Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE CENTERS AND TYPE A HOMES

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 Center
Home Address		City
State / Zip Code	Home Telephone Number	
Parent/Guardian Name	Relationship to Child	
Home Address		
City	State / Zip	
Home Telephone Number	Cell Phone	
Work/School Telephone Number	Work/School Name	
Work/School Address	City	

Please indicate if this name should be included on a parent roster ☐ Yes ☐ No
If you answered yes, please indicate which number above to list on the roster ☐ Work number ☐ Cell number ☐ Home number

Where can you be reached while your child is in this program?

Parent/Guardian Name	Relationship to Child	
Home Address		
City	State / Zip	
Home Telephone Number	Cell Phone	
Work/School Telephone Number	Work/School Name	
Work/School Address	City	

Please indicate if this name should be included on a parent roster ☐ Yes ☐ No
If you answered yes, please indicate which number above to list on the roster ☐ work number ☐ cell number ☐ home number

Where can you be reached while your child is in this program?

Emergency Contacts: Parents <u>cannot be listed</u> as emergency contacts. List the name <u>of 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 and at least one person listed must be within one hour of the center/home and able to take responsibility for the child in case you cannot be contacted.

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 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 type A 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 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, 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

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the center/type A home'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			**OR**	***Do Not Give Permission* to Transport**	
Center or Type A Home Name				Center or Type A 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.			**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 center's or type A home's policies and procedures/handbook.

Parent/Guardian Signature	Date

Signatures

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. The administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form to indicate the date reviewed.

Parent/Guardian Signature(s)			Date
Administrator/Designee Signature			Date
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 centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A 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/PHYSICAL CARE PLAN FOR CHILD CARE CENTERS & TYPE A HOMES

This form may be used for children with health conditions as defined in Rules 5101: 2-12-38 and 5101: 2-13-38.

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

Medical Procedures to be followed and Expected Benefit of Treatment

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

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

Signature of Trainer:		**Date:**	

Signature of trained staff members and staff who have been made aware of the condition. (There must always be a trained staff member present when the child is present.)

Signature:_____ Date: _____ ☐ Staff Informed ☐ Staff Trained
Signature:_____ Date: _____ ☐ Staff Informed ☐ Staff Trained
Signature:_____ Date: _____ ☐ Staff Informed ☐ Staff Trained
Signature:_____ Date: _____ ☐ Staff Informed ☐ Staff Trained

(Only trained staff members shall be permitted to perform medical procedures listed above.) Additional staff , may sign on the backside of this form, but need to indicate "trained" and/or "informed".

Additional services (educational/therapeutic) child is receiving

Who provides the above services?
Name: _____ Phone number: _____ May we contact? ☐ No ☐ Yes
Name: _____ Phone number: _____ May we contact? ☐ No ☐ Yes

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 Signature		**Date**	

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION

Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

Box 1 - The following section must **always** be completed by the parent/guardian.

Check all that apply:

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☐ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

Complete all of the following information:

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: _____

Parent/Guardian signature: _____ Date: _____

Box 2 -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____
(name of child) (name of medication, vitamin, diet)

as follows: _____
(include dosage and instructions)

Possible side effects to watch for are: _____

Expiration date: _____ (may not exceed 12 months from the date of this request for medications or food supplements)

_____ _____ _____
Signature of physician, dentist or advance practice nurse Date of signature Phone number

Box 3 - The section below must be completed by the **center or type A home staff** and each administration of medication must be documented. **All** dosages must be recorded on the reverse side of this form.

_____ was given _____ in the amount of _____
(Name of Child) (Name of Medication, Vitamin or Diet) (Dosage)

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.