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 cannot be listed as emergency contacts. List the name of at least one person 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

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? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ 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? (*check one*)

☐ 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? (*check one*)

☐ 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? (*check one*)

☐ 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? (*check one*)

☐ 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? (*check one*)

☐ 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

FIRST ENGLISH LUTHERAN EARLY LEARNING CENTER
53 Park Ave. West - Mansfield, Ohio 44902 - 419-522-7500

PARENTS PLEASE READ AND SIGN AGREEMENT	INITIALS
I hereby agree to comply with the rules and regulations of First English Lutheran Early Learning Center/ELC regarding fees, 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 persons 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 my 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 _____ Date _____	

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 *Permission* to Transport		OR Do not sign both	*Do Not Give Permission* 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.

FIRST ENGLISH LUTHERAN
CHRISTIAN DAY SCHOOL
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 First English Lutheran Christian Day School.

I have received a copy of the First English Lutheran Christian Day School parent handbook. I have read and understand and agree to abide by the policies contained therein. I further understand 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 daycare program.

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 daycare program. If 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 be sure you understand and agree to these policies.

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

_____ I understand that tuition payment is due every Friday before care is given. Late payment fee is $15.00.

_____ I understand the illness policy.

_____ I understand the meal policy.

_____ I understand the behavior policy and have read and shared the daycare rules with my child.

_____ I understand the pickup policy.

_____ I understand the dress policy and that my child must wear closed-toed shoes or sandals and that my child must have an extra change of clothes.

_____ I understand the potty training policy.

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

_____ _____

Signature Date

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:	Initials of 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):	Date

Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):	Signature of Parent
☐ 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):	Date

Ohio Department of Job and Family Services

BASIC INFANT INFORMATION
FOR CHILD CARE CENTERS AND TYPE A HOMES

This information should be completed by the parents prior to the child's first day at the center. 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)*
- ☐ Liquid foods (formula brand)
- ☐ Breast milk

Amount of feedings	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)*

Are foods served room temperature or warmed?

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

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

How frequently should staff check/change your child's diaper?

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 administrator for this form.*

Allergies

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					

Infant Room-What to bring

Complete **change of clothing**

Receiving Blanket to cover child while sleeping

Diapers: enough for the whole day~5. You may bring extra that we keep at the center.

Diaper Wipes: enough for the whole day. You may bring a box to keep at the center.

Bottles: must be labeled with child's name, date, and time it was made. Bottles must be mixed by parent or guardian.

Lunch/Baby Food: must be labeled with name and date. Children may not have hot dogs, grapes, popcorn, and peanut butter.

AM & PM Snacks: labeled with child's name and date
Labeling of bottles and food is state mandated

Box of Tissues

All over the counter oral medications given by our staff must have a doctor's notice. Topical ointments will require an Administration of Medication form to be filled out by the parent or guardian.

Infant Room
Policy on Diapering

We will check your child on arrival and every two hours while in our care, and will change your child when wet or soiled. We will also change your child's diaper in between times of wet or soiled. If your child is sleeping when the 2 hours are up, we will wait until your child wakes up.

Please sign and date:

Parent Signature:_____

Date:_____

Thank You

If you would like a different schedule
Please write down your instructions here.