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			Relationship to Child
Home Address			Home Telephone Number
City		State	Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Telephone Number		Parent's Work/School Name	
Parent's Work/School Address			City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) 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			Relationship to Child
Home Address			Home Telephone Number
City		State	Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Telephone Number		Parent's Work/School Name	
Parent's Work/School Address			City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) 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 within one hour of the center/home, 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 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 perform child specific care, such as: 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 family child care 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, 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, 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 "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.

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.
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 (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 Hugs-n-Hearts Early Learning Center			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.		**OR** **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 and 5101:2-13-15. 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.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination

Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number

Street Address

City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Optional
Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		

PICK-UP AUTHORIZATION

Child's Name:_____Date of Birth_____

Do the parents or legal guardians of this child have a court ordered custody agreement?
No_____ Yes_____ If yes, you must provide the appropriate court documents.

The person/persons listed below have my permission to pick up my child from Hugs-n-Hearts Early Learning Center/H-n-H Campus program. I will inform my child's teacher/director each time an alternate pick-up is necessary.

Name	Relation to Child	Brief Physical Description
Name	Relation to Child	Brief Physical Description
Name	Relation to Child	Brief Physical Description

This person is **Not** allowed to pick up my child: **(If this person is a parent or legal guardian, we must have court documentation supporting this request.)**

Name	Relation to Child	Brief Physical Description

PHOTOGRAPHS/ART WORK

I do_____ do not_____ give Hugs-n-Hearts/H-n-H Campus permission for my child to be photographed in the program, at program functions or at fieldtrips. I understand that these photographs and/or my child's artwork may be published in the center or on the center's website at: www.hugsnheartselc.com where third parties would be able to view the photographs and art work. While every effort will be made to protect the identity of your child, Hugs-n-Hearts ELC and The H-n-H Campus cannot guarantee that your child will not be able to be identified from the photograph and artwork. This consent will remain effective until such time as you advise the center otherwise.

Name of Parent:_____

Signature of Parent:_____ Date:_____

Child and Family History

Child's Name:_____ Birth Date:_____

Expected drop-off time:_____ pick-up time:_____

FAMILY AND SOCIAL INFORMATION

Adult family members residing in child's primary household:_____

Siblings: (names and ages)_____

Has your family recently moved to a new home or had any other major change in your child's life?_____

Has your child had previous childcare experience? Yes_____ No_____

If not, do you feel that your child will adjust easily to the childcare experience? _____

If yes, where was your child previously enrolled?_____

In your opinion, was your child's previous childcare experience a positive one for both your child and you? Yes_____ No_____

If "no", what made this experience a negative one?_____

EMOTIONAL HISTORY

Please circle the words that best describe your child:

Confident Insecure Anxious Responsible Shy Fearful

Leader Follower Cooperative Loving

In what types of situations do you believe that your child will need the most help from us?

_____

Describe your child's reaction to previous experiences with separation from you:_____

_____

Describe your child's reactions to new people/situations: _____

_____

Are you aware if any fears or anxieties that your child has?_____

What does your child find to be comforting?_____

In general, describe your child's typical behaviors when interacting/playing with other children:

_____

Please describe (if any) what you consider to be difficult behaviors demonstrated by your child:

_____

What type of action works best for your child in preventing or dealing with these behaviors:

_____

Who does most of the disciplining in your child's life?_____

What form of discipline/guidance works best for your child?_____

_____

Does your child have a transitional object (pacifier, stuffed toy, blanket) or a regular bedtime ritual of which we should be aware?_____

Does your child have a favorite toy or activity?_____

HEALTH INFORMATION

Does your child have any speech or hearing delays? _____
Does your child have any identified delays in physical or social development? _____

_____

Does your child have any eating problems we should be aware of? _____
Does your child have any restrictions or limitations to participation in our program? _____

_____

TODDLER SPECIFIC INFORMATION

Please complete for your 18 month –3 year old child

Does your child drink well from a "sippy" cup? _____
Does your child eat independently from a spoon? _____
Has your child mastered the potty-training process? _____
Is your child prone to diaper rash? _____

PRE-SCHOOL SPECIFIC INFORMATION

Please complete for your 3-5 year old child

Place a check mark in the column that best describes your individual child. This will provide the staff with one way of getting to know your child. We also understand that young children are constantly changing and developing.

	Most of the time	Occasionally	Rarely	Comments
Plays and share cooperatively with others.				
Plays alone happily.				
Follows directions.				
Stays focused and completes tasks.				
Demonstrates ability to lead.				
Demonstrates ability to follow.				
Empathetic of peers.				
Moves easily from one activity to another.				
Demonstrates willingness to try new activities.				
Expresses ideas well.				
Respects rules and routines.				

Parental Agreement Form

Child's Name:_____

Please check "yes" or "no" to the following statements, sign your name and return to the front desk.

	Yes	No
1. I have received the Hugs-n-Hearts or H-n-H Campus Parent Handbook.		
2. I have been informed of and understand the policies and procedures of Hugs-n-Hearts/H-n-H Campus.		
3. I am aware that I will be informed of center events and specifics through the monthly calendar and center newsletter.		
4. I have returned all enrollment forms, including a physician signed "Child's Medical Statement," as well as all other written information requested.		
5. **I understand that Hugs-n-Hearts/H-n-H Campus requires all children to be fully immunized, with the exception of a medical condition that would prove to be counter intuitive**; in which case, a medical statement from your child's current physician is required.		
6. I agree that it is the responsibility of both staff and parents to keep open lines of communication regarding my child. I understand there will be an evaluation of my child's development during the year.		
7. I understand that I will be responsible for an annual filing fee at the start of each fall program.		
8. I understand that tuition payments are due on the first day of the week that my child is scheduled for attendance. If late, a late payment fee will be added to my account balance. This fee will accrue weekly.		
9. I understand that I must give two weeks written notice to the Director if I wish to withdraw my child from Hugs-n-Hearts/H-n-H Campus or to change my child's weekly schedule. I understand that I will be responsible for two full weeks tuition if the written notice is not received before change or withdrawal.		
10. I understand that if my account becomes 14 days or more delinquent, Hugs-n-Hearts/H-n-H Campus may without liability suspend or deny services and obligations until payment has been made in full.		
11. I understand that upon withdrawal or disenrollment, past due accounts must be paid in full within 30 days. Failure to do so will result in your account being turned over to our third party collection agency.		
12. I agree that in order for Hugs-n-Hearts/H-n-H Campus to provide services or to collect payment that I may owe, I may be contacted by telephone, text message, or e-mail at any phone number/e-mail address associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable by a contracted third party.		
13. I understand that I am responsible for all financial obligations to Hugs-n-Hearts/H-n-H Campus.		

I have read and agree to the Hugs-n-Hearts/H-n-H Campus guidelines for promotion and transitioning to the next age group. (Guidelines are located in the Hugs-n-Hearts/H-n-H Campus Parent Handbook.) Students will be provided a two week transition period prior to our summer and/or fall sessions during which time they will be visiting their new classrooms and teachers.

Parent/Guardian Signature:_____ **Date:**_____

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REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☒ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

* Name of Child	* Date of Birth	* Weight

* Name of Medication (Brand of Sunscreen)	Exact Dosage
	Apply to exposed skin

To be administered at the following times	For the following period of time
Prior to and during sun exposure	12 months

☑ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

* Signature of Parent/Guardian	* Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement
Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

PERMISSION TO WALK BETWEEN BUILDINGS

My child, _____,

(date of birth _____)

has my permission to walk with Hugs-n-Hearts/H-n-H Campus staff to and from Hugs-n-Hearts Early Learning Center at 8987/8989 Antares Ave and the H-n-H Campus at 9005 Antares Ave on a daily basis for special activities such as cooking, gym, theater, and the playground.

Parent Signature: _____

Date: _____