and submitted to registrar with parent's photo ID)

NOTICE

In accordance with the Ohio Revised Code as noted below, submitting a false statement on this form for the purpose of enrolling a child without tuition is a criminal offense *and may be punishable as a felony* according to the amount of tuition owed.

ORC 2913.02 Theft by Deception
ORC 2921.13 Falsification

Student name: _____

Parent name(s): _____

Parent current home address: _____
Street Address

City, State, Zip

Parent contact numbers: _____
Home phone Cell phone

Please mark the following statements as True or False:

TRUE

FALSE

The above address is where I eat and sleep overnight a majority of the time.

The above address is where my child(ren) eat and sleep overnight a majority of the time.

The above address is the center of our family activities and recreation time.

There is no other address where my child(ren) sleep overnight on a regular basis.

I do not own a house or condominium inside or outside the Three Rivers Local School District.

TRUE

FALSE

I do not rent or lease a house, condominium or apartment outside the Three Rivers Local School District.

I am not provided with living space outside the Three Rivers Local School District by a friend, relative or government agency.

If you marked "False" on any of the previous statements, please explain below:

[Empty rectangular box for explanation]

I, hereby, swear or affirm that all of the above information is true to the best of my knowledge and belief.

Parent Signature

STATE OF OHIO)

S.S.

COUNTY OF HAMILTON)

Subscribed and sworn to before me, a Notary Public, on the _____ day of _____, 2_____.

Notary Public

Date Commission Expires



THREE RIVERS LOCAL SCHOOL DISTRICT

Tim Sies, Superintendent

401 N. Miami Avenue • Cleves, Ohio 45002

513-941-6400 Fax 513-941-1102

AFFIDAVIT OF PRIOR RESIDENCY (PARENT)

NOTICE

In accordance with the Ohio Revised Code as noted below, submitting a false statement on this form for the purpose of enrolling a child without tuition is a criminal offense *and may be punishable as a felony* according to the amount of tuition owed.

ORC 2913.02 Theft by Deception
ORC 2921.13 Falsification

Student name: _____

My prior residence was as follows:

_____ Street Address _____ City, State, Zip

I, _____, no longer live at the above listed residence.
Parent Name

I moved from that residence on _____.
Date

I, hereby, swear or affirm that all of the above information is true to the best of my knowledge and belief.

Parent Signature

STATE OF OHIO)
 S.S.
COUNTY OF HAMILTON)

Subscribed and sworn to before me, a Notary Public, on the _____ day of _____, 2 _____.

Notary Public

Date Commission Expires



THREE RIVERS LOCAL SCHOOL DISTRICT

Tim Sies/ Superintendent

401 N. Miami Avenue • Cleves, Ohio 45002
513-941-6400 Fax 513-941-1102

AFFIDAVIT OF LANDLORD

NOTICE

In accordance with the Ohio Revised Code as noted below, submitting a false statement on this form for the purpose of enrolling a child without tuition is a criminal offense *and may be punishable as a felony* according to the amount of tuition owed.

ORC 2913.02 Theft by Deception
ORC 2921.13 Falsification

Landlord must attach copy of current mortgage agreement, deed, or most recent property tax bill (with address listed) for landlord's property. Financial information is not necessary. Hamilton County Auditor website printouts are not acceptable.

I, _____, am the owner of the residential property located at

_____ Street Address _____ City, State, Zip

My contact numbers are: _____ Home number _____ Cell Number

I (we) also swear that the following is a true and accurate list of the persons (adults and children) who rent space from me (us) or are living free of charge at the above address:

I, hereby, swear or affirm that all of the above information is true to the best of my knowledge and belief.

Landlord Signature

STATE OF OHIO)
 S.S.
COUNTY OF HAMILTON)

Subscribed and sworn to before me, a Notary Public, on the _____ day of _____, 2 _____.

Notary Public

Date Commission Expires

OHIO SCHOOL HEALTH HISTORY

Instructions:

1. A parent or guardian must complete pages 1-3.
2. A physician must fill out and sign pages 4-5.
3. The oral assessment on page 6 is optional, but highly recommended.
4. Please document on the health history form and inform the health aide if your child has any health problems, allergies, or will be taking medication at school. If your child has an allergy, please have your physician document the prescribed treatment on the Physical Assessment form or appropriate medication form. Please inform the health aide if your child takes medication at home.
5. Vision and Hearing Screenings of Kindergarten students will be done next fall. Parents will be notified by a written referral if your child will need further medical evaluation.

If you have any questions, please contact the health aide at 467-3210 or 824-7549.

Thank you.

Immunization records for Kindergarten must include the following:

- DPT (minimum of 4)-5 doses if 4th dose given prior to 4th birthday
- Polio Vaccine (minimum of 3)-4 doses if 3rd doses of either OPV or IPV given prior to 4th birthday
- MMR-2 doses required
- Hepatitis B-(3 shot series)-must show evidence of having received 1 3 dose series or proof that the Hepatitis B Series is in progress.
- Varicella-(Chickenpox vaccine)-2 doses required

Immunization Records for Pre-School must include the following:

- DPT-(minimum of 4)
- Polio Vaccine-(minimum of 3)
- MMR-1 dose required
- Hepatitis B-(3 shot series)
- Varicella-(Chickenpox vaccine)-1 dose required

Ohio School Health History

To be used for Pre-and Elementary School

School _____
Enrolled _____

Child's Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Birthdate
Name of child's parent/legal guardian/s? _____			
Parent/Guardian address _____			
Home Phone number _____			
Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> Other			

Social Service History

Mark the box if you have contact with any of the following agencies:

- Child/Protective Services If yes, Case worker's name _____
- Legal/Court System
- Family Counseling Services
- Mental Health Provider
- Other: _____

Mark the box if you or your child receive any of the following medical assistance:

- SSI, Disability Healthy Start Insurance (Blue Cross/Blue Shield, HMO)
- LEAP Medicaid/CHIP Other

Family History

Please list the first and last name of all the child's family members including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain briefly _____
How old was the mother when the child was born? _____
What was the infant's birth weight? _____ lbs. _____ oz. <input type="checkbox"/> Full term <input type="checkbox"/> Early <input type="checkbox"/> Late
Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain briefly _____

Developmental History

Please give the approximate age at which this child:

Walked alone _____ Spoke in sentences _____

Toilet trained _____ Dressed self _____

How does this child's development compare to other children, such as his/her siblings or playmates?

About the same Delayed Advanced

Allergies

Please list and describe allergies and reactions

Medications/Drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

Injuries, Illnesses and Hospitalizations

Please list any severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures

Injuries/Illness/Hospitalizations	Age	If hospitalized, please explain

Does your child always wear a seatbelt while riding in automobiles? Yes No

Does the student wear a helmet when bicycling, skating/rollerblading or riding a motorcycle? Yes No

Medication Information

Please describe any medications that your child takes daily and/ or frequently.

Medication	What is the medication taken for?	How often is the medication taken? What time is the medication administered?

Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

- | | |
|--|--|
| <input type="checkbox"/> Abnormal spinal curvature (Scoliosis) | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Allergies/hayfever | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Anaphylactic reaction | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Juvenile Arthritis |
| <input type="checkbox"/> Attention deficit disorder (ADD) | <input type="checkbox"/> Kidney disease type _____ |
| <input type="checkbox"/> Behavior problem | <input type="checkbox"/> Measles (10 day) |
| <input type="checkbox"/> Birth or congenital malformation | <input type="checkbox"/> Meningitis or Encephalitis |
| <input type="checkbox"/> Cancer type _____ | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chickenpox when _____ | <input type="checkbox"/> Mutism |
| <input type="checkbox"/> Chronic Diarrhea or constipation | <input type="checkbox"/> Near-drowning/Near-suffocation |
| <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Nervous twitches or tics |
| <input type="checkbox"/> Concern about relation with siblings or friends | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizure disorder/Epilepsy |
| <input type="checkbox"/> Eczema/Chronic skin conditions | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Eye problems, poor vision | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Toothaches or dental problems |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Heart disease type _____ | <input type="checkbox"/> Urinary tract infections |
| | <input type="checkbox"/> Wetting during the day or night |

Behavioral History

The child is usually: very active normally active rather inactive

Has your child ever been violent or acted out in the following manner towards adults or children:

- hitting kicking biting fighting scratching

Do you have any concern about how your child gets along with other children?

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of.

Is the student enrolled in a special education course? Yes No
If yes, please list _____

Verification completed by: _____ Date _____

Ohio School Health History

Physical Assessment

School _____
 Enrolled _____

Child's Name	Gender	Age	Birthdate
	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Ethnicity	<input type="checkbox"/> Caucasian	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic
		<input type="checkbox"/> Asian American	<input type="checkbox"/> Other

Objective Data

Height	Weight	B.P.
--------	--------	------

Immunizations

Type	Date Mo/Day/Yr				
DTaP DPT or DT					5 th dose required if 4 th dose given before age 4
DT/Td					
POLIO					4 th dose required if 3 rd dose given before age 4
MMR					2 nd dose required for K
HEPATITIS B					3 doses required for K
VARICELLA					1 dose required for K
HIB (prior to age 5 only)					0-14 months: 3-4 doses 15-59 months: 1 dose
TUBERCULIN TEST					
ROTAVIRUS (given @ 2-4-6 mo, not after 12 months)					
OTHER					

Screening Tests

Vision	Date	Hearing	Date
Distance Acuity Right _____ Left _____		Pure tone testing:	
Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done		Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done	
Farsightedness <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done		Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done	
Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Not Done		Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Testing with hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No		Other test (specify) _____	
Specify Test/Equipment _____			
Speech Assessment	Date		
<input type="checkbox"/> Child has no discernible speech problem <input type="checkbox"/> Child has possible problem with: <input type="checkbox"/> Articulation <input type="checkbox"/> Rhythm <input type="checkbox"/> Voice <input type="checkbox"/> Language Speech evaluation is recommended: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Laboratory Tests

Hemoglobin/Hematocrit

Urine Protein

Urine blood

Urine glucose

Other _____

Physical Examination

Date of Examination: _____

This child is essentially within normal limits.

This child is not within normal limits.

Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

Activities & Limitations

Can the child participate fully in the following activities:

Classroom and academic activities Yes No

Physical education classes Yes No

Competitive athletics Yes No

Contact and collision sports Yes No

Specify any limitations:

Is this child on any medications?

Yes No

Explain:

Examiner's Signature _____ Date Signed _____

Examiner's Printed Name _____

Address _____

Phone _____

Ohio School Health History

Oral Assessment

School _____
Enrolled _____

Child's Name	Gender	Age	Birthdate
	<input type="checkbox"/> Male <input type="checkbox"/> Female		

The following services have been performed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Examination by dentist | <input type="checkbox"/> Orthodontic assessment | <input type="checkbox"/> Oral screening |
| <input type="checkbox"/> Dental sealants | <input type="checkbox"/> Radiographs | <input type="checkbox"/> Fluoride Application |
| <input type="checkbox"/> Oral Prophylaxis (cleaning) | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Prescription for fluoride supplements |

The following oral hygiene instruction was provided:

- | | |
|--|---|
| <input type="checkbox"/> Toothbrushing | <input type="checkbox"/> Diet counseling related to dental health |
| <input type="checkbox"/> Flossing | <input type="checkbox"/> Home/school use of fluoride mouthrinse |

The following statements are applicable:

- No apparent care needed at this time.
- 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. (ex. Orthodontic, restorative)

Comments:

Examiner's Signature _____ Date Signed _____

Examiner's Printed Name _____

Address _____

Phone _____