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 ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents <u>cannot be listed</u> as emergency contacts. List the name <u>of at least one person</u> 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

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

PARENTS, PLEASE READ AND SIGN AGREEMENT	INITIALS
I hereby agree to comply with the rules and regulations of First English Early Learning Center regarding fees, attendance, lunches, health, parking, clothing, and other items specified in the Parent's Handbook issued by the school. I am aware of the scheduled school holidays.	
I hereby give ELC permission to release my child to these people I have listed only. 1._____ 4._____ 2._____ 5._____ 3._____ 6._____	
I hereby agree to notify the school at least two (2) weeks in advance of withdrawal, should such event occur, or pay the difference.	
I understand that it is my responsibility to provide my child with a nutritious lunch as specified in the state guidelines, paper given to me "Note on Lunches". If I do not comply the ELC will provide that food, and I will be charged $1.00 for each missing item and $5.00 for missing lunch.	
My child has permission to go on regularly scheduled walking field trips in the downtown area with the ELC.	
My child has my permission to be videotaped/photographed during activities at the ELC.	
My school age child has my permission to be transported via ELC transportation to and/or from private/public school. Name of school: _____	
I have read and understand the attendance policy:	
Child's Name: _____ Parent/Guardian Signature: _____	

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

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 _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ 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

Ohio Department of Children and Youth

BASIC INFANT INFORMATION FOR CHILD CARE

This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.

Child's Name	Nickname
Child's Date of Birth	Siblings

What are you feeding your infant? *(Check all that apply)*

☐ Formula (include brand) ☐ Breast milk

Formula preparation *(if center/provider is to prepare.)*

Amount for each feeding	Frequency of feedings

My infant likes a bottle warmed: *(Check one)* ☐ Room temp ☐ Warm ☐ Very warm/NOT HOT

Juice *(type, amount, when?)*

Does child use a cup yet? ☐ No ☐ Yes

Solid foods *(baby food, brand, types, amounts, frequency)*
**you must have written permission from your child's physician if your child is under 4 months and given solid foods.*

Are foods served room temperature or warmed?

Table food *(types, amounts, frequency, special instructions)*

Security items *(pacifier, blankies, etc.)*

Nap schedule

Hints for getting baby to sleep

Sleeping Position ☐ Back ☐ Side* ☐ Tummy*
**You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a DCY 01235.*

Special Precautions

Any additional information about your child that would be helpful or you would like staff to know.

Parent Signature	Date
Primary Caregiver Signature	Date

Date form last updated					

Reset Form

53 PARK AVENUE WEST

MANSFIELD, OHIO 44902

419-522-7500

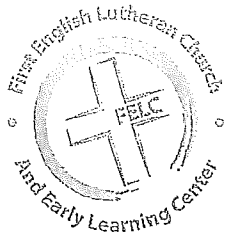
Records Transfer Policy

You have the right to have your child's paperwork transferred to another center if you choose to leave our center. You must provide us with the proper information needed. Please come to the office to ask for a records transfer paper. By signing below, you acknowledge that you have been made aware of this policy.

Child's Name: _____

Parent's Signature: _____

Date: _____



Enrollment Contract

It is my desire to have my child enrolled in the daycare program at the First English Early Learning Center.

I have received a copy of the First English Early Center parent handbook. I have read and understand and agree to abide by the policies contained therein. I understand further that if the policies outlined in this handbook were not adhered to, it would be sufficient cause for the removal of the child from the Early Learning Center.

I also agree to give a minimum of two weeks' written notice (ten full daycare days) of my intent to withdraw my child from the Early Learning Center Program. If the two weeks notice is not given, I agree to make full tuition payment for the final two weeks. Credit days cannot be applied to the final two-week period.

Please initial next to each item. We want to make sure you understand and agree to these policies.

_____ I understand that I must provide a completed medical statement within 30 days of starting and updated yearly.

_____ I understand that tuition payment is due every Friday before care is given. The late fee is $10 for 3 days late, $20 for 5 days late and $20+ pay past due and future week to return.

_____ I understand the illness policy.

_____ I understand the meal policy.

_____ I understand the behavior policy.

_____ I understand the potty-training policy.

_____ I understand the dress policy and that my child must wear closed toe shoes and have a change of clothes.

_____ I understand and agree with the days and times of my child's attendance listed on the contract. I understand that my child may not attend on different days than stated in the contract without prior permission. I also understand that I must pay the tuition for the enrollment listed.

_____ _____

Signature Date

Payment Schedule Agreement

Child's Name:_____

Choose how you would like to pay.

_____ Weekly

_____ Bi-Weekly

_____ Monthly

After a payment schedule is established, the following steps will take place:

- Payments are due on the Friday before the week of attendance. If payment is not received by that Friday, you will be required to pay the non-discounted rate (see the attached tuition rate chart for details).
- If payment is 3 days late after agreed upon schedule, a $10 late fee will be applied.
- If payment is 5 days late after agreed upon schedule, a $20 late fee will be applied.
- If payment is 7 days late, the child will not be able to attend until payment is made in full including late fees plus an additional future week of payment.

I, _____, have read and agreed upon the payment schedule I have selected. I understand the above information.

_____ _____

Signature Date

_____ _____

Director's Signature Date

Ohio Department of Children and Youth

FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)

We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL
Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.

Child's/Children's Name(s):	Caretaker's Name:	Date Completed:

	TOPICS	Briefly List CONCERN
Child Development and Education- Does anyone in your family have any need for resources or support in the areas listed below?		
Y N	Information on child growth and development.	
Y N	Guiding and supporting a child's behavior.	
Y N	Medical or disabilities or possible conditions for any child or adult in the family.	
Y N	Obtaining toys or activities to use to help any child in your home.	
Y N	Preparing your child for kindergarten.	
Child and Family Health- Does anyone in your family have any need for resources or support in the areas listed below?		
Y N	Health insurance and/or access to regular medical care, dental care, or medications.	
Y N	Medical or health supplies or supports that anyone in your family needs.	
Y N	Accessing immunizations.	
Y N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.	
Y N	Concerns with depression, anger, anxiety, or mental health needs.	
Y N	Concerns with alcohol, drug, or addiction problems.	
Financial and Household Supports- Does anyone in your family have any need for resources or support in the areas listed below?		
Y N	Help paying for child care.	
Y N	Help finding housing or safe housing.	
Y N	Help paying your mortgage or rent.	
Y N	Help with food expenses.	
Y N	Finding household items such as furniture, clothing, or school supplies.	
Y N	Access to transportation or transportation expenses.	
Y N	Attending school (such as a GED, Certifications, or college degrees)	
Y N	Help finding work or job training	

Are there other needs you or your family have that are not listed above:	
Parent Signature	Date:
Administrator or Designee Signature:	Date:

For Staff Use:

Bronze Rating Level	Silver Rating Level	Gold Rating Level
Resources provided to the family:	Resources provided to the family:	Resources provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
	Referrals provided to the family:	Referrals provided to the family:
	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
		Follow-up provided to the family:
		Administrator or Designee Signature & Date: