

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?					
Emergency Contacts: Parents cannot be listed 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 if you cannot be reached . 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 ____ 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 <u>Permission</u> to Transport		OR Do not sign both	<u>Do Not Give Permission</u> to Transport	
Program or Home Name Hosanna Lutheran Childhood Center			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			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, 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 (<i>please list in space below</i>):	
<i>Check below, if applicable:</i>	
<input type="checkbox"/> 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
Weight _____	Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
BMI _____	Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	Other: _____
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.

IMMUNIZATION (Complete ONLY ONE SECTION below)	
Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:	
Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.	
Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:	Initials of Examining Health Care Practitioner
<input type="checkbox"/> The above named child has been immunized against the diseases listed above.	
<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>	
	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):	Signature of Parent
<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):	
	Date

HOSANNA LUTHERAN CHILDHOOD CENTER AUTHORIZATION FOR RELEASE

Child's Name: _____ Birthdate: ___/___/___

Parent's Name (printed): _____

Class: Pre-K 2 Day ____ 3 Day ____ 5 Day ____
 (Room A, B, C)

 Preschool 2 Day AM ____ 2 Day PM ____
 (Class D) 3 Day AM ____ 3 Day PM ____
 5 Day AM ____ 5 Day PM ____

The following people have authorization to pick up my child from Hosanna Lutheran Childhood Center.

Note: Both parent/guardians and emergency contacts on page one of ODJFS form 01234 Child Enrollment & Health Information form do not need to be included here. They will automatically be authorized to pick up your child, unless otherwise shared with the director. Include here only ALTERNATE individuals (not parent/guardian or emergency contacts) who may also pick up your child.

1. _____ Phone (____) ____ - _____

2. _____ Phone (____) ____ - _____

3. _____ Phone (____) ____ - _____

4. _____ Phone (____) ____ - _____

5. _____ Phone (____) ____ - _____

6. _____ Phone (____) ____ - _____

I understand that if changes need to be made that it is my responsibility to contact the preschool administrator.

Parent/Guardian Signature: _____

Date: ___/___/___

HOSANNA LUTHERAN CHILDHOOD CENTER AUTHORIZATION FOR PHOTOGRAPHS

Child's Name: _____ Birthdate: ____/____/____

Parent's Name (printed): _____

Class: Pre-K 2 Day ____ 3 Day ____ 5 Day ____
 (Room A, B, C) .

 Preschool 2 Day AM ____ 2 Day PM ____
 (Class D) 3 Day AM ____ 3 Day PM ____
 5 Day AM ____ 5 Day PM ____

CHOOSE ONE ONLY:

_____ I grant permission for my child to be photographed while attending Hosanna Lutheran Childhood Center. I also understand that photographs of my child could appear in newsletters, local newspapers, and/or the HLCC website to promote Hosanna Lutheran Childhood Center.

_____ I grant permission for my child to be photographed while attending Hosanna Lutheran Childhood Center. I understand that my child will ONLY appear on the locked/password protected HLCC website for parents only (WEBSITE ONLY).

_____ I refuse to grant permission for my child to be photographed while attending Hosanna Lutheran Childhood Center. I also understand that NO photographs will appear in newsletter, local newspapers, and/or the HLCC website to promote HLCC (NO PHOTOS).

Parent/Guardian Signature: _____

Date: ____/____/____

HOSANNA LUTHERAN CHILDHOOD CENTER AFTER CARE REGISTRATION

Child's Name: _____ Birthdate: ____/____/____

Parent's Name (printed): _____

Cost

- \$6.00 per hour, billed in full hour increments only.
- \$15.00 per day for students in Pre-K for the full session 2-5 p.m.

Pre-K	Monday	Tuesday	Wednesday	Thursday	Friday
2-3 p.m. (1 Hour)					
2-4 p.m. (2 Hours)					
2-5 p.m. (3 Hours)					

Preschool (PM Only)	Monday	Tuesday	Wednesday	Thursday	Friday
3-4 p.m. (1 Hour)					
3-5 p.m. (2 Hours)					

Billing

- Students registered for regular after-care will have their full year of fees calculated, divided according to the number of tuition payments remaining, and added to each tuition invoice as a separate line item.
- Standard HLCC payment and withdrawal (30-day notice) policies will apply. Sibling and pay in full discounts are available for after-care services. Church activity rebate is not available for after-care services at this time.
- If school is cancelled, after-care is also cancelled. Credit for days closed will be applied to the oldest open invoice, or held on account for the next issued invoice.

Pickup & Late Pickup Fees

- Doors will close/lock at five minutes after the hour. Doors will be open at 2:45 (during PM preschool pick up) to 3:05 p.m., 3:55 p.m. to 4:05 p.m., and 4:55 p.m. for final pickup time.
- After the five-minute grace period at 3 p.m. and 4 p.m., the family will be charged for the next hour of care at \$6 per hour (no discount rate).
- If a parent arrives after the door is locked, they must wait for staff to become available to unlock the door. This is for safety of the students and to maintain proper staff/student ratios in accordance with ODJFS policies.
- Late pickups after 5 p.m. follow standard HLCC late pick up

Parent/Guardian Signature: _____

Date: ____/____/____

**Hosanna Lutheran Childhood Center
Financial Obligation 2023-2024**

Child's Name _____

Your child is registered for:

Preschool (3 years old & completely potty-trained) Half Day Sessions AM: 9 a.m. to 11:30 p.m.
PM: 12:30 p.m. to 3 p.m.

_____ 3 Day AM Monday/Wednesday/Friday \$210/monthly payment plan or \$1,890/year
_____ 3 Day PM Monday/Wednesday/Friday

_____ 2 Day AM Tuesday/Thursday \$180/monthly payment plan or \$1,620/year
_____ 2 Day PM Tuesday/Thursday

_____ 5 Day AM Monday-Friday \$355/monthly payment plan or \$3,195/year
_____ 5 Day PM Monday-Friday

Pre-K (4 years old, kindergarten readiness) All Day Sessions 9 a.m. to 2 p.m.

_____ 3 Day Monday/Wednesday/Friday \$310/monthly payment plan or \$2,430/year

_____ 2 Day Tuesday/Thursday \$250/monthly payment plan or \$1,890/year

_____ 5 Day Monday-Friday \$510/monthly payment plan or \$4,590/year

Payment Arrangements

_____ Pay in Full \$ _____ (Discount may be available upon board approval.)

_____ Nine Month Payment Plan - Your payment schedule is as follows:

Pmt #:	Due on:		
1	August 15	6	January 15
2	September 15	7	February 15
3	October 15	8	March 15
4	November 15	9	April 15
5	December 15		

****I would like to discuss alternate payment arrangements/due dates with the bookkeeper: YES _____**

Payments are due on the 15th of every month. If they are not received by the 20th of the month, you will be charged a late fee of 20% of the outstanding balance. Please see the parent handbook for information on late payments.

**** Please note that your Enhancement Fee is due on June 15th. ****

If you choose to withdraw, you must withdraw by August 15th or Enhancement and one month of tuition will be due.

Please return this copy to HLCC.

You will receive a bill through our billing system for your Enhancement Fee in June and Tuition fees in August.

If you have any questions, please contact the bookkeeper: accounts@hlccpreschool.org

Parent Name: _____

Parent Signature: _____

Date: ____/____/____

Family Information Sheet

Child's Name (Last)	(First)	Nickname (if any)
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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.?
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)?
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)?
Describe your child's personality and behavior along with any special interests.
Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?
What are your expectations of this program?
What other information would be helpful for the staff caring for your child to know?

Parent Signature

Date

HLCC Proposed Calendar
2023-2024

Wednesday, August 23 - Parent Orientation - 6 pm

Thursday, August 24 - Parent Orientation - 6 pm

Monday, August 28 - 3-day Preschool and 3-day Pre-K Meet the Teacher Day

Tuesday, August 29 - 2-day Preschool and 2-day Pre-K Meet the Teacher Day
(Times will be given at Parent Orientation Night)

Wednesday, August 30 - 3-day Preschool and 3-day Pre-K First Day of School

Thursday, August 31 - 2-day Preschool and 2-day Pre-K First Day of School

Monday, September 4 - No School, Labor Day

Wednesday, November 22 - Friday, November 24- No School, Thanksgiving Break

Wednesday, December 20 - Tuesday, January 2 - Winter Break

Wednesday, January 3, 2023 - Students return from Winter Break

Registration is open to HLCC Alumni for the upcoming 2024-2025 school year
Monday, January 15 - No School - Martin Luther King Jr. Day

Monday, February 19 - No School - President's Day

Friday, March 22 - Monday, April 1 - Spring Break

Tuesday, April 2 - Return to school

Friday, May 3 - Family Fun Night

Monday, May 13 - 3-day Preschool and 3-day Pre-K - Last day of School

Tuesday, May 14 - 2-day Preschool and 2-day Pre-K - Last day of School

Field trips will be scheduled accordingly. All dates on this calendar are subject to change at any time.

Student Supply List for 2023-2024

Art Supplies

Pre-K (Class A, B, C)

- Crayola Glitter Glue Tubes - 2 Pkg
- Crayola Washable Markers - FAT
- Crayola Washable Markers - Thin

Preschool (Class D)

- Crayola Glitter Glue - Bottle
- Crayola Crayons - FAT
- Crayola Crayons - Regular
- Crayola Watercolors - Tray

Supplies are shared. They will not need to be labeled with your student's name.

Each classroom will have a wishing tree with bonus items needed through the school year, too!

Paper & Cleaning Supplies

To alleviate storage issues and the number of items our families need to purchase in August, we are asking you to bring paper/cleaning supplies throughout the year instead of all at once in the fall.

This list is separated by first letter of your student's last name.

For example, in **August**, with the supplies above, students with last names beginning

- A, B, C, D - paper towels & sandwich bags
- E, F, G, H - tissues & napkins
- I, J, K, L, M, N, O, P, Q, R - Clorox wipes
- S, T, U, V, W, X, Y, Z - baby wipes

We will send out and post reminders each month, and we will make slight adjustments if necessary, since this is our first year staggering our bulk paper and cleaning supplies.

	Roll of Paper Towels	Box of Tissues - Rectangle (Plain)	Clorox Wipes Round Tub (@75 Ct)	Alcohol-Free Baby Wipe Refill (@100 Ct)	500 Napkins	Ziplock Bags (Sandwich @100 Ct)
First Days	A-D	E-H	I-R	S-Z	E-H	A-D
October	E-H	I-R	S-Z	A-D	-	-
November	I-R	S-Z	A-D	E-H	S-Z	I-R
December	S-Z	A-D	E-H	I-R	-	-
January	A-D	E-H	I-R	S-Z	A-D	E-H
February	E-H	I-R	S-Z	A-D	-	-
March	I-R	S-Z	A-D	E-H	I-R	S-Z
April	S-Z	A-D	E-H	I-R	-	-