

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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
<b>Emergency Contacts:</b> Parents <b>cannot be listed</b> as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness <b>if you cannot be reached</b> . 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 <b>or medical personnel</b> 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? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> No (If no, fill out the following)
The program's policy is to check diapers every <u>  2  </u> hours. Please indicate if you want your child's diaper checked according to the program's policy or another:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

**Emergency Transportation Authorization**

<b>Give <u>Permission</u> to Transport</b>	<b>OR</b>	<b><u>Do Not Give Permission</u> to Transport</b>
Program or Home Name Kids Encounter Preschool & Davcare	<b>OR</b>  <b>Do not sign both</b>	Program or Home Name Kids Encounter Preschool & Davcare
<b>has permission</b> 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.		<b>does not have permission</b> 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 _____

<b>Acknowledgement of Policies and Procedures</b>
I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>

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.



## Permission Form

I give my permission for my child, \_\_\_\_\_ to participate in The Kids Encounter Summer Camp at Encounter and to be involved in any and all activities and field trips scheduled and unscheduled. Scheduled and unscheduled field trips will take place away from the church building but always as a group with proper adult supervision. These activities include but are not limited to: movies, water parks, zoos, factories, parks, stadiums and museums. These activities may require your son/daughter to be transported on Encounter owned vehicles. Please complete and sign the following form to serve as the permission slip for all activities and transportation.

### HOLD HARMELSS AGREEMENT

I understand that participation in the summer camp involves a certain degree of risk. I have carefully considered the risk of involvement and have given consent for my child to participate in all activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release Encounter, Kids Encounter Summer Camp, the activity coordinators, and all employees, volunteers, related parties, and other organizations associated with the summer camp from any and all claims or liability arising out of this participation.

In case of an emergency involving my child, I understand every effort will be made to contact me. In the event these attempts prove unsuccessful, I hereby give my permission to the medical provider selected by the adult leader in charge to secure, at my expense, proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for the purposes of medical evaluation of the participant, follow up and communication with the participant's parents or guardian, and/or determination of the participants ability to continue in the program activities.

By signing this form you assume the entire responsibility and liability for losses, expenses, damages, demands and claims based on any sustained or alleged to have been sustained by Encounter, its agents, servants and employees from any and all such losses, expenses, damages, demands and claims.

Parent Name (Print): \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_