New Student Checklist

Name _____ **Start Date** _____

_____ **Physical**

_____ **Special Health Concern Plan**

_____ **Three Page Enrollment (CR Copy)**

_____ **Pick up Form**_____ **Parent info**

_____ **Sunscreen form (CR Copy)**

_____ **General Permission Form**

_____ **Swimming Permission**

_____ **Parent Handbook agreement**

_____ **Permission for use of name**

_____ **General Health Form**

_____ **Discipline Policy**

_____ **Feeding information (infants) + Waiver**

_____ **Time Sheet (CACFP)**

_____ **Ethnic (CACFP)P**

_____ **Infant Preference Letter (CACFP)**

_____ **Income Eligibility (CACFP)**

_____ **Three Page Family Information (SUTQ)/ (CR Copy)**

_____ **Remind**

_____ **Routine Permission form for Walks (CR Copy)**

_____ **Ages and Stages**

_____ **Guarantor**

_____ **Face book permission**

_____ **Website permission**

_____ **Amendment**

Fax #: (216) 226-5174

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		

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

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, if applicable

Medical procedures to be followed and expected benefit of treatment, if applicable

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

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?
☐ Yes ☐ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?
☐ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No

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/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

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 _____ 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			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.

February 2018

Child's Full Name: _____

Parent/Guardian #1:

Name: _____

Cell Phone Number: _____

Work Phone Number: _____

Home Phone Number: _____

Parent/Guardian #2:

Name: _____

Cell Phone Number: _____

Work Phone Number: _____

Home Phone Number: _____

Emergency Contact #1:

Name: _____

Cell Phone Number: _____

Work Phone Number: _____

Home Phone Number: _____

Emergency Contact #2:

Name: _____

Cell Phone Number: _____

Work Phone Number: _____

Home Phone Number: _____

Ohio Department of Job and Family Services

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 Sunscreen	Exact Dosage Cover exposed skin
To be administered at the following times Prior to sun exposure	For the following period of time

☐ 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

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.		
Date	Time	Dosage	Signature of Designated Person Administering Medication

Pick Up Permission List

The persons listed below have my permission to pick up my child/children from LCCC.

Child/Children's Name(s): _____

Child/Children's Classroom(s):_____

- Name: _____

  Relationship to Child: _____

  Phone Number: _____

- Name: _____

  Relationship to Child: _____

  Phone Number: _____

- Name: _____

  Relationship to Child: _____

  Phone Number: _____

- Name: _____

  Relationship to Child: _____

  Phone Number: _____

- Name: _____

  Relationship to Child: _____

  Phone Number: _____

Please do not allow anyone except parents to use the key fob to enter the building. We need to check identification at the door until staff if familiar with each person on your list.

This form is valid for one year from date of signature. You may make changes as needed.

If an emergency arises, you may send a handwritten fax giving permission to someone who is not on this list to pick up your child. This form must be signed and dated by you.

Parent/Guardian Signature: _____

Date: _____

lakewood community child care

EST • 1985

General Permission Slip

I consent to the enrollment of my child, _____

Lakewood community child care center and agree that the center not be responsible case of illness or injury while in attendance at the facility or in transit to and from the same.

_____

Please initial

I give permission for my child to take part in excursions within Lakewood and neighboring communities.

_____

Please initial

I agree to abide by the policies and procedures relative to Lakewood community child care, including responsibility for payments of all fees.

_____

Please initial

I give permissions for my child to be photographed and/or videotape to the purpose of publicizing the center, including for the center brochure and website.

_____

Please initial

_____ _____

Parent's Signature *Date*

_____ _____

Parent's Signature *Date*

_____ _____

Director's Signature *Date*

2019 Woodward Avenue Lakewood Ohio 44107 (216) 226-0080

Ohio Department of Job and Family Services

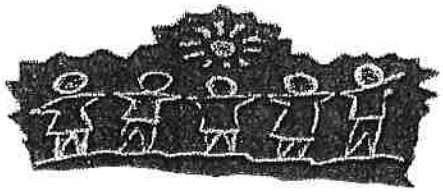
PERMISSION TO PARTICIPATE IN SWIMMING ACTIVITIES FOR CHILD CARE

Written parental permission is required for the water activities your child will be engaging in (check all that apply for this activity)

- ☐ Child swimming in water 18 inches or more in depth
- ☐ Child participating in activities near water 18 inches or more in depth (no water activities planned)
- ☐ Infants and toddlers using wading pools

I give permission for my child to participate in the following swimming/water activities

Swim Site	
Date(s)	
Departure/Arrival Times from Center	
Mode of Transportation (parent's driving, provider vehicle, public transportation, school bus, etc.)	
Child's Name	Child's Date of Birth
My child is a ☐ Swimmer ☐ Non swimmer	
Parent's Signature	Date



Lakewood Community Care Center

Parent Handbook Agreement

I have read the parent Handbook of Lakewood Community Care Center and I agree to abide by all Lakewood Community Care Center policies and procedures.

_____ _____

Parent's Signature Date

_____ _____

Parent's Signature Date

_____, give my permission for my child's name to be used in the monthly newsletter. This newsletter would go out to the parents via email. We would like to mention your child as they are moving up to the next room or achieved a milestone in their development. We would only use first names. We would also like to welcome new families into the center by family name.

◯ YES, I give permission to have my child's name used

◯ NO, I would rather not have my child's name used

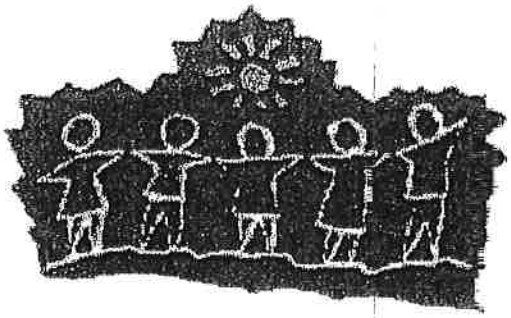
_____

Parent's name

_____

Date

Lakewood Community Care Center



LAKEWOOD COMMUNIY CARE CENTER
General Health Information

List any medications, food supplements, modified diets or fluoride supplements with which your child is Currently being treated_____

_____

_____

Please describe any chronic physical problems your child has_____

_____

Chicken Pox_____ Mumps_____
Hepatitis_____ Scarlet Fever_____
Diabetes_____ Measles_____
HIB_____ Other_____

Does your child exhibit any of the following conditions with frequency?

Colds_____ Vomiting_____
Ear Infections_____ Stomachaches_____
Diarrhea_____ Fever_____
Nose Bleeds_____ Other_____

Does your child have a history of convulsion?_____yes_____no
If yes, please describe:_____
Please list all allergies your child had:_____
Please describe the following:
Visits to the dentist_____
Vision Tests_____
Hearing Tests_____
Hospitizations_____

DISCIPLINE POLICY

Discipline is the heart of the program. We consider discipline to be a form of guidance to help out children learn to make correct choices. DISIPLINE IS NOT PUNISHMENT. We are careful to be clear and appreciate in our expectations and true always to be consistent. All employees of Lakewood Community Care Center shall follow the child guidance and management specifications as stated in Rule 22 of the Ohio Administrative Code Child Care Center Rule

*We take issue with what is important. Our rules are simple and few.

*We speak to the child face to face and use short, simple sentences to tell the child what his/her limits are and what is expected. Remember that young children neec to be told and reminded of expectations repeatedly.

*whenever possible, we speak in a positive way "Tell your feet to walk" " Chairs are for sitting" "Sand stays in the box"

*The older children will be offered appropriate choices and consequences such as, "If you'll continue to throw the Lego's, we will need to put them away" If the child continues, the Lego's will be put away.

* We redirect the child to another part of the room or substitute an appropriate alternative such as, "Timmy is using that truck, and here is one for you"

*When a child is exhibiting aggressive behavior, they will be addressed one on one by a teacher helping them to address what they want or need. If they need to be by themselves, we offer a quite area in each classroom for calming down.

*If an older child exhibits aggressive behavior towards another child or a teacher The teacher will help the child understand the cause and effect taking place.

*If a younger child is aggressive toward the teacher or another student, the child will be separated from the group for a brief period of time

*The teacher and/or administrator will talk with parents if there are repeated difficulties, aggressive behavior, or staff concerns. We rely on parental guidance in helping a child

*Rarely, a child may have to be removed from the center, This will be done only as a last resort after careful consideration and discussion with parents

*Children need our help when learning to make correct choice because frequently their life's experiences are very limited.

*We believe that children NEED and DESERVE reasonable and CONSETANT guideline each and every day from parents and their teachers.

Child's name_____ Date of birth_____

Parent's Signature_____ Date_____

*Only for infants Under 12 months.

Ohio Department of Job and Family Services

SLEEP POSITION WAIVER STATEMENT FOR CHILD CARE

Safe Sleep Practices

Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of an infant under one year of age. Doctors don't know what causes SIDS, but they have found some things that can make babies safer. The American Academy of Pediatrics and the National Institute of Child Health and Human Development state that one of the most important things that can help reduce the risk of SIDS is to put healthy babies on their backs to sleep. State regulations require child care centers, family child care, and in-home aides to place all infants to sleep on their back. A few babies have health or medical conditions that might require them to sleep in an alternative position. At the advice of the infant's physician, the child care program may be authorized to use an alternative sleep position for the infant due to health or medical conditions. If an infant is to be placed in the crib in any other positions than on their back, this form must be completed by the child's physician and signed by the parent.

To Be Completed by the Infant's Parent/Guardian

Name of Infant		Date of Birth
Name of Primary Care Physician		
Name of Practice		
Address		
Phone	Fax *(optional)*	Email *(optional)*
Signature of Caretaker/Parent *(authorizing this instruction)*		Date

To Be Completed by the Infant's Primary Physician

The above named infant has the following health or medical condition that necessitates an alternative sleep position
Describe the appropriate sleep position for the above named infant
Additional instructions

Signature of Physician	Date
This above instruction is effective from *(date)* to *(date)*	

LAKEWOOD COMMUNITY CARE CENTER

Feeding Instructions

Does your child take a bottle? YES _____ NO _____

Is the bottle warmed? YES _____ NO _____

Does your child hold his/her own bottle? YES _____ NO _____

Does your child eat: Strained Foods YES _____ NO _____

Formula YES _____ NO _____

Baby Food YES _____ NO _____

Whole Milk YES _____ NO _____

Table Foods YES _____ NO _____

Approximate Time — Type and Approximate Amounts of Food

Breakfast _____ _____

Lunch _____ _____

Dinner _____ _____

Diapering Instructions

Do you use powder? YES _____ NO _____

If so, what brand? _____ _____

Brand of Diapers _____

Additional Diapering Information _____

Sleeping Instructions

Does your child take a pacifier? YES _____ NO _____

Does your child need a special blanket or toy to sleep with?

YES _____ NO _____

If so, what? _____

Approximate length of morning nap _____ Afternoon Nap _____

Additional sleeping instructions _____

_____

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five groups)
Milk Fruit or Vegetable Grain Meat/meat alternate (may be substituted for the grain up to 3 times per week)	Milk Meat/meat alternate Grain Vegetable (two different vegetables can be substituted for a fruit) Fruit	Milk Meat/meat alternate Grain Vegetable Fruit

Participating Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers**: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes**: Licensed private homes.
- **After School Care Programs**: Centers in low-income areas provide free snack and/or meal to school-age children and youth.
- **Emergency Shelters**: Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center	Ohio Department of Education
	CACFP Program Specialist 25 S. Front Street, MS 303 Columbus, OH 43215-4183 Phone: 614-466-2945 Toll Free: 1-800-808-6235

Nondiscrimination

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;
(2) Fax: (202) 690-7442; or
(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

10/2017

CACFP
NON-DISCRIMINATION STATEMENT/POSTERS

Effective: June 2013

Listed below is the updated Nondiscrimination Statement for use by sponsors. Websites and materials which are being reprinted should be revised to include this updated statement. Other materials should be updated as supplies are depleted and new printing is ordered.

All sponsors need to make sure the following statement is included in their parent handbook if the text refers to the Child and Adult Care Food Program (CACFP), any other Child Nutrition Program, or USDA by name or if information is included regarding any of the meals/snacks for which reimbursement is received. This statement is to be also included, in full, on all materials that contain the aforementioned programs names or meal references and are produced for public information, public education or public distribution.

FULL STATEMENT:

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

If the material is too small to permit the full statement to be included (such as flyers or brochures), the material will, at a minimum, include the statement in print size no smaller than the text. Please note that the use of the shorter condensed version is the exception, not the rule. If written materials previously had the longer statement on them they should again have the full statement when re-printed.

CONDENSED STATEMENT:

"USDA is an equal opportunity provider and employer."

"AND JUSTICE FOR ALL" POSTER:

- At this point in time, USDA cannot provide updated "And Justice For All: posters.
- Until new posters are printed, sponsors are to continue to prominently display in a public place the same "And Justice For All" USDA poster at each site and at the agency office if at a different location. If posters and/or are needed in other languages, appropriate to the local population, please contact the state agency.

Ohio Department of Education - Office for Child Nutrition

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME		
CHILD'S NAME (please print)	**AGE**	**BIRTHDATE** ___ / ___ / ___ month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
		Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

☐ Yes, **The schedule listed above may frequently vary due to changes in parents/guardians schedule**

SIGNATURE OF PARENT/GUARDIAN	DATE	DAY PHONE NUMBER
MAILING ADDRESS: STREET /APT.	CITY	ZIP CODE

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program nformation (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;
(2) Fax: (202) 690-7442; or
(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

(rev. 12/3/2015)

ETHNIC and RACIAL DATA FORM

Agency/Daycare Center_____

Agency/Daycare Address _____

The agency or daycare listed above receives Federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive Federal financial assistance they are required to record and maintain the Ethnic and Racial data of all children enrolled in the CACFP. This information is used solely for the purpose of determining compliance with Civil Right laws and will be kept confidential. **We are requesting for each participant to 'Self Identify' and provide this information, however it is optional to Self Identify. If you choose not to Self Identify, then please be aware that the agency/daycare will need to make a judgment of your child's race and ethnicity because Civil Rights law require them to do so.** This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

To Self Identify, please answer the following questions.

Child's name _____

Ethnic Category: Choose one

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".	
Non-Hispanic or Latino:	

Racial Categories: Check all that apply

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains tribal affiliation or community recognition.	
Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Black or African American: A person having origins in any of the black racial groups of Africa.	
Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa	
Other	

Parent/Guardian Signature_____ Date_____

CHILD AND ADULT CARE FOOD PROGRAM
INFANT MEALS – PARENT PREFERENCE LETTER

TO: **Parents and Guardians of Infants under one year of age**

FROM:

NAME OF CENTER/PROVIDER	Lakewood Community Child Care

TOPIC: **Who will provide food for your infant's meals?**

Due to participation on the Child and Adult Care Food Program (CACFP), all children enrolled at this child care center or family child care (FCC) home receive meals free of charge. The CACFP is a U.S. Department of Agriculture (USDA) child nutrition program. Child care centers and family child care homes are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. These centers and FCC homes can be reimbursed daily for up to two meals and one snack served to each enrolled child, including infants. Emergency Shelters can be reimbursed for up to three meals. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, the center or FCC home is required to **offer** formula and other required infant food to all enrolled infants. The iron fortified infant formula we will provide for infants until they turn one year of age is:

NAME OF FORMULA	

A parent or guardian may decline the formula offered by the center or home and supply the infant's formula themselves. However, when an infant turns one year of age, the center or FCC home will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler age children.

To assist us in your infant formula and food preferences, please complete preferences below by checking one item each in the formula and solid food section.

PARENT OR GUARDIAN: PLEASE CHECK YOUR PREFERENCES FOR FORMULA AND FOOD

Formula or Breast Milk: (check one)

☐ I want the center or FCC home provider to provide formula for my infant

☐ I will bring iron fortified infant formula for my infant

Parent/Guardian: List Name of Formula You Will Provide

☐ I will bring expressed breast milk for my infant

☐ I will come to the center or FCC home to breast feed my infant

Solid Food: (check one)

☐ I want the center or FCC home to provide solid food for my infant when he/she is developmentally ready for it

☐ I will bring solid food for my infant when he/she is developmentally ready for it

***Note: If your feeding preferences change, the center or provider will ask you to complete a new form.**

INFANT NAME:	INFANT BIRTHDATE:
PARENT/GUARDIAN SIGNATURE:	DATE:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider. Rev. 9/2019

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2020-2021

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. 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 (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4 an* adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER

* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)
1.			☐
2.			☐
3.			☐
4.			☐

PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.

Check type of benefit: ☐ FOOD ASSISTANCE (SNAP) or ☐ OHIO WORKS FIRST (OWF)

CASE NO.	_ _ _ _ _ _ _
CASE NO.	_ _ _ _ _ _ _
CASE NO.	_ _ _ _ _ _ _
CASE NO.	_ _ _ _ _ _ _

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	☐	$ amount / how often	$ amount / how often	$ amount / how often	$ amount / how often
1.	☐	$ /	$ /	$ /	$ /
2.	☐	$ /	$ /	$ /	$ /
3.	☐	$ /	$ /	$ /	$ /
4.	☐	$ /	$ /	$ /	$ /
5.	☐	$ /	$ /	$ /	$ /
6.	☐	$ /	$ /	$ /	$ /

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* SIGNATURE OF ADULT HOUSEHOLD MEMBER	* DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number ☐☐☐☐ (Check if applicable) ☐ I do not have a Social Security Number
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

☐	American Indian or Alaska Native	☐	Asian	☐	Black or African American
☐	Native Hawaiian or Other Pacific Islander	☐	White	☐	Other

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

State Distribution: 7/1/2020

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion :
Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Application Certified/Categorized as:

☐ **FREE,** based on ☐ Food Assistance/OWF Case No. ☐ Household size and income ☐ Foster Child

☐ **REDUCED,** based on Household size and income

Total Household Size: _____

Total Household Income: $_____

Per: ☐ week ☐ every two weeks ☐ twice per month ☐ month ☐ year

☐ **PAID,** based on ☐ Income too high ☐ Incomplete ☐ Invalid case number or information

Signature of Sponsor / Center Representative

Date Sponsor Certified/Categorized Form

Effective Date (From the first of month of date signed)

Expiration Date (Valid until last day of month in which form was signed one year earlier)

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

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.

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?

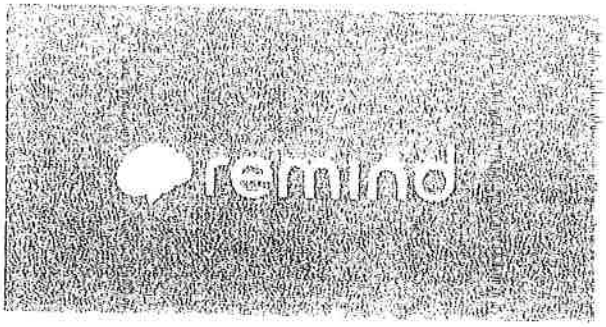
What words, gestures or signs does your child use if he/she needs to use the bathroom?

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



We are using the Remind system as a form of communication here at the center. This is a form of communication that allows us to send you messages directly to an app, your email, and/or your text messaging about important information.

If you any questions about Remind, please stop in the office.

_____ Yes, I am interested

_____ No, I am not interested

Child's name: _____

Parent(s) name(s): _____

Cell phone number to be added: _____

Ohio Department of Job and Family Services

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information

Routine Trip Destination(s)* Surrounding Neighborhood only
* around Atkins block - around Mckinley block, Hiland Madison / the grassy field / Harding Lakewood 44107

Date of Permission *(valid for one year)*

Mode of Transportation (*walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*

During this trip children will have access to water that is 18 inches or more in depth.
☐ Yes ☐ No

Are water activities planned in water that is 18 inches or more in depth? ☐ Yes ☐ No
(if yes, a swimming permission slip is required)

Child's Information

Child's Name

My child is
☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 8 years and/or over 4' 9"

Signature

I grant permission for my child to participate in the routine trips described above.

Parent's Signature	Date

lakewood
community
child care

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Ages and Stages

We here at Lakewood Community Care Center use a screening tool called Ages and Stages. We ask for all of our families to complete the ages & stages questionnaire for each of their children at key times in their child's development. The ASQ forms will be provided by your child's teacher. Your child's teacher will review your screening of your child and discuss goals for enhanced development for your child's growth at parent/teacher conferences held throughout the year.

Ages & Stages: the 4-60 month of age system covers five developmental areas: Communication, Gross Motor, Fine Motor, Problem Solving, and Personal-Social

I understand and agree with this screening/assessment procedure.

Name : _____ *Date:* _____

GUARANTOR

The Guarantor named below is managing the financial resources of the Enrollee.

The undersigned Guarantor (Guardian/Responsible Party/Legal Representative/Surrogate) agrees to guarantee payment for all enrollee's financial obligations to the The Center, as set forth in the enrollment handbook.

Enrollee's Name:_____
Guarantor's Name:_____
Address:_____
Home Phone:_____ Work Phone:_____
SSN:_____ Cell Phone:_____
DOB:_____
Current Employer:_____

Guarantor has the following relationship with Enrollee:

_____Trustee _____Guardian _____Next of Kin _____Parent

Guarantor agrees to allow The Center to make a copy of his/her driver's license or other governmental photo identification. **INITIAL:**_____

Guarantor certified that to the best of their knowledge, Enrollee's funds will be available to meet the terms of the rates established in the enrollment handbook indefinitely, or until a date specified :_____.
INITIAL:_____

Guarantor agrees to give The Center **IMMEDIATE WRITTEN NOTIFICATION** if any of the above information changes or he/she no longer can carry out the duties of Guarantor for the Enrollee.

_____ _____
SIGNATURE DATE

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Facebook Photo Release

(Please initial next to the appropriate statement)

_____ ***I give*** *Lakewood Community Care Center permission to take and share photos of my child to the LCCC Parent Facebook group.* ***(This is a private page in which only current parents of LCCC may request to join)***

_____ ***I DO NOT give*** *Lakewood Community Care Center permission to take and share photos of my child to the LCCC Parent Facebook group.*

Parents Name: (Please Print neatly)

_____

Parent's Signature:

_____

Date signed: _____

Child's First and Last Name: _____

We must receive a separate form for each child enrolled, thank you!

2019 Woodward Avenue Lakewood Ohio 44107 (216) 226-0080

lakewood community child care

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Website Photo Release

(Please initial next to the appropriate statement)

_____ ***I give*** *Lakewood Community Care Center permission to take and share photos/name of my child on the LCCC website.* ***(LCCC website is not a private and it can be found in Google browser)***

_____ ***I DO NOT give*** *Lakewood Community Care Center permission to take and share photos/name of my child on the LCCC website.*

Parents Name: (Please Print neatly)

_____

Parent's Signature:

_____

Date signed: _____

Child's First and Last Name: _____

****We must receive a separate form for each child enrolled, thank you!****

2019 Woodward Avenue Lakewood Ohio 44107 (216) 226-0080

COVID 19 PROTOCOL

Amendment- Handbook (Rev. 06/01/2020)

We are excited and looking forward to re-opening Lakewood Community Care Center!!! Along with our excitement, of course come precautions to keep everyone safe and healthy. In an effort to keep our children, families, and staff safe and healthy, we are implementing the following protocols at the center:

- Staff will have their temperature taken upon arrival for work.
- Anyone who displays signs and symptoms that include: cough, shortness of breath, difficulty breathing, fever (100 degrees or above), chills, repeated shaking with chills, muscle pain, headaches, sore throat, and new loss of taste or smell will be sent home immediately.
- Staff and/or children must be fever free/symptom free for 48 hours without fever-reducing medicine to be able to return back to the center.
- Staff and/or children, who have been diagnosed with COVID-19, will require shutdown for the class room for that particular case.

Drop Off/Pick Up

We will be conducting "curbside" drop off and pickup to reduce contact with the families.

- When arriving in the turn around, please call (216) 226-0080 and we will send a staff member out. Parents are responsible for securing their child (ren) in and out of their car seat. Please wear a mask while doing this.
- One staff member will pick up/drop off child from and to the car.
- Staff member will sign child (ren) in/out.
- Child (ren) will have temperature taken upon arrival.
- Staff will also perform a symptom assessment for each child (ren) arriving to the center.
- Upon arrival and departure, children are required to wash their hands in their designated classroom.

Please do not get out of your car while another family is being serviced. Please wait until staff arrive to your car before taking your child(ren) out of their car seat.

Daily Responsibilities

All children must follow hand washing procedures when engaging in the following activities:

- Upon arrival and departure
- After toileting or diaper changes
- After blowing nose
- Contact with bodily fluids
- After playing with "selected" toys

Staff will sanitize non-porous toys and surfaces after each use. Toys that cannot be sanitized (play dough, soft toys, etc.) will not be used for play.

Bathrooms will be sanitized after each use. This includes sinks, door knobs, toilet handles and toilet seats.

Staff will sanitize non-porous toys and surfaces after each use. Toys that cannot be sanitized (play dough, soft toys, etc.) will not be used for play.

Bathrooms will be sanitized after each use. This includes sinks, door knobs, toilet handles and toilet seat.

If we experience a case of positive Covid we register the information into the state data base of Ohio Child Licensing and Quality System. We contact Cuyahoga Health Department and follow the required protocol. Each case will handle different based on the circumstances.

Regarding the families affected by the quarantine and tuition:

This is an event beyond the control of the center as this a force majeure. Therefore the center is not obligated to credit paid tuition.

Thank you for your patience and understanding as we are adjusting to these changes. If you have any questions or concerns, please contact us at (216) 226-0080 or email us at lakewoodccc@ohiocoxmail.com.

COUPON

Today's Date: _____

This coupon entitles, _____, to _____ absent day(s) free of charge. You may use a maximum of two (2) or three (3) days if part-time or a maximum of five (5) days if full-time

Please be sure to return this coupon to the office so that it can be credited to your account.

This coupon will then be placed in your child's file to enable us to keep track of how many coupons have been issued. The coupon is good for one year from the date you used your first coupon.

Thank You,

Pam

Date(s) Used: _____

Parent Signature: _____

COUPON

Today's Date: _____

This coupon entitles, _____, to _____ absent day(s) free of charge. You may use a maximum of two (2) or three (3) days if part-time or a maximum of five (5) days if full-time

Please be sure to return this coupon to the office so that it can be credited to your account.

This coupon will then be placed in your child's file to enable us to keep track of how many coupons have been issued. The coupon is good for one year from the date you used your first coupon.

Thank You,

Pam

Date(s) Used: _____

Parent Signature: _____