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 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
«First_Name» «Last_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.

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."

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? X 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 YMCA of Central Ohio			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. X 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.

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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")*	
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	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
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
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
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

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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	Exact Dosage

To be administered at the following times	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

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.

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

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.

Name:
Grade and School:
Locations:
Swimming ability:
Any additional info:

The YMCA of Central Ohio 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.
«The_YMCA_of_Central_Ohio_has_permission_»

* I understand that the Parent Handbook can be viewed and downloaded at ymcacolumbus.org/child-care/sdo/hilliard, and I acknowledge that the YMCA has met its obligation to inform me of its policies and procedures by providing me with the Handbook. I understand that if I have a question regarding a specific area of content in the Handbook, a YMCA staff member will clarify the area for me.
* I agree to follow all program policies as stated in the YMCA Parent Handbook, with special attention to the following areas: Guidance Policy, Fees and Collection Policies, and Supervision/Safety Policy. I have reviewed the YMCA Employee Code of Conduct Review for Parents that is included in the Parent Handbook.
* I am aware that certain activities are physically demanding. (If you have concerns regarding your child's abilities to participate fully, please contact the Site Director.) I have noted that the most activities are conducted outside, in all kinds of weather. I will send my child to the program with the appropriate equipment, such as rain gear, sturdy shoes, protective clothing, sunscreen, water bottles, etc. I further understand that equipment, clothing, backpacks, coolers, etc. will experience heavy wear and tear. I understand that both my child and their belongings may come home wet, dirty, muddy, and tired.
* I understand that money, video games, toys, electronic devices, cell phones, trading cards, jewelry, and personal sporting equipment are not to be brought to the program. I understand that the YMCA is not responsible for their loss or misplacement.
* I understand that clothing, towels, shoes, coolers, swimsuits, and water bottles will be marked with the child's name. I understand the YMCA is not responsible for their loss or misplacement.
* I understand that my child may not be released to anyone without prior written documentation and presentation of a valid photo identification.
* I understand that the YMCA staff cannot withhold a child from a biological or custodial parent without legal documentation (i.e. court orders, custody papers, etc.)
* I understand my child will be expelled from the program if he/she is found to be in the possession of knives, kitchen cutlery, guns, pocket knives, or weapon of any sort. In addition, I understand that my child may be expelled if me, any member of my family or my child verbally or physically threatens another participant or staff.
* I understand that any and all prescription medicine to be administered by program staff must be sent to the program in a current prescription bottle. I understand that over the counter medications must be sent in their original container. I understand that camp personnel may only administer medication as it is prescribed on the proper container.
* I understand some specific hazards that may be encountered during the course of a normal program day may include: slipping or falling, insect bites, ticks, poison ivy, or bodily injury. I understand and recognize the element of risk inherent in any adventure program, sport, or activity associated with the outdoors. I certify that my child is capable of participation in all of the daily activities and I agree to reinforce the established safety rules and procedures.
* I understand that credits will not be issued for any absences. Credits will only be issued for program closings due to severe weather or other facility closings where other arrangements have not or could not be made by the YMCA.
* I understand that the YMCA is not responsible for and discourages employees from providing paid care and custody for a YMCA participant under the age of 18 outside of a YMCA Program (i.e. babysitting).
* The information given in the registration and medical information paperwork is correct and complete to the best of my knowledge and the person herein described has permission to engage in all activities in the program, except as noted. (all necessary and important medical information regarding my child has been documented on the medical forms provided in the registration paperwork.)
* I understand that there will be a lifeguard on duty when my child is swimming and will be asked to perform a swim test if desired to enter the deep end of the pool.
* I give my permission for my child to take part in the field trips provided by the program. I understand that my child will walk, or be transported by YMCA vans or busses.
* I understand YMCA staff may photograph or video record my child for YMCA promotional or onsite activity purposes.
* I agree to hold harmless the YMCA, its agents and employees for all incidents alleging bodily injury or property damage or loss occurring while the person herein described is a participant at a YMCA sponsored activity on or off the YMCA premises. I will not hold harmless the YMCA from any liability arising out of negligence of the YMCA.

Sign and Date: