

CHURCH OF THE SAVIOUR EARLY LEARNING CENTER

REGISTRATION FORM-GREEN

Name: _____

Address: _____

City: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail Address: _____

Child's Name: _____

Age/Date of Birth: _____

Desired Start Date: _____

Days Per Week: _____

Circle one: Toddler 18 mos. - 36 mos. Pre-K 36 mos.- 60 mos.

Child's Name: _____

Age/Date of Birth: _____

Desired Start Date: _____

Days Per Week: _____

Circle one: Toddler 18 mos. - 36 mos. Pre-K 36 mos.- 60 mos.

Do you want to be part of the Parent's committee? Yes or No

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 <u>cannot be listed</u> 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 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		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	Do Not Give <u>Permission</u> to Transport	
Program or Home Name			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.

Church of the Saviour Early Learning

Diaper Changing Schedule Notice

Dear Parent/Guardian,

In compliance with the childcare licensing regulations we must document our diaper changing procedures with you. Should you have any additional needs or instructions, please indicate below.

We change diapers every two hours but check diapers every hour. So, we change diapers anytime in between hours as needed. Please sign below if you agree with our procedures or complete the written section for your child.

Child's Name: _____

_____ Yes, I agree with your diaper changing procedure.

_____ No, I do not approve. Please see my written instructions below.

If you decide a change is to be made in the future, you must complete a new form.

Parent/Guardian's Signature

Date

Staff Signature

Date

Parent's Written Instructions: _____

Church of the Saviour Early Learning Center

2537 Lee Road - Cleveland Heights, Ohio 44118

(216) 321-1685 Fax (216) 321-3019

Diaper wipes restrictions: yes ____ no ____

Note restrictions: _____

Daily Medicine: _____

Explanation: _____

If a child receives daily medications, medical treatments, or special dietary restrictions, a medical statement must be attached to this form and signed by the child's physician.

Napping Schedule: ____ a.m. ____ p.m.

Pacifier: _____

At what times during the day do you want your child to have their pacifier? Sometimes:

If your child will have their pacifier continuously throughout the day, the center requests that parents provide a pacifier attachment strap to accompany their child each day.

The Early Learning Center requests that parents leave a change of clothing at the center.

If your infant's clothes become untidy do you want your child changed? Yes ____ No ____

If so, please remember to bring a new change of clothes to the center

Parent/Guardian Signature

Date

Administrator Signature

Date

Teacher Signature

Date

**COVID 19 ACKNOWLEDGEMENT AND
WAIVER OF LIABILITY**

I, as parent/guardian of _____, and personally, acknowledge that COVID-19 is a disease spread and transmitted from person to person. I understand that such disease may be spread without the knowledge of the Church of the Saviour Early Learning Center (hereinafter "ELC"). I understand that the ELC will follow state and federal (CDC) guidelines for day care centers but such efforts may not prevent the potential spread of COVID-19 within the ELC. Recognizing the possibility of spread of COVID-19, I understand and accept the risks associated with COVID-19 to my child and my own person as part of my bringing my child to the ELC.

I, as parent/guardian of _____, and personally, hereby waive, release, discharge and/or otherwise indemnify the ELC, its employees, Church of the Saviour against any claims by or on behalf of my minor child or myself for any spread or care needed due to any COVID-19 infections arising from my child's participation with the ELC.

Signed: _____

Parent's Name Printed: _____

Signed: _____

Parent's Name Printed: _____

Parent(s) of _____

Date: _____

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

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

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:

- The above named child has been immunized against the diseases listed above.

If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):

Initials of Examining Health Care Practitioner

Date

Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):

- 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):

Signature of Parent

Date

- 14. Screen for behavioral and socio-emotional problems per "Promoting Optimal Development; Screening for Behavioral and Emotional Problems" (https://doi.org/10.1542/peds.2016-3716). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Clinical Practice Guidelines for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/Hyperactivity Disorder (https://doi.org/10.1093/peds/kpaa288). Screening for Anxiety in Adolescent and Adult Women: Assessment Recommendation From the American Psychiatric Association (https://pubmed.ncbi.nlm.nih.gov/32410956/). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See Poverty and Child Health in the United States (https://doi.org/10.1542/peds.2016-0339). The Impact of Racism on Child and Adolescent Health (https://doi.org/10.1542/peds.2019-2753) and Preventing Child Abuse and Neglect (https://doi.org/10.1542/peds.2021-052582).
- 15. A recommended assessment tool is available at <https://bit.ly/2GtZl8A>.
- 16. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 17. Addressing Adolescent Depression: A National Academies of Medicine Statement (https://doi.org/10.1542/peds.2019-2175). Addressing Adolescent Depression: A National Academies of Medicine Statement (https://doi.org/10.1542/peds.2019-2175).
- 18. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 19. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 20. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 21. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 22. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 23. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 24. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 25. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 26. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 27. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 28. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 29. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).
- 30. Screen adolescent for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death in Adolescent (https://doi.org/10.1542/peds.2016-0456) and The Impact of Suicide on Families (https://doi.org/10.1542/peds.2016-0457).

Summary of Changes Made to the Bright Futures/IAAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in December 2022. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN DECEMBER 2022

- HIV**
 - The HIV screening recommendation has been updated to extend the upper age limit from 18 to 21 years to account for the range in which the screening can take place in alignment with recommendations of the US Preventive Services Task Force and AAP Policy (Pediatrics and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis).
 - Footnote 30 has been updated to read as follows: "Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per Human Immunodeficiency Virus (HIV) Infection: Screening (https://www.uspreventivservices.org/uspsf/comm/2021/human-immunodeficiency-virus-hiv-infection-screening). After initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis (https://doi.org/10.1542/peds.2021-055207)."
- CHANGES MADE IN NOVEMBER 2021**
 - HEPATITIS B VIRUS INFECTION**
 - Assessing risk for HBV infection has been added to occur from newborn to 21 years to account for the range in which the risk assessment can take place to be consistent with recommendations of the USPSTF and the 2021–2024 edition of the AAP Red Book: Report of the Committee on Infectious Diseases.
 - Footnote 31 has been added to read as follows: "Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventivservices.org/uspsf/comm/2021/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP Red Book: Report of the Committee on Infectious Diseases, making every effort to preserve confidentiality of the patient."
 - SUDDEN CARDIAC ARREST AND SUDDEN CARDIAC DEATH**
 - Assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years to account for the range in which the risk assessment can take place to be consistent with AAP Policy ("Sudden Death in the Young: Information for the Primary Care Provider").
 - Footnote 33 has been added to read as follows: "Perform a risk assessment, as appropriate, per 'Sudden Death in the Young: Information for the Primary Care Provider' (https://doi.org/10.1542/peds.2021-052444)."
 - DEPRESSION AND SUICIDE RISK**
 - Screening for suicide risk has been added to the existing depression screening recommendation to be consistent with the GLAD-PC and AAP Policy.
 - Footnote 16 has been updated to read as follows: "Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I: Practice Preparation, Identification, Assessment, and Initial Management (https://doi.org/10.1542/peds.2017-4081). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Suicide and Sudden Death Attempts in Adolescents (https://doi.org/10.1542/peds.2016-1420) and The 21st Century Cures Act and Adolescent Confidentiality (https://www.adolescenthealth.org/advocacy/advocacy-act/act/2019-11/AASPAAG-SAHM_Statement_ABPX)."
 - BEHAVIORAL/SOCIAL/EMOTIONAL**
 - The Psychosocial/Behavioral Assessment recommendation has been updated to Behavioral/Social/Emotional Screening (annually) from newborn to 21 years to align with AAP Policy, the American College of Obstetricians and Gynecologists' (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines.
 - Footnote 14 has been updated to read as follows: "Screen for behavioral and socio-emotional problems per 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (https://doi.org/10.1542/peds.2016-3716). Mental Health Competencies for Pediatric Practice (https://doi.org/10.1542/peds.2019-2175). Clinical Practice Guidelines for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders (https://doi.org/10.1093/peds/kpaa288) and Screening for Anxiety in Adolescent and Adult Women: Assessment Recommendation From the American Psychiatric Association (https://pubmed.ncbi.nlm.nih.gov/32410956/). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See Poverty and Child Health in the United States (https://doi.org/10.1542/peds.2016-0339). The Impact of Racism on Child and Adolescent Health (https://doi.org/10.1542/peds.2019-2753) and Preventing Child Abuse and Neglect (https://doi.org/10.1542/peds.2021-052582). Partnering With Families and Communities to Promote Relational Health (https://doi.org/10.1542/peds.2021-052583)."
 - FLUORIDE VARNISH**
 - Footnote 37 has been updated to read as follows: "The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventivservices.org/uspsf/comm/2021/fluoride-varnish-and-interventions). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in Fluoride Use in Child Prevention in the Primary Care Setting (https://doi.org/10.1542/peds.2020-094627)."
 - FLUORIDE SUPPLEMENTATION**
 - Footnote 38 has been updated to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See Fluoride Use in Child Prevention in the Primary Care Setting (https://doi.org/10.1542/peds.2020-094627)."



HRSA
 Health Resources and Services Administration
 U.S. Department of Health and Human Services
 4770 Rhode Island Avenue, NE
 Washington, DC 20012
 202-205-7000
 www.hrsa.gov

Ohio Department of Job and Family Services
REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

<p>This form is to be completed for each prescription or non-prescription medication that a child needs to receive while in care.</p> <p>It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).</p>		
Child's Name	Date of Birth <i>(if needed to determine the correct dosage)</i>	Weight <i>(if needed to determine the correct dosage)</i>
<p>Box 1 The following section must always be completed by the parent/guardian.</p>		
Name of medication	Dosage <input type="checkbox"/> See attached	
To be administered at the following times	For the following period of time	Medication expiration date
<p><i>I understand:</i></p> <ol style="list-style-type: none"> 1. <i>This form expires twelve months from the date of my signature, if box 2 has not been completed.</i> 2. <i>That my child must receive at least one dose of medication at home prior to the program administering the medication (unless the medication is used for emergencies).</i> 		
Signature of Parent/Guardian		Date
<p>Box 2 The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant when any of the following apply:</p>		
<ol style="list-style-type: none"> 1. The nonprescription medication contains codeine or aspirin; 2. A physician's instruction is needed for a nonprescription medication; 3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication; 4. The nonprescription medication is to be given longer than three consecutive days within a fourteen-day period; 5. The intended use differs from the manufacturer's instructions or use 		

Instructions

See Attached

Possible side effects to watch for are

See Attached

The child is under my care and should receive the above medication as written. I understand this form expires twelve months from the date of my signature.

Signature of licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant

Date of Signature

Phone Number

This form shall be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name		Name of Medication	
Date	Time	Dosage	Signature of designated person administering medication

Church of the Saviour Early Learning Center

CHILD PICK-UP FORM

Please list the names of those people who have permission to pick up your child from the Center.

If you participate in the PFCC/TAP Program, please put a check mark next to the person's name who is authorized to TAP your child in/out.

Name	✓ Authorized to TAP	Phone Number	Relationship

Parent's Signature

Date

Church of the Saviour Early Learning Center

2537 Lee Road

Cleveland Heights, Ohio 44118

(216) 321-1685 Fax (216) 321-3019

Photo Release

I hereby grant Church of the Saviour Early Learning Center permission to use my child's likeness in photograph in any and all its publications, including audiovisual presentations, promotional literature, advertising, or website entries, without payment or other consideration.

Name (print full name): _____

Signature: _____

Child's name: _____

Relation to minor: _____

Address: _____

City, State, Zip code: _____

Telephone #: _____

Date: _____

ETHNIC and RACIAL DATA FORM

Agency/Daycare Center _____

Agency/Daycare Address _____

The agency or daycare listed above receives Federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive Federal financial assistance they are required to record and maintain the Ethnic and Racial data of all children enrolled in the CACFP. This information is used solely for the purpose of determining compliance with Civil Right laws and will be kept confidential. We are requesting for each participant to 'Self Identify' and provide this information, however it is optional to Self Identify. This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

To Self Identify, please answer the following questions.

Child's name _____

Ethnic Category: Choose one _____

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".	
Non-Hispanic or Latino:	

Racial Categories: Check all that apply

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains tribal affiliation or community recognition.	
Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Black or African American: A person having origins in any of the black racial groups of Africa.	
Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa	
Other	

Parent/Guardian Signature _____ Date _____

Ohio Department of Education - Office for Child Nutrition
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be completed annually and signed by the child's parent or guardian.

CENTER NAME *Sunshine Child Care*

CHILD'S NAME
(please print)

ANNIE JONES

AGE
5

BIRTH DATE *9 / 4 / 2009*
month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE
AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday ✓	7:00 am	8:15 am	4:15 pm	6:00 pm	✓			✓		
Tuesday ✓	7:00 am			6:00 pm				✓		
Wednesday ✓	7:00 am	8:15 am	4:15 pm	6:00 pm				✓		
Thursday ✓	7:00 am			6:00 pm				✓		
Friday ✓	7:00 am	8:15 am	4:15 pm	6:00 pm				✓		
Saturday										
Sunday										

Yes, The schedule listed above may frequently vary due to changes in parents/guardians schedule

SIGNATURE OF

PARENT/GUARDIAN *Mary Jones*

DATE

7/13/2015

DAY PHONE

NUMBER *(614) 222-3344*

MAILING ADDRESS:

STREET /APT. *123 Park St.*

CITY *Columbus*

ZIP CODE *43215*

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

(rev. 12/3/2015)

Ohio Department of Education - Office of Nutrition
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be completed annually and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME
(please print)

AGE

BIRTHDATE

month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE
AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.

**SIGNATURE OF
PARENT/GUARDIAN**

DATE

**DAY PHONE
NUMBER**

**MAILING ADDRESS:
STREET /APT.**

CITY

ZIP CODE

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;

(2) fax: (833) 256-1665 or (202)690-7448; or (3) email: program.intake@usda.gov.

This Institution is an equal opportunity provider.

Revised 8/2022

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2023-2024

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME		CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court. Attach documentation)		PART 2 - LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.	
PART 1 - PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER					
* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	<input type="checkbox"/>	Check type of benefit:	<input type="checkbox"/> FOOD ASSISTANCE (SNAP) or <input type="checkbox"/> OHIO WORKS FIRST (OWF)
1.			<input type="checkbox"/>	CASE NO.	_____
2.			<input type="checkbox"/>	CASE NO.	_____
3.			<input type="checkbox"/>	CASE NO.	_____
4.			<input type="checkbox"/>	CASE NO.	_____

PART 3 - TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. *If Part 2 is completed, skip to Part 4.*

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	<input type="checkbox"/>	\$ amount / how often	\$ amount / how often	\$ amount / how often	\$ amount / how often
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

PART 4 - SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box.

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* If Part 3 is completed, insert last 4 digits of Social Security Number

* SIGNATURE OF ADULT HOUSEHOLD MEMBER _____ DATE _____ I do not have a Social Security Number

Print Name: _____ Daytime Phone Number: _____ Work Phone Number: _____
 Street / Apt: _____ City / State / Zip: _____ County: _____

PART 5 - RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other

Please mark one ethnic identity: Hispanic or Latino Not Hispanic or Latino

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program. **State Distribution: July 2023**

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3.
 Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion:
 Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Application Certified/Categorized as:

FREE, based on Food Assistance/OWF Case No.
 Household size and income
 Foster Child

REDUCED-PRICE, based on Household size and income

Total Household Size: _____	Total Household Income: \$ _____ Per: <input type="checkbox"/> week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice per month <input type="checkbox"/> month <input type="checkbox"/> year	<input type="checkbox"/> PAID, based on <input type="checkbox"/> Income too high <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information
-----------------------------	---	--

Signature of Sponsor / Center Representative _____ Date Sponsor Certified/Categorized Form _____ Effective Date _____ Expiration Date _____
Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. (Valid until last day of month in which form was signed one year earlier)
If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

Building For the Future

This childcare facility participates in the Child and Adult Care Food Program (CACFP), a federal program that provides healthy meals and snacks to children receiving day care.

Each day millions of children participate in CACFP at childcare homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals

CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the five components)
Milk Fruit OR Vegetable Grains or Bread* *Meat/Meat Alternate may replace entire grain up to 3x/week	Milk Meat or meat alternate Grains or bread Vegetable AND Fruit or Second Vegetable (If serving two vegetables they must be different foods)	Milk Meat or meat alternate Grains or bread Fruit Vegetable

Participating Facilities

Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit childcare centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes:** Licensed private homes.
- **After School Care Programs:** Centers in low-income areas provide free snack and/or meal to school-age children and youth.
- **Emergency Shelters:** Programs providing meals to homeless children.

Eligibility

State agencies reimburse facilities that offer non-residential day care to the following children:

- Children aged 12 and under,
- Migrant children aged 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact Information

If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

**Church of the Saviour
Early Learning Center
2537 Lee Rd
Cleveland Hts, OH 44118**

Ohio Department of Education

CACFP Program Specialist
25 S. Front Street, MS 303
Columbus, OH 43215-4183
Phone: 614-466-2945
Toll Free: 1-800-808-6235

Nondiscrimination In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. Mail:

U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

2. fax:

(833) 256-1665 or (202) 690-7442; or

3. email: Program.Intake@usda.gov

This institution is an equal opportunity provider.

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name <i>(Last)</i>	<i>(First)</i>	Nickname <i>(if any)</i>
<p><i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</i></p>		
Who is in the child's immediate family?		
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.? Additional Details?		
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) Additional Details?		
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? <input type="checkbox"/> Yes or <input type="checkbox"/> No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice or <input type="checkbox"/> water. <i>(Check all that apply)</i> How much and how often?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)		

Please check all of the words that best describe your child's personality and behavior

active adventurous affectionate anxious bossy bright busy calm cautious cheerful
 content creative curious easily-angered emotional energetic excitable friendly gives-in-easily
 happy hesitant insecure jealous likes structure/routines loud loving mellow outgoing
 prefers adult attention quiet sensitive serious shares-well social spontaneous stubborn tentative
 other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a high chair, booster, child size chair or adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.	
What might you and/or your child be anxious about as he/she starts in this program?	
What are you and/or your child excited about as he/she starts in this program?	
What are your expectations of this program?	
What other information would be helpful for the staff caring for your child to know?	
Parent/Guardian's Signature	Date

Ohio Department of Job and Family Services
ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information	
Routine Trip Destination(s)	
Date of Permission <i>(valid for one year)</i>	
Mode of Transportation <i>(walking, school bus, public transportation, parent vehicles, provider vehicle and driver)</i>	
During this trip children will have access to water that is 18 inches or more in depth. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? <i>(if yes, a swimming permission slip is required)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child's Information	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 8 years and/or over 4' 9"	
Signature	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date

**CHURCH OF THE SAVIOUR EARLY LEARNING CENTER
TUITION PAYMENT POLICIES**

WEEKLY RATES EFFECTIVE April 1, 2023

		PRE-SCHOOL	TODDLERS	INFANTS
		\$280.00	\$300.00	\$320.00

Payable:

Tuition **must** be paid, in advance, on Monday by check, cash or money order.

Registration Fee:

To register your child, you must first complete a registration form and pay an initial non-refundable \$75.00 family registration fee. An annual registration fee of \$35.00 is due each September.

Discounts:

A 10 % discount will be given to private-pay families when two children from the same family are attending at the same time. The discount will be applied to the tuition of the 2nd child (lowest rate).

Deposit:

A security deposit of one week's tuition must be prepaid for all children. Upon withdrawal, this deposit will be refunded if the ELC receives a 2-week written notification that the student will be withdrawn.

Delinquent Tuition Payments:

A late fee of \$10.00 will be imposed on delinquent accounts every week.

Center Closing:

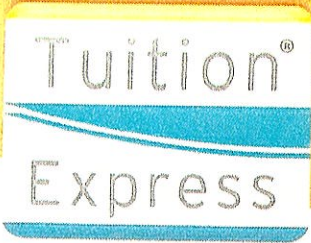
Tuition is not charged when the center is officially closed for one week during the Christmas and New Year's holidays.

Student Vacation/Sickness:

There can be no reduction of tuition for student absences due to illness or vacations. Our expenses are directly related to the number of enrolled students and are not reduced when a student is temporarily absent due to illness or vacations.

Withdrawal:

Please remember that we must have written notice at least 2 weeks in advance of your intent to withdraw your child from the program. **If we do not receive this notification, you will not be refunded your security deposit.**



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 _____

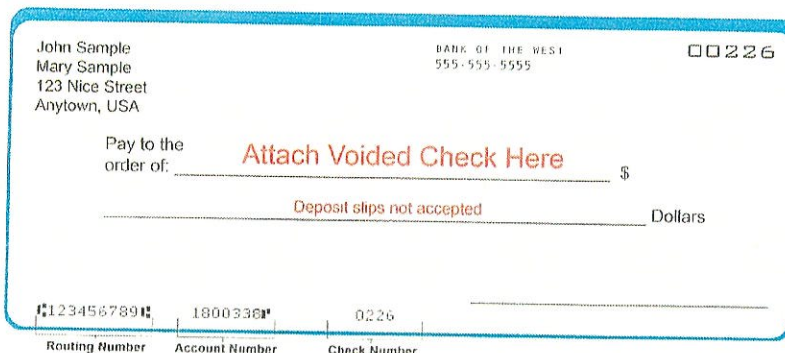
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ Checking Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



A service of

