Ohio Department of Children and Youth

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 DCY 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 DCY 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 DCY 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 DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 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

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 2 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 Planting Seeds of Hope Children's Center		**OR** **Do not sign both**	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 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.

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.

Reset Form

PLANTING SEEDS OF HOPE
CHILDREN'S CENTER

Pick Up Authorization Form

_____ (Name of Student)

_____ (Classroom)

Persons Authorized to Pick Up Student

Name	Address	Phone Number

UNDER **NO** CIRCUMSTANCES WILL A CHILD BE RELEASED TO ANYONE NOT KNOWN TO THE CENTER WITHOUT ADVANCE, WRITTEN AUTHORIZATION FROM PARENTS OR LEGAL GUARDIAN. ALL PERSONS PICKING UP CHILDREN MUST BE AT LEAST 18 YEARS OF AGE. THIS IS FOR THE SAFETY OF THE CHILDREN.

_____ Signature of Parent/Guardian

_____ 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: ☐ 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):*	**Initials of Examining Health Care Practitioner**
	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ 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):	**Signature of Parent**
	Date

Child & Family Information

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in our care. List any information about your child's habits, abilities or personality that you feel will be helpful.

Child's Name:_____

Who lives at home with your child?

_____

_____

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc? (center requires a copy of all court orders)_____

Are there any changes or transitions that your child has recently experienced or is experiencing?

_____

_____

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? (center based, home based etc?)

_____

Do you have any concerns about any aspect of your child's development?

_____

_____

What routines/actions or items do you use to comfort 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 is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken) _____

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used. _____

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? _____

What might you and/or your child be anxious and/or excited about as he/she starts in this program?

_____

_____

Publicity Authorization

During the school year, there may be times when newspapers, TV or staff will take pictures of the children. Some of these pictures may be used for the center's website, center's Facebook, local newspaper/magazine articles, for educational TV or for program promotion and/or publicity. We would like your permission to include your child in such pictures.

_____Yes, my child may be photographed for these purposes.

_____No, my child may not be photographed.

Signature:_____ Date:_____

Family Needs Assessment for Step Up to Quality (SUTQ)

As part of our program, we provide families with resources and referrals for support. Please complete the questionnaire below to help us provide any additional resources or referrals that your child/family may need. Please see the administrator if you have questions. Thank you!

Does anyone in your family have any developmental or educational needs in which you would like additional resources or referrals? (Examples could include: Information on child growth and development; guiding and supporting a child's behavior; medical or disabilities or possible conditions for any child or adult in the family; obtaining toys or activities to use to help any child in your home; preparing your child for kindergarten.)

☐ Yes, please list the needs for which you would like to receive additional resources or referrals:_____

_____

_____

☐ No

Does anyone in your family have any health needs in which you would like additional resources or referrals? (Examples could include: Health insurance and/or access to regular medical care, dental care, or medications; medical or health supplies or supports that anyone in your family needs; accessing immunizations, finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner; concerns with depression, anger, anxiety or mental health needs; concerns with alcohol, drug or addiction problems.)

☐ Yes, please list the needs for which you would like to receive additional resources or referrals:_____

_____

_____

☐ No

Does anyone in your family have any financial or household support needs in which you would like additional resources or referrals? (Examples could include: Help paying for child care; help finding housing or safe housing; help paying for mortgage or rent; help with food expenses; finding household items such as furniture, clothing or school supplies; access to transportation or transportation expenses; attending school (such as GED, certifications, or college degrees); help finding work or job training.)

☐ Yes, please list the needs for which you would like to receive additional resources or referrals:_____

_____

_____

☐ No

Are there other needs you or your family have that are not listed above:

Parent Signature	Date Completed:

Child's/Children's Name(s): Guardian's Name:

_____ _____

Family Needs Assessment for Step Up to Quality (SUTQ)

Administrator Signature	Date Received:

For staff use only:

Resources provided to the family:
Administrator Signature & Date:
Referrals provided to the family:
Administrator Signature & Date:
Follow-up provided to the family:
Administrator Signature & Date:

Child's/Children's Name(s): _____

Guardian's Name: _____