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 **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.<br><br>☐ 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.<br><br>☐ Not applicable |
| List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.<br><br>☐ Not applicable |
| List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.<br><br>☐ 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 *Permission* to Transport** | | | **Do Not Give *Permission* to Transport** | |
|---|---|---|---|---|
| Program or Home Name | | **OR** | 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. | | **Do not sign both** | **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.

## TRIBE TIME RATES AND IMPORTANT INFORMATION

### BEFORE AND AFTER SCHOOL RATES

$5 PER SESSSION (PAID EACH MONDAY ACCORDING TO THE NUMBER OF DAYS SCHEDULED)

$40 UNLIMITED WEEK (PAID EACH MONDAY PRIOR TO ATTENDING)

$100 **UNLIMITED** (PAID 1ST SCHOOL DAY OF THE MONTH)

**COUNTY ASSISTANCE FOR THOSE WHO QUALIFY.*

NO AM services when Southern Local is on a 2hour delay

NO services when Southern local does not have school

If payment is not made in full by required day, a $25 late fee will apply and child will be unable to attend until payment is made. Tribe tim accepts cash/check/venmo payments

Children MUST submit schedule of session they will attend the Friday PRIOR via remind.

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I, _____, choose:

*per session, per week, unlimited* services (circle one)

for my child(ren). I am fully aware of due dates and stipulations.

Signature: _____

Date: _____

I, _____ , the parent or legal guardian of _____
PARENT/GUARDIAN NAME CHILD'S NAME

grant Tribe Time _____ permission to use photos of my child,
CENTER NAME

and agree to the following:

I understand that my child, whose name is listed above, may be photographed at the center during normal daycare hours, field trips or activities. I understand that these photographs may be used in promoting child care services in either print or on the Internet.

With my signature below I grant permission for my child to be photographed, or their images recorded for print or electronic use in promoting the Center's services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

_____
PARENT/GUARDIAN SIGNATURE

PARENT/GUARDIAN NAME

_____
CHILD'S NAME

_____
PHONE NUMBER

_____
DATE

fill in * parts

Ohio Department of Job and Family Services

# DEVELOPMENTAL AND EDUCATIONAL GOALS FOR STEP UP TO QUALITY (SUTQ)

| Name of Child | Date of Birth |
|---|---|
| | |

*For Three to Five-Star Rated programs, the program must work with families to develop goals for children. These goals must be updated at least annually.*

Developmental/Educational Goal

| Action Steps | Person(s) Responsible | Resources Needed | Timeline | Comments on Progress |
|---|---|---|---|---|
| | | | | |

Developmental/Educational Goal

| Action Steps | Person(s) Responsible | Resources Needed | Timeline | Comments on Progress |
|---|---|---|---|---|
| | | | | |

| Lead Teacher's Name | Signature | Date |
|---|---|---|
| | | |

| Parent/Guardian's Signature | Date |
|---|---|
| | |

Ohio Department of Job and Family Services

# FAMILY INFORMATION
# FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

| Child's Name *(Last)* | *(First)* | Nickname *(If any)* |
|---|---|---|

*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's.*

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 all 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. *(Check the one that applies.)*

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?

| |
|---|
| Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain. |
| What might you and/or your child be anxious about as he/she starts in this program? |
| What are you and/or your child excited about as he/she starts in this program? |
| What are your expectations of this program? |
| What other information would be helpful for the staff caring for your child to know? |

| | |
|---|---|
| Parent/Guardian's Signature | Date |

only if being transported to activity

# written parent permission

*(for school-age children to leave the center for specific activities)*

Child's name

Location of the activity

Arrangements for going to and from the activity

Start and end time of the activity

Time period for when permission is given

Parent's signature

date

# IMPORTANT POLICY REMINDERS:

Sign up for our remind text. This is a very important form of communication. It is a 2-way thread that you can respond to and it will only come to the center. Schedules must be submitted here! If you get a new phone/number you must Resubscribe.

Text the number: 81010
with the message: @SLTT2020

ALL county clients MUST swipe in and out DAILY or you will be responsible for payment.

Schedules must be submitted Friday PRIOR of each week. If not received by NOON your child will not have a spot. Any changes/cancellations must be notified ASAP. Please send all scheduling messages to the remind thread.

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## Closings/delays

Tribe Time will follow Southern Locals school schedule.

-We will be CLOSED on scheduled days off.

-We will CLOSE for inclement weather.

-If there is a 2hr delay, we will not open until afterschool

*Preschool children only - filled out by doctor

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 |