Ohio Department of Children and Youth

# CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

**Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.**

| | | | |
|---|---|---|---|
| Child's Name | | Date of Birth | First Day at Program |
| Address | | | |
| City | | State | Zip Code |
| Parent #1 Name | | Parent #1 Phone Number | |
| Parent #1 Address ☐Same as Child's | | City | State / Zip Code |
| Parent #1 Email Address (if applicable) | | Parent #1 Cell Phone (if applicable) | |
| Parent #1 Work/School Name (if applicable) | | Parent #1 Work/School Phone Number (if applicable) | |
| Check here if Not Applicable ☐ | Parent #2 Name | Parent #2 Phone Number | |
| Parent #2 Address ☐Same as Child's | | City | State / Zip Code |
| Parent #2 Email Address (if applicable) | | Parent #2 Cell Phone (if applicable) | |
| Parent #2 Work/School Name (if applicable) | | Parent #2 Work/School Phone Number (if applicable) | |
| Primary Emergency Contact #1 Name (cannot be parent/guardian) | | Check here if Not Applicable ☐ | Optional Emergency Contact #2 Name (cannot be parent/guardian) |
| Primary Emergency Contact #1 Phone Number | | Optional Emergency Contact #2 Phone Number | |
| Primary Emergency Contact #1 Other number or email address for emergency contact *(if applicable)* | | Optional Emergency Contact #2 Other number or email address for emergency contact *(if applicable)* | |
| My child may be released to this emergency contact<br>☐ Yes<br>☐ No | | Optional My child may be released to this emergency contact<br>☐ Yes<br>☐ No | |

Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication?

☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

| Child's Name | Date of Birth |
|---|---|
| | |

Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes
☐ No

Name of service provider(s) and frequency

☐ N/A

**Emergency Transportation Authorization**

☐ **The program 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.

☐ **The program 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:

**SIGNATURE**

**This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.**

**Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures**

By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures (parent handbook).

| Parent Signature | Date |
|---|---|
| | |

**Program Acknowledgement of Completion**

By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.

| Program Administrator/Designee Signature | | | Date |
|---|---|---|---|
| | | | |
| 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 |
| | | | |

Ohio Department of Children and Youth

# HEALTH CARE PLAN DOCUMENTATION & PERMISSION TO ADMINISTER MEDICATION FOR EARLY CARE AND EDUCATION PROGRAMS

**Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance and update annually and as needed when a child has a special chronic health condition that may require the program to perform a medical procedure or administer medication. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.**

## HEALTH CARE PLAN DOCUMENTATION

| Child's Name | Date of Birth |
|---|---|
| | |

**If the child does not have a special chronic health condition or diagnosis check here:** ☐
**Skip to page 2 to give permission to administer medication/medical food.**

Complete a new form or provide separate documentation for each condition that requires different actions to be taken.

☐ **Check here if additional information/documentation is attached from a licensed dentist, licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN).** This documentation may serve as a substitute for page 1.

**Special Chronic Health Condition**

What are the signs, symptoms, or situations which require staff to take action, perform a medical procedure and/or administer medication or medical food?

What are the activities, foods, conditions, etc. to avoid? ☐ Not Applicable

What are the instructions to care for the child or perform a medical procedure?

If the child's health condition does not improve or side effects to medication appear, trained staff will do one or more of the following:

☐ Call 9-1-1

☐ Call Parent

☐ Other:

Additional Information and/or what is needed if the child care program must be evacuated:

**If the special health condition does not require administering medication/medical food: STOP HERE AND SKIP TO PAGE 3**

Page 1 is completed to provide instructions for performing a medical procedure.

## PERMISSION TO ADMINISTER MEDICATION

Instructions from a licensed dentist, licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) are required for administering:

- Medical foods.
- Prescription medications, including samples.
- Non-prescription medicines containing aspirin.
- Topical preventative products and lotions or non-prescription medications, when the instructions for use exceed or do not match the manufacturer's instructions or are not stored in original container.

| Child's Name | Date of Birth | Weight (if needed to determine dosage) |
|---|---|---|
| | | |

What are the instructions to administer medication or medical food?

☐ **Not Applicable: Instructions are not required if the prescription medication is stored in the original container with prescription label that includes the child's full name, exact dosage, and directions for use.**

What actions are to be taken if the medication or medical food is not available?

| Name of Medication/Medical Food | Name of Medication/Medical Food | Name of Medication/Medical Food |
|---|---|---|
| Dosage of Medication/Medical Food | Dosage of Medication/Medical Food | Dosage of Medication/Medical Food |
| Time of Medication/Medical Food Administration<br><br>☐ Administer because symptoms are present | Time of Medication/Medical Food Administration<br><br>☐ Administer because symptoms are present | Time of Medication/Medical Food Administration<br><br>☐ Administer because symptoms are present |

## SIGNATURE PAGE

Child's Name

**PARENT/GUARDIAN**

By signing this form I attest that: (check all that apply)

- ☐ I have provided information for care or implementing a medical procedure
- ☐ I have trained staff and have given permission to perform the procedure
- ☐ I have trained staff and have given permission to administer medication to my child

| Parent Signature | Date of Signature |
|---|---|

**LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE REGISTERED NURSE, LICENSED DENTIST**

Health Care Professional's signature is only required in this box if their instructions have been provided on this form, prescribed medication does not have a prescription label, or as directed by the manufacturer's instructions.

| Physician Signature | Date of Signature |
|---|---|

**CERTIFIED PROFESSIONAL TRAINER**

**(A signature from a Certified Professional Trainer is not required if the parent/guardian has provided instructions for care, training, or administering medication)**

If a Certified Professional Trainer provided instructions, my signature indicates that:

☐ I have provided instructions for care and/or training for the medical procedure.

☐ I have provided instructions for administering medication.

| Certified Professionals Name (please print) | Phone Number |
|---|---|
| Certified Professionals Signature | Date of Signature |

**PROGRAM STAFF**

Signatures of all individuals who have received instructions for care, have been trained in performing the procedure for this child and/or administering medication. Additional names and signatures can be attached on a separate sheet.

| Printed Name | Signature | Date |
|---|---|---|
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |
| Printed Name | Signature | Date |

| DOCUMENTATION OF ADMINISTRATION OF MEDICATION OR MEDICAL FOOD | | | |
|---|---|---|---|
| Child's Name | | | Name of Medication/Medical Food |
| **Date** | **Time** | **Dosage** | **Signature of person administering medication/medical food** |
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# 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

_____

# 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)

# ST. John Paul II Early Childhood Education Center

## Tuition Fees 2026-2027

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

### Please check the days/times your child will attend

| | M, W, F | T, TH | M-F |
|---|---|---|---|
| Half Day 9:00 am - 12:00 pm $39 per day | | | |
| Full Day 9:00 am - 3:00 pm $59 per day | | | |
| Extended care 7:30 am - 9:00 am $11 per day | | | |
| Extended care 3:00 pm - 5:00 pm $21 per day | | | |

*Tuition is 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