



Start Date	_____
Rate	_____
Reg. Fee	_____
Discount	_____
Full/Part Time	_____

# Infant Enrollment Packet



*Liberty Township*

6532 Princeton-Glendale Road  
Liberty Township, OH 45011  
513.863.3001

<https://kidsrkids.com/liberty-township/>



*Maineville*

6493 South State Route 48  
Maineville, OH 45039  
513.583.8899

<https://kidsrkids.com/maineville/>



*West Chester*

9077 Union Centre Blvd.  
West Chester, OH 45069  
513.860.5437

<https://kidsrkids.com/west-chester/>

**New Year, New Look & New Beginnings! Visit Us Today!**



*Mason*

7439 Mason Montgomery Rd.  
Mason, OH 45040  
513.398.9944

<https://kidsrkids.com/mason/>



*Fairfield*

8750 Holden Blvd.  
Fairfield, OH 45014  
513.870.0696

<https://kidsrkids.com/fairfield-ohio/>

# Enrollment Application

Entrance Date \_\_\_/\_\_\_/\_\_\_

Withdrawal Date \_\_\_/\_\_\_/\_\_\_

## Child

Child's Full Name \_\_\_\_\_ Age \_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Child's Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

## Parent/Guardian(s)

Parent/Guardian Name \_\_\_\_\_  Parent  Guardian

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Business Phone \_\_\_\_\_

Employment Address \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_  Parent  Guardian

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Business Phone \_\_\_\_\_

Employment Address \_\_\_\_\_

Marital Status:  Married  Separated  Divorced  Widowed  Other \_\_\_\_\_

Child's Legal Guardian(s):  Both parents/guardians  Mother  Father  Other \_\_\_\_\_

Child's Living Arrangements:  Both parents/guardians  Mother  Father  Other \_\_\_\_\_

## Emergency Contacts

The child may be released to the person(s) signing this agreement or to the following with photo ID:

Name	Address	Telephone	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

Emergency contact(s) when parents cannot be reached:

Name	Address	Telephone	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

Doctor to be contacted when parents cannot be reached:

Name	Address	Telephone
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_

Date



- Distribution**
- Child's File
  - Transportation Log
  - Field Trip Log (School-Age Only)

## Health and Emergency Permission

This form must be completed for all enrolled children annually and as changes occur

Child			
Child's Full Name _____		Age _____	Gender _____
Date of Birth ____/____/____		Child's Home Address _____	
Home Phone _____			
Parent/Guardian(s)			
Parent/Guardian Name _____		Phone 1: _____	Phone 2: _____
Parent/Guardian Name _____		Phone 1: _____	Phone 2: _____
Medical Information			
Doctor to be contacted when parents cannot be reached:			
Name _____	Full Address _____	Telephone _____	
Dentist:			
Name _____	Full Address _____	Telephone _____	
Health Insurance Provider:			
Name _____	Full Address _____	Telephone _____	
Does your child have special needs affecting participation in school activities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Specify: _____			
Does your child have allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is your child on prescribed medication for Illness/Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Specify: _____			
Actions Taken: _____			
Weight of Child: _____			
Emergency Contacts			
The child may be released to the person(s) signing this agreement or to the following with photo ID:			
Name _____	Address _____	Telephone _____	Relationship _____
Emergency contact(s) when parents cannot be reached:			
Name _____	Address _____	Telephone _____	Relationship _____

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Owner/Director Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



## **Parental/Guardian Agreement with Kids 'R' Kids Liberty Township**

Below is a breakdown of the policies and procedures at our school. Our goal is to create a partnership between our program and your family. We have implemented the following policies and procedures at the school to provide the highest quality early education experience. The three most important things we need from our families is:

### **Partnership, Communication and Patience.**

These are the highlights of our policies and procedures that we have found come up more often. A full list of our policies and procedures are available in our parent handbook.

Please initial each section below to ensure there is a clear understanding.

**Child Name:**

**Date of Birth:**

**General (Please initial)**

\_\_\_\_\_ I understand that Kids 'R' Kids of Liberty Township, a Kids 'R' Kids franchise, is independently owned and operated and that neither Kids 'R' Kids International, nor any other Kids 'R' Kids is responsible for the actions or obligations of this school.

\_\_\_\_\_ I agree to provide Kids 'R' Kids with all information about my child's needs. If my child has an Individual Education Plan, I will share all paperwork with the school director to ensure that Kids 'R' Kids is able to meet the needs of my child. I understand that Kids 'R' Kids can make changes to my child's enrollment at any time.

\_\_\_\_\_ I understand that it is my responsibility to escort my child into and out of the school and to sign my child in and out of the school. I understand that all children must be picked up by a person, 18 years or older. I understand that a staff member will escort my child into the school when being transported to school by Kids 'R' Kids transportation.

\_\_\_\_\_ If I have not picked up my child 30 minutes after closing, and all attempts to contact my emergency contacts and me fail, Kids 'R' Kids will call the proper authorities.

\_\_\_\_\_ I understand that it is my responsibility to keep the school advised of any changes to the information provided in this application.

**Health and Safety (Please Initial)**

\_\_\_\_\_ I agree to follow all requirements of the school's medical policy.

\_\_\_\_\_ My child **IS or IS NOT** (Circle One) currently on medication(s) prescribed for "long term" continuous use and/or has the following pre-existing illness, allergies, or health concerns: Please list any medications and/or conditions. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_, I agree to provide the school with all necessary information pertaining to the administration of medication (date, prescription#, doctor's notes, direction, medication in original pharmaceutical container, etc.}.

\_\_\_\_\_, I understand that if my child is ill, including, but not limited to, a severe cough or sore throat, undetermined rash or spots, temperature over 100.4 degrees, severe headaches, upset stomach and/or diarrhea, he or she cannot be accepted into the school until well. In the event my child has a notifiable disease, a release form from a medical source may be required before my child re-enters the school. Kids 'R'. Kids will notify parents if a notifiable disease has been introduced into the school and guidelines will be followed per the CDC Chart/Health Dept.

\_\_\_\_\_ Children must be symptom free for 24 hours unless otherwise recommended by a doctor, before returning to school.

\_\_\_\_\_, I understand that when I am notified that my child is sick, I must pick up within 45 minutes.

\_\_\_\_\_ In the event that a child is found with living lice or knits, the child will be sent home for treatment. After treatment, the child may return to the school with the understanding that the child will be retreated in 7-10 days of the initial treatment.

\_\_\_\_\_ Should (child's name) \_\_\_\_\_ (Date of birth) \_\_\_\_\_ suffer any injury or illness while in the care of Kids R Kids Liberty Township and the facility is unable to contact me immediately, it shall be authorized to secure medical attention and care for the child as may be necessary.

(Parents name) \_\_\_\_\_ shall be responsible for payment of services.

**Financial: (Please Initial)**

\_\_\_\_\_ Hours of Operation 6:30 am - 6:30 pm Monday- Friday

\_\_\_\_\_ Tuition payments made after close of business Monday will be assessed a \$50.

\_\_\_\_\_ There will be a \$6 service fee for all credit card transactions.

\_\_\_\_\_ Please refrain from using cash for any transactions.

\_\_\_\_\_ Weekly Supply Fee, per child \$5

\_\_\_\_\_ Any check or tuition payment returned will be charged a NSF fee of \$50.

\_\_\_\_\_ Registration fee of \$200 (One child) & \$250 (Family)

\_\_\_\_\_ All students will be subject to an initial registration fee upon enrollment. (Non-Refundable)

\_\_\_\_\_ Late Pick Up Fee starting at 6:31PM is \$25.00 dollars.

\_\_\_\_\_ Two weeks' 1 written notice via email is required to disenroll your child. Should a 2 week notice not be provided, your account will be billed accordingly.

\_\_\_\_\_ Tuition includes, breakfast, snack & lunch

**Holidays:** Our published tuition takes into consideration of the following holidays or events for which we are closed. We will be closed on the following holidays: New Year's Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day and the Friday after Thanksgiving, Christmas Eve and Christmas Day. We close at 2pm on New Year's Eve. If the Holiday falls on the weekend, we will observe the day prior. Additionally, our school will close 2 additional days for teacher training.

**Vacation Credit:** All families will be awarded one half week credit after their first 6 months of continuous enrollment. Families will be awarded two half weeks of credit upon their one- year anniversary.

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



**Distribution**

- Infant/Toddler Classroom Forms
- Preschool/School-Age Classroom Forms
- Kitchen Log
- Child's File

### Child Allergy Profile

Update annually or as child's information changes

Child's Full Name: \_\_\_\_\_ Suite: \_\_\_\_\_

Please list any known allergies:

\_\_\_\_\_

Symptoms of Allergic Reaction:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Care Plan:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Owner/Director Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



Distribution
• Child's File

Release

For and in consideration of the opportunity to have my minor child's name, voice, picture, portrait, artwork and/or likeness published and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the undersigned, on behalf of myself and my minor child, hereby agree as follows:

1. I hereby grant Kids 'R' Kids International, Inc., Kids 'R' Kids # \_\_\_\_\_, and its affiliates, franchisees, nominees, licensees, successors and assigns and those acting under their permission (hereinafter "KRK"), the unrestricted, absolute, perpetual, worldwide right to:

a. use my and my minor child's name, voice, picture, portrait, artwork and/or likeness, however obtained;

b. reproduce, copy, modify, alter, edit, publish, use, create derivatives in whole or in part, without limitation, my and my minor child's image, picture, portrait, artwork and/or likeness in still and/or video photography, film or tape taken of me or my minor child by or on behalf of KRK.

c. display, exhibit, distribute, transmit or broadcast the above or any part thereof; in any project or medium, whether now or hereafter existing, including, without limitation printed publications, television, radio, the internet, any online service or website, blog or social media, including, without limitation: Twitter, Facebook, Instagram, any number of times and for any purpose, including, without limitation, promotional, advertising and marketing purposes.

2. I agree that any picture, portrait, artwork or other product or material derived there from is wholly owned by KRK and that KRK may copyright any product or material containing same. If I receive any copy thereof, I shall not use it for any purpose nor authorize its use by anyone else.

3. I hereby waive my right to inspect and/or approve the finished product or material, or to the eventual use that it might be applied.

4. I hereby release and discharge KRK from and against any claim or liability arising out of invasion of privacy, right of publicity, defamation, portrayal in a false light, misappropriation, and copyright infringement arising out of or in connection with the use of materials referenced hereunder, including without limitation the use of my or my minor child's name, voice, picture, portrait, artwork and/or likeness in any manner authorized by this Release, whether now known or arising in the future.

5. I hereby warrant that I am eighteen years old or older and am the parent and/or legal guardian of the minor child named below and am competent to contract for the minor child named herein as the above is concerned. I have read the foregoing release and warrant that I fully understand the contents hereof. I agree that this Release is intended to be as broad and inclusive as permitted under the laws of the State of Georgia, and that if any portion thereof is held to be invalid, that the balance shall continue in full force and effect.

6. This Release constitutes an Agreement between myself and KRK and contains the entire understanding between myself and KRK regarding the subject matter hereof. This Release cannot be modified except in a writing signed by all parties hereto and shall be governed in accordance with the laws of the State of Georgia.

Child's Full Name

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.





**Distribution**  
 •Child's File  
 •Infant/Toddler Classroom Forms  
 •Pre-School/School-Age Classroom Forms

### Child Profile

For children ages 1 and up  
 A new form is required with each classroom transition

This profile will help your child's teacher get to know your child better. Your input will also help with your child's adjustment to the new classroom.

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Parent/Guardian's Name: \_\_\_\_\_  
 (Please Print)

1. List any nicknames your child may have. \_\_\_\_\_

2. Has your child had previous group care experiences?  Yes  No

3. What language(s) is spoken in your home? \_\_\_\_\_

4. List the names and ages of siblings.  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Do you have pets at home?  Yes  No If yes, please list type of pet and name.  
 \_\_\_\_\_

6. What words are spoken in your home to describe everyday things (I.e. toileting, nap, eat, play and outside)?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_/\_\_\_/\_\_\_  
 Date



**Distribution**

- Infant/Toddler Classroom Forms
- Front Desk Forms

\_\_\_\_\_  
(Month)

**Infant Feeding Plan**  
For children ages 6 weeks-12 months

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Instructions to Parents/Guardians:**

- Bottles must be pre-mixed (if applicable), labeled with child's full name, current day's date and ready to be served.
- Disposable Nurser Bags must be refrigerated or frozen, stored only with the amount of milk for one feeding, labeled with the child's full name, and date of collection.
- Update diet information as needed or every 30 days. Use a new form or initial/date changes on this form.

Does child feed self?  Yes  No

Child's diet includes (check all that apply):

- |             |                          |                |                          |
|-------------|--------------------------|----------------|--------------------------|
| Formula     | <input type="checkbox"/> | Juice          | <input type="checkbox"/> |
| Breast Milk | <input type="checkbox"/> | Baby Foods     | <input type="checkbox"/> |
| Whole Milk  | <input type="checkbox"/> | Strained Foods | <input type="checkbox"/> |
| Water       | <input type="checkbox"/> | Table Foods    | <input type="checkbox"/> |

Formula type: \_\_\_\_\_  
 Bottle's Formula Amount: \_\_\_\_\_  
 Breast Milk Storage:  Bottles  Disposable Nurser Bags  
 Bottle's Breast Milk Amount: \_\_\_\_\_  
 Bag's Breast Milk Amount: \_\_\_\_\_

Food Likes: \_\_\_\_\_  
 Food Dislikes: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Restrictions: \_\_\_\_\_

Feeding	Time of Day	Type and Approximate Amount of Food

**Additional Instructions** (i.e. for the introduction of solid foods, dietary changes):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I understand it is my responsibility to keep Kids 'R' Kids # \_\_\_\_\_ updated, in writing, as my child's needs change or **every 30 days**, and that it is Kids 'R' Kids policy that bottles are held, not propped, during feeding & that bottles are discarded within an hour after warmed. Unused breast milk will be sent home. Not discarded.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



**Distribution**  
 • Child's File  
 • Infant/Toddler Classroom Forms

## Infant Child Profile

For children ages 6 weeks-12 months

A new form is required with each classroom transition and should be updated as information changes.

This profile will help your child's teacher get to know your child better. Your input will also help with your child's adjustment to the new classroom.

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Parent/Guardian's Name: \_\_\_\_\_  
 (Please Print)

1. Has your child had previous group care experiences?  Yes  No
2. What language(s) is spoken in your home? \_\_\_\_\_
3. List the names and ages of siblings.  
 \_\_\_\_\_  
 \_\_\_\_\_
4. Do you have pets at home?  Yes  No If yes, please list type of pet and name.  
 \_\_\_\_\_
5. What milestone(s) has your child reached? (I.e. rolling over or crawling)  
 \_\_\_\_\_  
 \_\_\_\_\_
6. Does your child take a pacifier?  Yes  No When? \_\_\_\_\_
7. How often and how long does your child nap? \_\_\_\_\_
8. How many hours does your child sleep at night? \_\_\_\_\_
9. List any additional care plan instructions, i.e. diapering or sleeping \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_/\_\_\_/\_\_\_  
 Date

*This form was developed by Kids 'R' Kids International, Inc. It's important to review State Guidelines regularly to ensure compliance.*



**Distribution**

- Child's File
- Transportation Log

### Transportation Agreement

The following information is required to be updated by Kids 'R' Kids annually and when transportation situation changes

Child's Full Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

**Kids 'R' Kids (Liberty Township, Fairfield, West Chester, Maineville, Mason) emergency transportation/medical procedure:**

1. Call emergency medical team, if necessary
2. Contact parent/guardian (phone, email, text)
3. Contact alternate emergency contact, if necessary
4. Emergency medical team transports child to hospital.
5. Kids 'R' Kids representative will accompany child to hospital.

Emergency Medical Facility the center uses: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

I, \_\_\_\_\_ give permission for Kids 'R' Kids \_\_\_\_\_ to seek medical attention and /or transport my child \_\_\_\_\_, in the event of any emergency. I further agree to hold harmless and release Kids 'R' Kids \_\_\_\_\_ and Kids 'R' Kids International, Inc. from all liability. I further agree to keep the facility informed of any changes in the information below.

**For School Age Use Only:** *If the child relocates to another school or the hours change, this form must be updated immediately*

Name of School: \_\_\_\_\_

School Address: \_\_\_\_\_

School Phone: \_\_\_\_\_

- In the event the designated location is unable to receive children they will be returned to Kids 'R' Kids \_\_\_\_\_.
- It is vital that Kids 'R' Kids \_\_\_\_\_ be notified of any changes in the above scheduled transportation.
- Kids 'R' Kids \_\_\_\_\_ will assume the above schedule of transportation will be followed unless we receive different instructions from parents in writing. Instructions should be received at Kids 'R' Kids \_\_\_\_\_ by the earliest possible time before scheduled pickup or drop off.

I, \_\_\_\_\_ agree for my child to be transported by Kids 'R' Kids \_\_\_\_\_

To school at \_\_\_\_\_ (am/pm)

From school at \_\_\_\_\_ (am/pm)

**On the following days: Monday Tuesday Wednesday Thursday Friday**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner/Director Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

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 #1			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip		
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information 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 #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip		
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information 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 <u>at least one person</u> 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 able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name			Name		
City		State	City		State
Telephone Number		Relationship to Child	Telephone Number		Relationship to Child
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State	Telephone Number		

Child's Name

**Allergies, Special Health or Medical Conditions, and Medical Foods**

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

- No  
 Yes - *check all that apply*     Food     Medication     Environmental    Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

- No  
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

- No  
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

- No  
 Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

- No  
 Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

- No  
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

- No  
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No  
 Yes - written instructions from the child's health care provider must be on file.  
 N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Child's Name \_\_\_\_\_

**Diapering Statement**

Is your child toilet trained?  Yes (If yes, skip to Emergency Transportation Authorization section)  
 No (If no, fill out the following:)  
 The program's policy is to check diapers every 2 hours. Please indicate if you want your child's diaper checked according to the program's policy or another:  
 I agree with the program's schedule       I do not agree, please check my child's diaper every \_\_\_\_\_ hours.

**Emergency Transportation Authorization**

<b>Give <u>Permission</u> to Transport</b>	<b>OR</b>  <b>Do not sign both</b>	<b>Do Not Give <u>Permission</u> to Transport</b>
Program or Home Name Kids R Kids		Program or Home Name Kids R Kids
<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 _____

**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, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.



Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT FOR CHILD CARE**

Child's Name ( <i>print or type</i> )	Date of Birth
---------------------------------------	---------------

**Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):**

**Section A- EXAMINATION**

- The above named child has been examined.
- The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).
- The above named child does not have allergies OR is allergic to the following (*please list in space below*):

*Check below, if applicable:*

Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

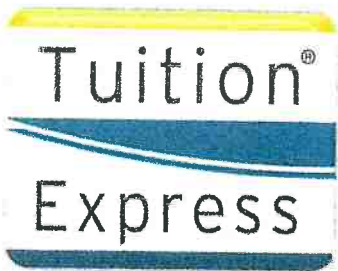
Height _____	Vision _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lead _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight _____	Hearing _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemoglobin _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BMI _____	Dental _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

**ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.**

<p><b>IMMUNIZATION (Complete ONLY ONE SECTION below)</b></p> <p><b>Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:</b> Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.</p>	
<p><b>Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:</b></p> <p><input type="checkbox"/> The above named child has been immunized against the diseases listed above.</p> <p><i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i></p>	<p>Initials of Examining Health Care Practitioner</p> <hr/> <p>Date</p> <hr/>
<p><b>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</b></p> <p><input type="checkbox"/> I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):</p>	<p>Signature of Parent</p> <hr/> <p>Date</p> <hr/>



# Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® – a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

## ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR **BANK ACCOUNT** and **CREDIT CARD**

I (we) hereby authorize (business name) \_\_\_\_\_ to initiate credit card charges to the below referenced credit card account (**Section A**) OR, initiate debit entries to my (our) Checking or Savings Account, indicated below (**Section B**). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

### COMPLETE ONE SECTION ONLY

#### SECTION A (Credit Card)

Cardholder Name _____		Phone # _____	
Cardholder Address _____	City _____	State _____	Zip _____
Account Number _____		Expiration Date _____	
Cardholder Signature _____		Date _____	

#### SECTION B (Bank Account)

Your Name _____		Phone # _____	
Address _____	City _____	State _____	Zip _____
Bank or Credit Union Name _____			
Bank or Credit Union Address _____	City _____	State _____	Zip _____
		<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
Routing Transit Number (see sample below) _____		Account Number (see sample below) _____	

### For Official Use Only

Date Received
Employee Signature



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