CHURCH OF THE SAVIOUR EARLY LEARNING CENTER

REGISTRATION FORM

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: Infant 1 6wks – 12 mos.   Infant 2 12 mos. – 18 mos.

Child's Name: ______________________________

Age/Date of Birth: ______________________________

Desired Start Date: ______________________________

Days Per Week: ______________________________

Circle one: Infant 1 6 wks.-12 mos.   Infant 2 12 mos.- 18 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 ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No
If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

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

Parent/Guardian Name #2		Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No
If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

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

Emergency Contacts: Parents __cannot be listed__ as emergency contacts. List the name __of 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
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 *Permission* to Transport			***Do Not Give Permission* to Transport**	
Program or Home Name		**OR** **Do not sign both**	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

<u>Diaper Changing Schedule Notice</u>

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 ACKOWLEDGEMENT 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 *(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 (*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 ____________ ☐ Yes ☐ No Lead ____________ ☐ Yes ☐ No
Weight ____________ Hearing ____________ ☐ Yes ☐ No Hemoglobin ____________ ☐ Yes ☐ No
BMI ____________ Dental ____________ ☐ Yes ☐ 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

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits 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 *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics; 2017).

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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	INFANCY								EARLY CHILDHOOD						
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●			
Weight for Length		●	●	●	●	●	●	●	●	●	●				
Body Mass Index[5]												●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●
SENSORY SCREENING															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●
Hearing		●[8]	●[9] ←	—	→	★	★	★	★	★	★	★	★	★	●
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH															
Maternal Depression Screening[11]				●	●	●	●								
Developmental Screening[12]								●			●		●		
Autism Spectrum Disorder Screening[13]											●	●			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]															
Depression and Suicide Risk Screening[16]															
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]															
Newborn Blood		●[19]	●[20] ←	—	→										
Newborn Bilirubin[21]		●													
Critical Congenital Heart Defect[22]		●													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★
Tuberculosis[27]				★			★		★			★		★	★
Dyslipidemia[28]												★			★
Sexually Transmitted Infections[29]															
HIV[30]															
Hepatitis B Virus Infection[31]		★ ←	—	—	—	—	—	—	—	—	—	—	—	—	—
Hepatitis C Virus Infection[32]															
Sudden Cardiac Arrest/Death[33]															
Cervical Dysplasia[34]															
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★
Fluoride Varnish[37]							←	—	—	—	●	—	—	—	—
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

	MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																	
Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference																	
Weight for Length																	
Body Mass Index[5]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																	
Vision[7]	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing	●	●	★	●	★	●	←	—	●[10]	→	←	●	→	←	—	●	→
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																	
Maternal Depression Screening[11]																	
Developmental Screening[12]																	
Autism Spectrum Disorder Screening[13]																	
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]							★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]								●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																	
Newborn Blood																	
Newborn Bilirubin[21]																	
Critical Congenital Heart Defect[22]																	
Immunization[23]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]	★	★															
Tuberculosis[27]	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]		★		★	←	●	→	★	★	★	★	★	←	—	—	●	→
Sexually Transmitted Infections[29]							★	★	★	★	★	★	★	★	★	★	★
HIV[30]							★	★	★	★	●	—	—	—	—	—	→
Hepatitis B Virus Infection[31]	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	→
Hepatitis C Virus Infection[32]														●	—	—	→
Sudden Cardiac Arrest/Death[33]							★	—	—	—	—	—	—	—	—	—	→
Cervical Dysplasia[34]																	●
ORAL HEALTH[35]	★	★															
Fluoride Varnish[37]	→																
Fluoride Supplementation[38]	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←—— ★ or ● ——→ = range during which a service may be provided

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14. Screen for behavioral and social-emotional problems per "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (https://doi.org/10.1542/peds.2014-3716), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders" (https://pubmed.ncbi.nlm.nih.gov/32439401), and "Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative" (https://pubmed.ncbi.nlm.nih.gov/32510990). 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.2019-1765), and "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health" (https://doi.org/10.1542/peds.2021-052582).
15. A recommended assessment tool is available at http://crafft.org.
16. 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.2019-2757), "Suicide and Suicide Attempts in Adolescents" (https://doi.org/10.1542/peds.2016-1420), and "The 21st Century Cures Act & Adolescent Confidentiality" (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (https://doi.org/10.1542/peds.2011-0322).
18. These may be modified, depending on entry point into schedule and individual need
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (https://doi.org/10.1542/peds.2009-0329).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (https://doi.org/10.1542/peds.2011-3211).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://publications.aap.org/redbook/pages/immunization-schedules. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (https://doi.org/10.1542/peds.2016-1493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (https://www.cdc.gov/nceh/lead/docs/final_document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. 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/uspstf/recommendation/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).
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/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.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.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 tested for HCV infection and reassessed annually.
33. 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).
34. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (https://doi.org/10.1542/peds.2010-1564).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
36. Perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/). See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
37. 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.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). 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 Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).
38. 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.org/10.1542/peds.2020-034637).

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

This schedule reflects changes approved in December 2022 and published in April 2023. 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) to align with recommendations of the US Preventive Services Task Force and AAP policy ("Adolescents 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.uspreventiveservicestaskforce.org/uspstf/recommendation/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.uspreventiveservicestaskforce.org/uspstf/recommendation/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.2021-052044)."

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.

- 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.2019-2757), 'Suicide and Suicide Attempts in Adolescents' (https://doi.org/10.1542/peds.2016-1420), and 'The 21st Century Cures Act & Adolescent Confidentiality' (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx)."

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 social-emotional problems per 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (https://doi.org/10.1542/peds.2014-3716), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders' (https://pubmed.ncbi.nlm.nih.gov/32439401), and 'Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative' (https://pubmed.ncbi.nlm.nih.gov/32510990/). 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.2019-1765), and 'Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health' (https://doi.org/10.1542/peds.2021-052582)."

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.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). 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 Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

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.org/10.1542/peds.2020-034637)."

HRSA

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling [illegible] with 10 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This form is to 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	Date of Birth *(if needed to determine the correct dosage)*	Weight *(if needed to determine the correct dosage)*

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

Name of medication	Dosage ☐ See attached	
To be administered at the following times	For the following period of time	Medication expiration date

I understand:

1. *This form expires twelve months from the date of my signature, if box 2 has not been completed.*
2. *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).*

Signature of Parent/Guardian	Date

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:

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**

8/2023

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 | BIRTHDATE 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

EXAMPLE

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, 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.

CENTER NAME

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER

PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.

Check type of benefit: ☐ FOOD ASSISTANCE (SNAP) or ☐ OHIO WORKS FIRST (OWF)

* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court. Attach documentation)	CASE NO.
1.			☐	CASE NO. ___ ___ ___ ___ ___ ___ ___
2.			☐	CASE NO. ___ ___ ___ ___ ___ ___ ___
3.			☐	CASE NO. ___ ___ ___ ___ ___ ___ ___
4.			☐	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	☐	$ amount / how often	$ amount / how often	$ amount / how often	$ amount / how often
1.	☐	$_____ /_____	$_____ /_____	$_____ /_____	$_____ /_____
2.	☐	$_____ /_____	$_____ /_____	$_____ /_____	$_____ /_____
3.	☐	$_____ /_____	$_____ /_____	$_____ /_____	$_____ /_____
4.	☐	$_____ /_____	$_____ /_____	$_____ /_____	$_____ /_____
5.	☐	$_____ /_____	$_____ /_____	$_____ /_____	$_____ /_____
6.	☐	$_____ /_____	$_____ /_____	$_____ /_____	$_____ /_____

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.

* ______________________ **SIGNATURE OF ADULT HOUSEHOLD MEMBER**	* ______________ **DATE**	* If Part 3 is completed, Insert last 4 digits of Social Security Number ☐☐☐☐ ☐ **(Check if applicable) 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).

☐	American Indian or Alaska Native	☐	Asian	☐	Black or African American
☐	Native Hawaiian or Other Pacific Islander	☐	White	☐	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: ☐ week ☐ every two weeks ☐ twice per month ☐ month ☐ year	☐ **PAID,** based on ☐ Income too high ☐ Incomplete ☐ Invalid case number or information

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized Form	Effective Date (From the first of month of date signed)	Expiration Date (Valid until last day of month in which form was signed one year earlier)

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. 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.

08/2023

Ohio Department of Job and Family Services

FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name *(Last)*	*(First)*	Nickname *(If any)*

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.

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? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
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 *(valid for one year)*	
Mode of Transportation (*walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*	
During this trip children will have access to water that is 18 inches or more in depth. ☐ Yes ☐ No Are water activities planned in water that is 18 inches or more in depth? ☐ Yes ☐ No (if yes, a swimming permission slip is required)	
Child's Information	
Child's Name	
My child is ☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 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

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			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.

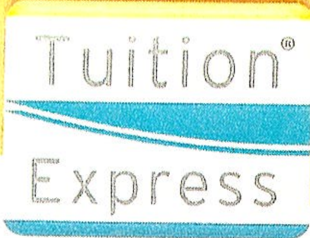
Delinquent Tuition Payments:
A late fee of $10.00 will be imposed on delinquent accounts every week.

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 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.**

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

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

John Sample
Mary Sample
123 Nice Street
Anytown, USA

BANK OF THE WEST
555-555-5555

00226

Pay to the order of: Attach Voided Check Here $

Deposit slips not accepted Dollars

⑆123456789⑆ 1800338⑈ 0226

Routing Number Account Number Check Number

A service of

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