

Ohio Department of Job and Family Services
**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 of <u>at least one person</u> who can be contacted in the event of an emergency or illness if <u>you cannot be reached</u> . 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
Allergies, Special Health or Medical Conditions, and Medical Foods
Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.
Does your child have any food, medication or environmental allergies? <i>(check all that apply)</i> ☐ No ☐ Yes - <i>check all that apply</i> ☐ Food ☐ Medication ☐ Environmental Please list and explain:
Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? <i>(check one)</i> ☐ No ☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.
Does your child have a developmental delay or special health or medical condition? <i>(check one)</i> ☐ No ☐ Yes - please explain
Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? <i>(check one)</i> ☐ No ☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.
Is your child currently using any medication or medical food? <i>(check one)</i> ☐ No ☐ Yes - please explain
If yes, does this medication or medical food need to be administered at the child care program/home? ☐ No ☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.
Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? <i>(check one)</i> ☐ No ☐ Yes - please explain
Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group? ☐ No ☐ Yes - written instructions from the child's health care provider must be on file. ☐ N/A - program does not provide meals or snacks to the child.

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

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section)

☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport		OR Do not sign both	Do Not Give <u>Permission</u> to Transport	
Program or Home Name			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No (check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name (Last)	(First)	Nickname (If any)
<i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</i>		
Who is in the child's immediate family?		
Who lives at home with your child?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?		
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. (Check all that apply) How much and how often?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)		

Please check <u>all</u> of the words that best describe your child's personality and behavior ☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful ☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily ☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing ☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative ☐ other:
Are there additional personality and behavior characteristics that would be useful to know about your child?
Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?
What routines/actions or items do you use to comfort your child?
What causes your child to feel angry or frustrated?
What methods do you use to respond to your child's negative behavior?
Does your child use any special comfort or support items that help him/her go to sleep? If so, what?
What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?
My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. <i>(Check the one that applies.)</i>
Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.
Does your child need assistance when using the toilet? If so, how?
What words, gestures or signs does your child use if he/she needs to use the bathroom?
What time does your child normally go to bed at night and wake up in the morning?
What time(s), and for how long, does your child usually nap?

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)		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 (<i>please list in space below</i>):		
<i>Check below, if applicable:</i>		
☐ 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
Weight _____	Hearing _____	☐ Yes ☐ No
BMI _____	Dental _____	☐ Yes ☐ No
Notes:		Lead _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No Other: _____
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. <i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i>	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

ST. John Paul II Early Childhood Education Center

Weekly Tuition Fees 2023/2024

Basic Fees per Week

*There is an additional **\$100 non-refundable** enrollment fee per student*

Please circle the days/times you would like your child to attend

	2 Day T, TH	3 Day M, W, F	5 Day M - F
Half Day 7:30am-12pm	\$77.00	\$115.00	\$190.00
Half Day 9:00am-12pm	\$66.00	\$99.00	\$165.00
Full Day 7:30am-3pm	\$135.00	\$202.00	\$335.00
Full Day 9:00am-3pm	\$108.00	\$162.00	\$270.00
Extended Care 7:30am-5:30pm	\$160.00	\$240.00	\$400.00

*All tuitions are billed monthly. Tuition payments should be received by the 15th day of the preceding month (i.e. September's payment should be received by August 15th.)

There will be a 10% sibling discount for families with more than 1 child, if children are enrolled at the same time.

CHILD'S NAME: _____

DATE: _____

Parent's Signature: _____

DATE: _____

For further Information, please contact the Director at:

stjohnpaul2preschool@gmail.com or (614)372-5656

St. John Paul II Early Childhood Education Center

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal, state, county and city health agencies recommend many safe practices, including but not limited to social distancing and have, in many locations, prohibited the congregation of groups of people.

Although St. John Paul II Early Childhood Education Center ("Center") has implemented certain preventative measures attempting to reduce the spread of COVID-19,, the Center cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, entering the Center or interacting with its employees, volunteers, or other participants increases your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending the St. John Paul II Center and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at the Center may result from the actions, omissions, or negligence of myself and others, including, but not limited to, St. John Paul II Center employees, volunteers, and program participants and their families.

In exchange for the Center's efforts to open and be available for my child(ren) and I in the following days, I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at the Center. On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, indemnify, and hold harmless the St. John Paul II Center, its employees, volunteers, and other participants, , of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of the Center, its employees, volunteers, and other participants, whether a COVID-19 infection occurs before, during, or after participation in a Center activity.

Signature of Parent/Guardian

Date

Print Name of Parent/Guardian

Name of Center participants(s)

PHOTO PERMISSION

St. John Paul II Center takes photographs for Facebook, Instagram and our website.
We would like your permission to use pictures of your child

NAME: _____

_____ YES. I grant permission to use photos of my child.

_____ NO. I do NOT grant permission to use photos of my child.

I have reviewed and received a copy of St. John Paul II Center Policies and Procedures.

Parent\Guardian signature
