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.**

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| 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 NoIf 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 NoIf 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 |

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| 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*)NoYes - *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*)NoYes - 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*) NoYes - 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*)NoYes - 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*) NoYes - please explain |
| If yes, does this medication or medical food need to be administered at the child care program/home?NoYes - 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*) NoYes - please explain |
| Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?NoYes - 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. |

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| 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 tobe 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 |

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| 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**

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

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| **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 req uirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This formmust be on file at the program or home on or before the child’s first day of atten dance and thereafter while the child is enrolled.