

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE CENTERS AND TYPE A HOMES**

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 Center	
Home Address				City	
State		Zip Code		Home Telephone Number	
Parent/Guardian Name			Relationship to Child		
Home Address					
City			State		Zip
Home Telephone Number			Cell Phone		
Work/School Telephone Number			Work/School Name		
Work/School Address				City	
Please indicate if this name should be included on a parent roster <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which number above to list on the roster <input type="checkbox"/> Work number <input type="checkbox"/> Cell number <input type="checkbox"/> Home number					
Where can you be reached while your child is in this program?					
Parent/Guardian Name			Relationship to Child		
Home Address					
City			State		Zip
Home Telephone Number			Cell Phone		
Work/School Telephone Number			Work/School Name		
Work/School Address				City	
Please indicate if this name should be included on a parent roster <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which number above to list on the roster <input type="checkbox"/> work number <input type="checkbox"/> cell number <input type="checkbox"/> home number					
Where can you be reached while your child is in this program?					
<p>Emergency Contacts: Parents cannot be listed 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 you cannot be reached. Any person listed should be able to assist in contacting you and at least one person listed must be within one hour of the center/home and able to take responsibility for the child in case you cannot be contacted.</p>					
Name			Name		
City		State		City	
Telephone Number		Relationship to Child		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

Allergies, Special Health or Medical Conditions, and Food Supplements

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 monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A 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 child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

No

Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a 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, monitor your child for symptoms or administer medication during child care hours? (*check one*)

No

Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

No

Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

No

Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

N/A - program does not administer any medications.

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 the JFS 01217 "Request for Administration of Medication."

N/A - child does not attend a full time program.

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.

List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? Yes (If yes, skip to Emergency Transportation Authorization section) No

The program's policy is to check diapers every 2 hours. Please indicate if you want your child's diaper checked according to the center/type A home'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	
Center or Type A Home Name			Center or Type A 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 center's or type A home's policies and procedures/handbook.

Parent/Guardian Signature	Date
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Signatures

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. The administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form to indicate the date reviewed.

Parent/Guardian Signature(s)		Date	
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

Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. The form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

Liberty Community Center
Supplemental Information Sheet

Date Completed _____

Child's Name _____ DOB _____

Parent's marital status _____

Special Custody Arrangements _____

Siblings Names	Age	Living in Household?
1 _____		
2 _____		
3 _____		
4 _____		
5 _____		

Pick-up Authorization

Name	Phone#	Relationship	When
1 _____			
2 _____			
3 _____			
4 _____			
5 _____			

Approximate time of arrival _____ Approximate time of Departure _____

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT
 For Child Care Centers and Type A Family Child Care Homes

Child's Name (<i>print or type</i>)	Date of Birth
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This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) _

Immunizations (<i>enter month, day, and year</i>)					
Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

Recommended Assessments/Screenings:

Vision: Yes No Date: _
 Dental: Yes No Date: _
 BMI: Yes No Date: _

Hearing: Yes No Date: _
 Lead: Yes No Date: _
 Other: Hemacrit

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination
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Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care center or type A home.

Name of Physician /Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State and Zip Code	

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37

**CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED PRICE MEALS – 2009-2010**

– 2009 - 2010 INSTRUCTIONS: To apply for free and reduced price meals, read the Household Letter/instructions on backside. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving Food Assistance or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* is to be completed for foster children.

* Asterisks indicate information that must be completed. Form must be updated annually and is valid for only 12 months including the month signed.

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER			PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 10 OR 12 DIGITS. DO NOT USE SWIPE CARD NUMBER.		
	CHILD(REN) NAME	AGE	BIRTH DATE*	Circle type of benefit FOOD ASSISTANCE OR OWF	
1.				CASE NUMBER:	
2.				CASE NUMBER:	
3.				CASE NUMBER:	
4.				CASE NUMBER:	

PART 3 – HOUSEHOLD SIZE AND HOUSEHOLD INCOME: If Part 2 is completed skip to Part 5.

Income Conversion: Weekly x 52, Bi-weekly (every 2 weeks) X26, Semi-monthly (twice a month) X24, Monthly X12.

*LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	*Gross MONTHLY Earnings (before deductibles)		*MONTHLY Welfare Payments, Child Support, Alimony	*MONTHLY Pensions, Retirement, Social Security	*ANY OTHER MONTHLY Income
	Job 1	Job 2			
1.	\$	\$	\$	\$	\$
2.	\$	\$	\$	\$	\$
3.	\$	\$	\$	\$	\$
4.	\$	\$	\$	\$	\$
5.	\$	\$	\$	\$	\$

PART 4 – FOSTER CHILD: (check if yes) List foster child's monthly personal use income. Enter "0" if none. \$ _____

PART 5 – SIGNATURE AND SOCIAL SECURITY NUMBER: I certify that the above information is true and correct and that all income is reported. I understand that this information is being given for receipt of federal funds; that program officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal criminal statutes.

* _____ SIGNATURE OF ADULT HOUSEHOLD MEMBER	* _____ DATE	* _____ SOCIAL SECURITY NUMBER (SSN) Required only for Part 3 Write "None" if adult signer doesn't have a SSN.
Print Name: _____	Daytime Phone Number: _____	Work Phone Number: _____
Street / Apt: _____	City / State / Zip: _____	County: _____

PART 6: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race or ethnicity of your child(ren).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other

Please mark one of the following ethnic entities: Hispanic or Latino Not Hispanic or Latino

Privacy Act Statement: Section 9 of the National School Lunch Act (NSLA) requires that, unless your child's Food Assistance or OWF case number is provided, you must include the social security number of the adult household member signing the application or indicate that the household member does not have a social security number. Provision of a social security number is not mandatory, but if a social security number is not given or an indication is not made that the signer does not have such a number, the application cannot be approved. This notice must be brought to the attention of the household member whose social security number is disclosed. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application or shared with other persons directly connected with the administration or enforcement of the program under the NSLA or Child Nutrition Act of 1966 to determine program eligibility. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a Food Assistance or welfare office to determine current certification for receipt of Food Assistances or OWF benefits, contacting the state employment security office to determine the amount of benefits received and checking the documentation produced by household members to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal action if incorrect information is reported.

State Distribution: Week of 6/22/09

-----FOR CENTER USE ONLY-----

<p>Zero Income</p> <p>Temporary Free Approval Until: _____</p> <p>Must be reviewed again in 45 days.</p>	<p>Total from Part 3, if applicable: _____</p> <p>Total Household Size _____</p> <p>Total Monthly Income \$ _____</p>	<p><input type="checkbox"/> Free <input type="checkbox"/> Food Assistances/OWF</p> <p><input type="checkbox"/> Foster Child</p> <p><input type="checkbox"/> Household Size & Income</p> <p><input type="checkbox"/> Reduced</p> <p><input type="checkbox"/> Paid Reason:</p> <p><input type="checkbox"/> Income Too High <input type="checkbox"/> Invalid</p> <p><input type="checkbox"/> Incomplete</p>
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Signature of Center Official	Today's Date	Effective Date (No earlier than first of current month)	Expiration Date
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Ohio Department of Job and Family Services
CHILD MEDICAL/PHYSICAL CARE PLAN
FOR CHILD CARE CENTERS & TYPE A HOMES

This form may be used for children with health conditions as defined in Rules 5101: 2-12-38 and 5101: 2-13-38.

Child's Name	Date of Birth
Special Health Conditions	
Symptoms to watch for and Emergency Action to be taken if the following symptoms occur	
Activities/Foods/Environmental Conditions to Avoid	
Medical Procedures to be followed and Expected Benefit of Treatment	

Are any medications required? No Yes (If yes, complete JFS 01217 Request for Administration of Medication)

If yes, what medications?

Training Instructions (Trainer must be a parent/guardian or certified professional)
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Signature of Trainer:	Date:
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Signature of trained staff members and staff who have been made aware of the condition.	(There must always be a trained staff member present when the child is present.)
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Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained
Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained
Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained
Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained

(Only trained staff members shall be permitted to perform medical procedures listed above.) Additional staff, may sign on the backside of this form, but need to indicate "trained" and/or "informed".

Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name: _____	Phone number: _____	May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Name: _____	Phone number: _____	May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes	

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator Signature	Date

Ohio Department of Job and Family Services
REQUEST FOR ADMINISTRATION OF MEDICATION
Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 - The following section must always be completed by the parent/guardian.

<u>Check all that apply:</u>	
<input type="checkbox"/> Prescription medication	<input type="checkbox"/> Topical product or lotion
<input type="checkbox"/> Nonprescription medication	<input type="checkbox"/> Food supplement
<input type="checkbox"/> Refrigeration required	<input type="checkbox"/> Modified diet
<u>Complete all of the following information:</u>	
Name of child: _____	Date of birth: _____ Weight: _____
Name of medication: _____	Exact dosage: _____
To be administered at the following times _____	
For the following period of time: _____	
Parent/Guardian signature: _____	Date: _____

Box 2 - The following section must be completed by a licensed physician, a licensed dentist or an advance practice nurse when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated) or food supplement; or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____
(name of child) (name of medication, vitamin, diet)
as follows: _____
(include dosage and instructions)
Possible side effects to watch for are: _____
Expiration date: _____ (May not exceed 12 months from the date of this request for medications or food supplements)
Signature of physician, dentist or advance practice nurse Date of signature Phone number

This form must be used by child care centers and type A homes to meet the requirement of OAC rules 5101:2-12-31 and 5101:2-13-31