RECISTRATION FORM-GREEN

THURCH OF THE SAVIOUR EARLY LEARNING CENTER

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: Toddier 18 mos 36 mos Fre-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		Da	ate of Birth			First Day at Program/Home						
Home Address						City						
State	Zip Code	Ho	Home Telephone Number									
Parent/Guardian Name #1				Relatio	nship to C	Child						
Home Address Same as Child's			HomeT	<u>l</u> elephone	Number [☐ Same as	Child's					
City				State		Zip						
Email Address (if applicable)			Cell Pho	ne (if app	licable)							
Parent's Work/School Name		MIN.	Parent's	Work/Sch	ool Telep	hone Numb	er					
Parent's Work/School Address					City	/						
Please indicate if this name should be for other parents/guardians.			an, of a child	attending	the progr	am/home re	quests co	ontacti	nformation			
If you answered yes, please indicate v	which informa	ation above to ir		elist 🔲 '	Work_#	☐ Cell#	☐ Hor	ne#_	☐ Email			
Where can you be reached while your	child is in thi	s program/hon	ne?									
Parent/Guardian Name #2				Relation	onship to	Child						
Home Address Same as Child's			Home Telephone Number 🔲 Same as Child's									
City				Sta	ate		Z	ip.				
Email Address (if applicable)			Cell Phone	<u> </u>								
Parent's Work/School Name			Parent's Wo	ork/School	Telephor	ne Number						
Parent's Work/School Address					City							
Please indicate if this name should be		•	an, of a child	attending	the progra	am/home, re	equests c	ontact	information			
for other parents/guardians.			nclude on the	elist 🔲 V	Vork #	☐ Cell#	☐ Hon	ne#	☐ Email			
Where can you be reached while your	child is in this	s program/hom	ne?									
Emergency Contacts: Parents <u>cann</u>	ent be listed	as emergency	contacts. Lis	st the nam	e of at lea	est one perso	on who ca	an be (contacted			
in the event of an emergency or illness one person listed must be able to take 18 years of age.	s if you cann	ot be reached	. Any perso	n listed sh	ould be al	ble to assist	in contac	cting yo	ou. At least			
Name			Name	Name								
City		State	City					State)			
Telephone Number	Relationship	to Child	Telep	hone Num	ber	Relationship to Child						
Other numbers where emergency con applicable)	tact can be re	ached (if		Other numbers where emergency contact can be reached (if applicable)								
Name of Physician or Clinic/Hospital				·								
Street Address												
City		State	Telepi	hone Num	ber							

JFS 01234 (Rev. 10/2021) Page 1 of 4

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)										
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? (<i>check one</i>) ☐ No										
Yes - please explain										
If yes, does this medication or medical food need to be administered at the child care program/home?										
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?										
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.										

JFS 01234 (Rev. 10/2021) Page 2 of 4

Child's Name
List any history of hognitalization outpotions current expressions hogely account the second day and the second day of
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.
poroonical in all onlongonoy oldation.
□ Makanattankia
□ 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.
, and the same and
□ Not applicable
□ Not applicable
List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.
I I

JFS 01234 (Rev. 10/2021) Page 3 of 4

Child's Name								
	Die	monine C						
	es (If yes, skip to Emergen o (If no, fill out the followin	i <i>cy Trans_i</i> ig:)	itatement portation Authorization section) indicate if you want your child's d	lignovetoples de consultir se de				
program's policy or another:								
— Tagree war are program see			se check my child's diaper every	hours.				
Give <u>Permission</u> to		ransport	ation Authorization <u>Do Not Give Permis</u>	ssion to Transport				
Program or Home Name			Program or Home Name	<u> </u>				
has permission to secure emerg my child in the event of an illness emergency treatment. The emerg service will determine the facility that transported.	or injury which requires gency transportation	Do not sign both	does not have permission to secure emergency transportation for my child in the event of an illness or injur which requires emergency treatment. I wish for the following action to be taken:					
Parent's Signature	Date		Parent's Signature	Date				
I have reviewed and received a co	Acknowledgemen	nt of Polic ne's polic	cies and Procedures lies and procedures/handbook.]Yes □No (check one)				
This form, after being completed administrator/designee prior to the	and signed by the parent/gue child receiving care.	uardian, r	nust be reviewed for completenes	s and signed by the				
Parent/Guardian Signature(s)				Date				
Administrator/Designee Signature	9			Date				
The form is to be initialed and date information has stayed the same of	ed, at least annually, after it or changes have been note	t has bee d. If sign	n reviewed by the parent/guardia ificant changes are needed, pleas	n. This is to indicate all se 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 formmust be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

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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 instru		
If you decide a change is to be made in the future, you mu	st 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 were delicated	
Daily Medicine:	
Explanation:	
If a child receives daily medications, medical treatments, o statement must be attached to this form and signed by th	or special dietary restrictions, a medical e child's physician.
Napping Schedule:a.mp.m.	
Pacifier:	
At what times during the day do you want your child to ha	ave their pacifier? Sometimes:
If your child will have their pacifier continuously throughou parents provide a pacifier attachment strap to accompany	at the day, the center requests that their child each day.
The Early Learning Center requests that parents leave a cha	ange of clothing at the center.
If your infant's clothes become untidy do you want your chi	ild 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 ACKOWLEDGEMENT AND WAIVER OF LIABILITY

I, as parent/guardian of	, and personally, acknowledge that COVID-19 is a
disease spread and transmitted from p	erson to person. I understand that such disease may be spread
without the knowledge of the Church of	of the Saviour Early Learning Center (hereinafter "ELC"). I
understand that the ELC will follow sta	te and federal (CDC) guidelines for day care centers but such
efforts may not prevent the potential s	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.
l, as parent/guardian of	, and personally, hereby waive, release, discharge
and/or otherwise indemnify the ELC, it	s 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 i	ELC.
	Signed:
	Parent's Name Printed:
	Signed:
	Parent's Name Printed:
	Parent(s) of
	Detail

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

Child's Name (print or type)		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>):											
Check below, if applicable: Additional information that will assist the child care p named child (special health care and developmental)											
Optional: Measurements and Recommended Assessments/Screenings Height Vision											
Signature of Examining Health Care Practitioner			Date of Examination								
Name of Examining Health Care Practitioner		Telephone Number									
Street Address	City, State and Z	ip Code									
ATTACH A COPY OF THE CHILD'S IMMU (MM/DD/YYYY FORMAT) OF DO											
IMMUNIZATION (Complete ONLY ONE SECTION bel Section 5104.014 of the Ohio Revised Code requires Chicken pox, Diphtheria, Haemophilus influenzae type b, Hep Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and	s <i>immunization</i> patitis A, Hepatitis	s B, İnfluenza,	Measles, Mumps, Pertussis,								
Section B - To be completed by the EXAMINING HE PRACTITIONER: The above named child has been immunized against listed above. If an immunization is medically contraindicated or not medical for the child's age, note any exceptions by listing the specific	Initials of Exa	amining Health Care Practitioner									
immunization(s):		Date									
Section C - To be completed by the child's parent O WAIVING AN IMMUNIZATION(S): I have declined to have my child immunized for reas conscience, including religious convictions against a diseases listed above or against the following disease	ons of Il of the	Signature of Parent									
		Date									

American Academy of Pediatrics

Bright Futures/American Academy of Pediatrics

Recommendations for Preventive Pediatric Health Care

Bright Futures

Each child and family is unique; therefore, these Recommendations for Peaventive Pediatric Health Care are designed for the care of children who are receiving nutruring parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory flashion. Developmental, psychosocial, and directive disease issues for children and adolescents may require more frequent counteiling and treatment withis separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns. These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright, Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Stight Foruns Guidalines* (Fagan JF, Shaw JS, Duncan PA), eds. *Bright Ravance Guidalines for Hadift Supervision of Infants, Children, and Adolesce*nts. 4th ed. American Academy of Pediatrics, 2017, 1

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

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ANTICIPATORY GUIDANCE		Fluoride Supplementation ²⁷	Fluoride Varnish ¹⁷	Orost HEND Ha		Cervical Dysplasin ²⁴	Sudden Cardiac Arrest/Death ²²	Hepatitis C Virus Infection ¹⁰	Hepatitis B Virus Infection ¹⁷	- WH	Sexually Transmitted Infections ²⁵	Dyslipidemia	Tuberculosis	Lead -	Anema:	ON CONTRACTOR OF THE PROPERTY		Critical Congenital Heart Defect	Newborn Biltrubin*	Newborn Blood	PROCEDURES**	PHYSICAL EXAMINATION ¹⁰	Depression and Suicide Risk Screening 9	robacto, record, or proj use Assessment	Tobaco State Consultation of the Consultation	Behavioral/Social/Emotional Screenings	Developmental Surveillance	Autism Spectrum Disorder Screening ¹³	Developmental Screening ¹³	Maternal Depression Screening**	DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH	Hearing	Vision?	SENSORY SCREENING	Blood Pressure*	Body Mass Index	Weight for Length	Head Circumference	Length/Height and Weight	MEASUREMENTS	indiainterval		
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- 2. A promabl wist is recommended for paients who are at high tils, for fits value parents, and for those who request a conference. The processal wist should incube antispatory guidance, perform needed history, and a discussion of benefits of broadfording and planned methods of fitseld antispatory guidance, performed methods of feedings on The Pennatu Virginia ("RIEM/deed.pdf) (15.2 Oped.pdf) (17.6).
 3. Newtomis should have an explaint on all by thirty and broadfeeding should be encouraged tand instruction and support
- About the effered.

 I terminant doubt have an evaluation within 3 to 5 days of birth and within 43 to 72 hours after discharge from the hospital to include evaluation for feeding and jancation. Seasy telesisting newborns should receive dismail beautheding or obtained, and their months of the doubt section of the seasy telesisting in the state of the seasy telesisting on the first feeding months of the doubt and the seasy telesisting of the seasy telesistic of the seasy telesistic of the seasy telesistic of the seasy telesistic or the seasy telesistic of the seasy telesistic or th

- 5. Screin, per "Expert Committee Recommendations Beganding the Prevention," Assessment, per "Expert Committee Recommendations Beganding the Prevention," 22 Jean 10,152 Jean 20,252 Jean 10,152 Jean 20,155 Jean 2
- 10. Scream vith audiennsty including (a)00 and 8,000 ht high frequencies conce between 11 and 14-years, once between 16 and 17 years, and donce between 16 and 21 years. See "The Sentiathy of Andream Housing Occess Significantly improves by Adding High Frequenciar (https://www.scream-colored.com/scream-colored-andream
- https://doi.org/10.1542/peds.2019-3447).

KEY:

- Relational Health (<u>Intracillotic and 10.1542/peds.2021-057383</u>).

 5. A recommended sassament too it a vailable at <u>Mutoriferations</u>.

 6. Scenen addiscious for depression and audicil risk, making away officit to preserve confidentiality of the addisscent. See "Guidelines to Addisscent Depression in Primary 14. Staten for behavioral and stated-amountains problems por Pormothing (Introduction and International States) of Behavioral and Ernollman Foodbard (Introduction and International States) of Behavioral and Ernollman Foodbard (Introduction and International States) of International States (International States) of International States (International States) and States (International States) of International States (International States) and States (International States) of International States (International States) and International States (International States) of International States (International States) (International Stat screening Jabud ke kindly, centrees and mayinfolde asking about caregiver enrotional and metal health conterms and acold televiminant of health, patient, poverty, and creational health. See "Powerty and Child Health in the United States" (https://doi.org/10.1542/peds.2016-0339). The Impact of Restorm of Child and Adabsector. Health (https://doi.org/10.1542/peds.2016-0339). The Impact of Restorm of Child and Adabsector. Health (https://doi.org/10.1542/peds.2016-1325). Ard "Poweroning Olidhood Toxic Stress: Partnering With Families and Communities to Promote on Childhood Toxic Stress: Partnering With Families and Communities to Promote
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 19. Confirm initial Secretor was accomplising on notify point that and Selective up in the Recommended Uniform Secretoring Force (Intelligible Chapterness Ch te newborn screening laws/regulations (https://www.babysfirsttest.org/ establish criteria for and coverage of newborn screening procedures and programs.
- Verify results as soon as possere, uno numerous money.
 Confirm Initial screening was accomplished, verify results, and follow up, as appropriate.
 Confirm Initial screening was accomplished, verify results, and follow up, as appropriate.
 See "Hyporbifulinemials in the Areodom Initials, 28 Works" Gestations. An Update With See "Hyporbifulinemials in the Areodom Initials, 2009, 0229).
- Qarifications' (https://dai.org/10.1542/peds.2009-0229)

 2. Screening for critical congenital heart disease using pulse oximetry should be performed in nevertoris, side 24 hours of large before distrategy from the fragital, per "Endorsement of Health and Human Services Recommendation for Pulse per "Endorsement of Health and Human Services Recommendation for Pulse tal Heart Disease"
- counter y oceaning for crucian business marks cossesse (https://do.box/161.125/pcds.2011-231.2014) Diseases, are available at Chindrica, per the AAP Committee on historica Diseases, are available at https://publication.abp.org/redbook/pages/immunitation_cybedules_Every visit should be an opportunity to update and complete at child's immunitations.
- For children at risk of lead exposure, see "Prevention of Childhood Lead Toxidity" (https://doi.org/10.15-2/peds.2016-1453) and "Low Level Lead Exposure Harms Children: A Renewed Call for Firmary Prevention" (https://www.cdc.gov/ncehilead/ Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Performs Nutrition Policy of the American Academy of Revisition from chapter).

- Converse in Account Conference (2017) 2017.

 26. Perform 158. Instruments or streterings as appropriate, based on universal screening requirements for patients with Nedicular or in high prevalence areas.

 27. Teleprolasis setting per acommendations of the AAP Committee on infectious to the patient of the AAP Committee on infectious continued on infectious discount internal edition of the AAP Committee on infectious discount internal planed be performed on recognition of high-risk factors. See "Integrated Conditional Conference Confer

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- 3. Green accidences for Infl. at least once between the age of 15 and 21 making every offert to process on anotherwising of the accidenced, as per "Human Introduction on your Infl." Infl. of the control of the Infl. of the Infl. of In and Pre- and Postexposure HIV Prophylaxis" (https://doi.org/10.1542)
- Perform a risk assessment for heparitis B virus (HBV) infection according to recommendations per the USPSTE (https://www.uspgreventheservices.gask
- to the USPSTF (https://www.uspreventiveservicetaskfocce.org/uspstf)
 recommendation/hepatitis-cacreening) and Centers for Disease Control and Prevention virus (HCV) infection according
- (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/srin/902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be
- rested for HCV infection and discussessed annually.

 33. Perform a risk passessment, as appropriate, per "Sudden Death in the Young Information for the Perhary Case Provider ("https://doi.org/10.1542/peds.2021.053244).

 4. See USPST is ecommendations ("https://www.uspsevenibsesvicestisticro.org/uspstif/ recommendations/economic-conomic-received-in-organizations for policy constraintions provided to age 21 are native in "opineologic Examination for Adoluscents in the Pedituric Office
- Setting" (https://doi.org/10.154/beds.2010/3546.

 Setting" (https://doi.org/10.154/beds.2010/3546.

 Seesse whether the chied has a devial frome. (I nod ernal home is identified, perform a risk assessment (flugs//www.ajaconder/doi.fabet.cen/oral-health/oral-health-pastite-stocks) and roler to a denial home. Recommend brushing with fluoride
- (migra/manustrateshelment-oriotestaskinteet-projestastif-secommentation/prevention-of-dental-cuter-in-fredering-consistential project of the consistential Deds.2020-034657).
- See "Fluoride Use in Caries Prevention in the (https://doi.org/10.1542/peds.2020-034637). rrce is deficient in fluoride, consider gral fluoride supplementation.

CHANGES MADE IN DECEMBER 2022

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 age limit from 18 to 21 years to account for the range in which the screening can take place) to align with recommendations of the US Preventive Services. Task Force and AAP policy ("Adolescents and Young Adults: The Pediatridan's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis").

immunodeficiency-virus-hiv-infection-screening): after initial screening, youth at increased risk of HIV infection should be reteated annually or more frequently, as per 'Adolescents and Young Adults: The Pediatrician's Role in HIV festing and Pre- and Vosseyosure HIV Prophylaxis' (https://doi.org/10.1542/peds.2021-055207)." 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. uspreventiveservicestaskforce.org/uspstfirecommo

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 USPTF and the 2012–2024, edition of the AAP Red Book-Report of the Committee on Infectious Diseases.

for hepatitis byins (HBV) Infection according to recommendations per the USPSTE (https://www.uspere-inhvezervi.extaskforce.org/.spsft/ recommendation/hepatitis-b-vins-infection-screening) and in the 2021-2024 edition of the AAP Red Book: Report of the Committee on Infectious Footnote 31 has been added to read as follows: "Perform a risk assessment 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 lake placely be go consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider").

Footbote 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.2021-052044)."

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.

hitial Management (https://doc.org/10.1542/jees.2017-408), Weenlah Reithi Competencies for Pediatric Practice (https://doi.org/10.1542/jeeds.2015-2757), Suicide and Suicide Attempts in Adolescents (https://doi.org/10.1542/jeeds.2015-2757), peds.2015-1422/) and "The 21st Century Cures Act & Adolescent 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-PG): Part I. Practice Preparation, Identification, Assessment, and Contraentielity (https://www.adoiescenthealth.org/Advocacy/Advocacy-Activities/2019-(IJ/N/ASPAG-SAHM-Statement.aspx)."

visit www.aap.org/periodicityschedule updated to Behavioral/Social/Ernotional Screening (annually-from newborn to 2) yeast's lost growth. AAP policy, the American College of Obstetricians and Gynecologists (Women's Persentine Services Intilative) is commendations, and the American Academy of Child & Adolescent Psychiatry guidelines. The Psychosocial/Behavioral Assessment recommendation has been BEHAVIORAL/SOCIAL/EMOTIONAL

This schedule reflects changes approved in December 2022 and published in April 2023. For updates and a list of previous changes made, Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

Footnote 14 has been updated to read as follows: "Screen for behavioral and social-emotional problems per "Fromoting Optimal Development: Screening for Behavioral and foroitonal Problems (https://doi.org/10.1542)/ peds.2014-0.316). Whental Health Competencies for Pediatric Practice (https://doi.org/10.1542)/ whental Health Competencies for Pediatric Practice (https://doi.org/10.1542)/ peds.2014-0.316). Whental Health Competencies for Pediatric Practice (https://doi.org/10.1542)/ peds.2014-0.316. With Anxiety Disorders (https://doi.org/10.254940), and "Screening for Newton in Screening for Anxiety in Adolescent and Adult Womens A Recommendation from the Womens's Preventive Services Initiative (https://doi.org/10.1541/ peds.2014). The screening should be fearning s https://doi.org/10.1542/peds.2021-052582)."

FLUORIDE VARNISH

Footnote 37 has been updated to read as follows: "The USPSTF recommends that primary are clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (<a href="https://discoveries.org/legs/fluoride-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-ligitary-toothe-live-ligitary-toothe-ligitary-toothe-live-ligitary-toothe-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-live-ligitary-toothe-ligitary-t

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 Caries Prevention in the Primary Care Setting" (https://doi.



Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This for in care.	m is to be completed for each prescription	or non-prescription m	nedication th	at a child n	eeds to receive while					
It is not (JFS 01:	required to be completed for topical produ 236).	ucts, lotions, or if the n	nedication is	required b	y a health care plan					
Child's N	ame	Date of Birth (if neede determine the correct		(if needed to determine ect dosage)						
		Geternime the correct	aosage)	ine concer	rest dusage/					
Box 1	The following section must always be co									
Name of	medication		Dosage							
			☐ See att	ached						
To be ad	lministered at the following times		For the follo		Medication expiration date					
				•						
l unders										
	This form expires twelve months from the That my child must receive at least one do medication (unless the medication is used	ose of medication at t								
Signatur	e of Parent/Guardian				Date					
Box 2	The following section must be completed registered nurse or certified physician's a				Ivanced practice					
2. A ph 3. The one nong 4. The	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;									

JFS 01217 (Rev. 10/2021) Page 1 of 3

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 und	derstand this form expires
the dimensional forms the data of my dimensions	
twelve months from the date of my signature.	
Signature of licensed physician, licensed dentist, advanced practice registered nurse or	Date of Signature
Signature of notined physician, notined defines, advanced practice registered incide of	
certified physician's assistant	
and project and the second sec	
Phone Number	

JFS 01217 (Rev. 10/2021) Page 2 of 3

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).

Child's Name

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.

Name of Medication

Date	Time	Dosage	Signature of designated person administering medication

JFS 01217 (Rev. 10/2021) Page 3 of 3

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 an 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 or file for 3 years and will only be accessible to authorized personnel.	d on
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

CACEP p	rogram	Red s exempt from	quired Ford boving an enroll	m for use l	by Child	Ca	ncy Shelters, Out	and Hea	d Start P	rograms		
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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 incare. If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box belowchart. 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 AGE BIRTHDATE month year day (please print) CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE Check (✓) meals child normally receives while in care Check (✓) List hours child normally in care Days Child Evening AM PM Normally in Arrive Depart Arrive Depart Breakfast Snack Lunch Snack Supper Snack Care Monday Tuesday Wednesday Thursday Friday Saturday Sunday Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule. DAY PHONE DATE SIGNATURE OF NUMBER PARENT/GUARDIAN MAILING ADDRESS: ZIP CODE STREET /APT. 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; (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. CHECK IF PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWE CASE NUMBER, IF ANY A VALIE CENTER NAME A FOSTER CHILD (The legal PART 1 PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER responsibility of a welfare agency FOOD ASSISTANCE (SNAP) or or court. Attach * NAME OF ENROLLED CHILD(REN) AGE BIRTH DATE of benefit: OHIO WORKS FIRST (OWF) documentation) CASE NO. 1. 2 CASE NO. CASE NO. CASE NO. 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. c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and LIST NAMES OF ALL b. CHECK HOUSEHOLD MEMBERS HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually NO/ZERO 2. Welfare payments, UDING CHILDREN 1. Earnings from work 3. Pensions, retirement, 4. All Other Income INCOME LISTED ABOVE IN PART before deductions child support, alimony Social Security, SSI, VA EXAMPLE: JANE SMITH \$ amount / how often 1 2. 3, \$ \$ \$ 4 \$ \$ \$ \$ 5. \$ \$ \$ 6. \$ \$ \$ \$ PART 2 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 (Check if applicable) 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: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren). American Indian or Alaska Native Black or African American Asian Other Native Hawaiian or Other Pacific Islander White Not Hispanic or Latino Hispanic or Latino Please mark one ethnic identity: 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 inclicate 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. Application Certified/Categorized as: 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 ☐ FREE, based on ☐ Food Assistance/OWF Case No. Guidelines to determine correct categorization. When income is listed in different frequencies □ Household size and income of pay in Part 3, you must convert all income to annual income before determination. Use the □ Foster Child following Annual Income Conversion: REDUCED-PRICE, based on Household size and Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12 ☐ PAID, based on ☐ Income too high Total Total Household Income: \$ □ Incomplete Household Per: g week g every two weeks g twice per month g month g year Invalid case number or information Size: **Expiration Date** Effective Date Date Sponsor Certified/Categorized Form Signature of Sponsor / Center Representative (Valid until last day of month in which (From the first of month of date signed) Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. form was signed one year earlier) date of parent signature is not within month of certification or immediately preceding month, efective 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 (Ifserving 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/siles/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

(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 (Last)	(First)	Nickname (If any)
		Thomas (in arry)
By providing complete information about care. List any information about your child your child.	your child, you will be assistin i's habits, abilities or personal	g staff in creating a positive experience for him/her while in ily that you feel will be helpful to the staff while caring for
Who is in the child's immediate family?		
Who lives at home with your child?		
What is the primary language spoken in yo	our child's home?	
Are there any special family arrangements Additional Details?	s, such as shared parenting, li	ring in two homes, or custody specifications, etc.?
Are there any changes or transitions that y divorce, new home, death of family membe	our child has recently experie er, friend or pet) Additional Di	nced or is experiencing? (moved from crib to bed, etails?
Are there any cultural or religious practices etc.)	of your family we should be a	aware of? (Dietary restrictions, clothing, head coverings,
Do you have any pets at home? If so, what	are they and what are their n	ames?
	and they and tries are then the	
Has your child had a previous care arrange with parents, etc.)	oment? 🗌 Yes or 🗍 No Ac	ditional Details? (Center based, in home, with family,
My child drinks	e or 🗍 water. <i>(Check all that</i>	apply)
Does your child have any favorite foods?		
Does your child disfike any foods?	44 1144 4144 4144	
Are there any foods your child should not be allergies and/or dietary restrictions)	e fed? (Licensing requires do	cumentation be completed for children with food

	Please check all of the words that hast departs your still a series it.
	Please check <u>all</u> 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?
	Vhat is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?
	ly child sits in a high chair, booster, child size chair or adult size chair. (Check the one that applies.)
	your child tollet trained? If not, have you started the tollet training process? Please explain the process used.
	oes your child need assistance when using the toilet? If so, how?
	/hat words, gestures or signs does your child use if he/she needs to use the bathroom?
	hat time does your child normally go to bed at night and wake up in the morning?
VV.	hat time(s), and for how long, does your child usually nap?

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Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Ple	ase explain.
Miles - July 1	
What might you and/or your child be anxious about as he/she starts in this program?	
What are you and arrow shill and talk it is to be a first	
What are you and/or your child excited about as he/she starts in this program?	
Mind was a state of the control of t	
What are your expectations of this program?	
What other information would be helpful for the staff caring for your child to know?	
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grant/Quardiania Clamatica	T man
arent/Guardian's Signature	Date
arent/Guardian's Signature	Date

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

Routine Trip Information	Processing Communication Control		
Routine Trip Destination(s)			
Date of Permission (valid for one year)			7,0
Mode of Transportation (walking, school	ol bus, public transportation, paren	nt vehicles, pro	vider vehicle and driver)
During this trip children will have access ☐ Yes ☐ No	s to water that is 18 inches or mor	e in depth.	
Are water activities planned in water tha (if yes, a swimming permission slip is re	at is 18 inches or more in depth?	☐ Yes	☐ No
Child's Information			
Child's Name			
My child is		***	100.1
not over 4 years and/or 40 lbs	over 4 years and 40 lbs	☐ 8 year	rs and/or over 4' 9"
Signature			
grant permission for my child to par	ticipate in the routine trips des	cribed above	
Parent's Signature		****	Date

CHURCH OF THE SAVIOUR EARLY LEARNING CENTER TUITION PAYMENT POLICIES

WEEKLY RATES EFFECTIVE April 1, 2023

PRESCHOOL	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 <u>written notice at least 2 weeks in advance</u> 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.

8/2023



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

notice. Credit union member Check with the center for a	siness name) t card account (Section A) OR, it card account (Section A) OR, it can be account affect the cancella ers: please contact your credit ur ccepted credit card types.	MAN At this agreement I have	to initiate	e credit card charges to rings account,
COMPLETE ONE SECTIO	N ONLY			
SECTION A (Credit Card)				
Cardholder Name		Phone #		
Cardholder Address		City	S	State Zip
Account Number		Expiration Date		
Cardholder Signature			D	ate
SECTION B (Bank Account)				aic
Your Name		Phone #		
Address		City	St	ate Zip
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample	e below)	Account Number (see sample	below) C	hecking Savings
Authorized Signature			Da	te
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Employee Signature	***************************************	Voided Check Here \$		
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	Routing Number Account Number	Check Number		