



# Registration Form

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_  
First Middle Last

Program enrolled: **3-4yr. old:** \_\_\_ 3 ½ day \_\_\_ 5 ½ day \_\_\_ 3 Full Day \_\_\_ 5 Full Day  
**4-5yr. old:** \_\_\_ 5 ½ day \_\_\_ 5 Full Day

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Parent Phone - Cell \_\_\_\_\_ Home \_\_\_\_\_  
Work \_\_\_\_\_ Provider \_\_\_\_\_  
(At&t, Verizon, Sprint, etc.)

**\*Please check  if you wish to receive preschool related text messages.\***

## Other parent (if different than above)

Parent's Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Parent Phone - Cell \_\_\_\_\_ Home \_\_\_\_\_  
Work \_\_\_\_\_ Provider \_\_\_\_\_  
(At&t, Verizon, Sprint, etc.)

**\*Please check  if you wish to receive preschool related text messages.\***

## Roster Release

I do/do not wish my information to be printed in the preschool parent roster.

Preferred number to be released: \_\_\_\_\_ Email: \_\_\_\_\_

## Photo Release

I do/do not give permission for my child's picture to be and used in monthly preschool newsletters, displayed in the preschool classroom, put on the JMP Facebook page, and/or used the Bexley Recreation Brochure.

## Release/Permission

I, as parent or legal guardian representing this minor, agree to release the City of Bexley, its officers, employees and volunteers from any and all liability for accidents, injuries, loss of and / or damage to my / our person or property that may arise out of my child's participation in or at the listed activity / activities. I / we are aware that participating in activities or use of facilities involves certain risk of injury despite safety precautions. I give permission for my child to take part in all preschool activities, including use of playground equipment and trips off the preschool grounds. In the event of an accident or emergency, if my child's physician is not available, I grant permission to call another licensed physician. I authorize the preschool staff to act for me according to their best judgment.

\_\_\_\_\_  
Signature of Parent, Custodian, or Guardian

\_\_\_\_\_  
Date



## Security Deposit & Direct Withdrawal Form

**Name of Child/Children:**

1. \_\_\_\_\_

<b>3 &amp; 4 Year Old Program</b> ___ 3-Day Half (\$190)    ___ 3-Day Full (\$510) ___ 5-Day Half (\$315)    ___ 5-Day Full (\$620)	<b>4 &amp; 5 Year Old Program</b> ___ 5-Day Half (\$315) ___ 5-Day Full (\$620)
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2. \_\_\_\_\_

<b>3 &amp; 4 Year Old Program</b> ___ 3-Day Half (\$190)    ___ 3-Day Full (\$510) ___ 5-Day Half (\$315)    ___ 5-Day Full (\$620)	<b>4 &amp; 5 Year Old Program</b> ___ 5-Day Half (\$315) ___ 5-Day Full (\$620)
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**Name on Card:** \_\_\_\_\_ **Credit Card Type:**    \_\_\_ VISA    \_\_\_ MC

**Account #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ / \_\_\_\_\_ **Exp. Date:** \_\_\_\_ / \_\_\_\_ **3-Digit Code:** \_\_\_\_\_

**All credit card numbers will be kept on file as a security deposit. Cards will not be charged unless a child drops from the program or the MONTHLY box is checked below for automatic withdrawal. If a child drops, the card listed above will be charged immediately. Monthly payments will be charged on the 1<sup>st</sup> of each month.**

**DEPOSIT**    Cost of one month's tuition (not charged)    
  **MONTHLY**

By signing this form, you are giving permission to the Bexley Recreation & Parks Department to charge to the above listed credit card and/or account number the amount owed each week for Jeffrey Mansion Preschool. All late fees, cancellation charges, and outstanding payments will be assessed to this card. Payment for any other Bexley Recreation sponsored program may NOT be charged as a result of this form.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Month Attending**  
 September 2016  
 October 2016  
 November 2016  
 December 2016  
 January 2017  
 February 2017  
 March 2017  
 April 2017  
 May 2017

**Account to be Charged on:**  
 September 1, 2016  
 October 1, 2016  
 November 1, 2016  
 December 1, 2016  
 January 1, 2017  
 February 1, 2017  
 March 1, 2017  
 Friday, April 1, 2017  
 May 1, 2017



## Dismissal Form

My Child has permission to be picked up at preschool by any of the following people:

Name of Child/Children: \_\_\_\_\_

Name of Authorized Person(s)

Relationship to Child (friend, relative, ect.)

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\_\_\_\_\_ (parent)

\_\_\_\_\_ (parent)

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Parent Signiture

Date

Comments:

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Ohio Department of Job and Family Services  
**CHILD ENROLLMENT AND HEALTH INFORMATION  
 FOR CHILD CARE CENTERS AND TYPE A HOMES**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth		First Day at Center	
Home Address				City	
State	Zip Code	Home Telephone Number			
Parent/Guardian Name			Relationship to Child		
Home Address		Home Telephone Number			
City		State	Zip		
Email Address (if applicable)		Cell Phone			
Parent's Work/School Telephone Number		Parent's Work/School Name			
Parent's Work/School Address			City		
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
<b>Where can you be reached while your child is in this program?</b>					
Parent/Guardian Name			Relationship to Child		
Home Address		Home Telephone Number			
City		State	Zip		
Email Address (if applicable)		Cell Phone			
Parent's Work/School Telephone Number		Parent's Work/School Name			
Parent's Work/School Address			City		
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
<b>Where can you be reached while your child is in this program?</b>					
<b>Emergency Contacts: Parents <u>cannot be listed</u> as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.</b>					
Name			Name		
City	State	City		State	
Telephone Number	Relationship to Child		Telephone Number	Relationship to Child	
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State	Telephone Number		

Child's Name

**Allergies, Special Health or Medical Conditions, and Food Supplements**

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A home.

Does your child have any food, medication or environmental allergies? *(check all that apply)*

- No  
 Yes - check all that apply     Food     Medication     Environmental    Please list and explain:

Does your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? *(check one)*

- No  
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? *(check one)*

- No  
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, 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 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? *(check one)*

- No  
 Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

- No  
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.  
 N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? *(check one)*

- No  
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No  
 Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."  
 N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

**Diapering Statement**

Is your child toilet trained? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> 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 center/type A home's policy or another:	
<input type="checkbox"/> I agree with the program's schedule	<input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

**Emergency Transportation Authorization**

<b>Give <u>Permission</u> to Transport</b>	<b>OR</b>	<b><u>Do Not Give Permission</u> to Transport</b>
Center or Type A Home Name	<b>Do not sign both</b>	Center or Type A Home Name
<b>has permission</b> 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.		<b>does not have permission</b> to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature                      Date		Parent's Signature                      Date

**Acknowledgement of Policies and Procedures**

I have reviewed and received a copy of the center's or type A home's policies and procedures/handbook.     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. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.

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 centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT**  
 For Child Care Centers and Type A Family Child Care Homes

Child's Name ( <i>print or type</i> )	Date of Birth
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This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: \_\_\_\_\_

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) \_\_\_\_\_

<b>Recommended Immunizations (<i>enter month, day, and year</i>)</b>					
Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

**Recommended Assessments/Screenings:**

Vision:  Yes  No Date: \_\_\_\_\_      Hearing:  Yes  No Date: \_\_\_\_\_  
 Dental:  Yes  No Date: \_\_\_\_\_      Lead:  Yes  No Date: \_\_\_\_\_  
 BMI:  Yes  No Date: \_\_\_\_\_      Other: \_\_\_\_\_

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination
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**Ohio Administrative Code rules 5101:2-12-37 and 5101:2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care center or type A home.**

Name of Physician /Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State and Zip Code	

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37 of the Administrative Code.

Ohio Department of Job and Family Services  
**REQUEST FOR ADMINISTRATION OF MEDICATION**  
**Child Care Centers and Type A Homes**

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

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

<b><u>Check all that apply:</u></b>	
<input type="checkbox"/> Prescription medication	<input checked="" type="checkbox"/> Topical product or lotion
<input type="checkbox"/> Nonprescription medication	<input type="checkbox"/> Food supplement
<input type="checkbox"/> Refrigeration required	<input type="checkbox"/> Modified diet
<b><u>Complete all of the following information:</u></b>	
Name of child: _____	Date of birth: _____ Weight: _____
Name of medication: <u>Hand Sanitizer</u>	Exact dosage: <u>1 pump</u>
To be administered at the following times <u>before eating snack and lunch</u>	
For the following period of time: <u>while at preschool</u>	
Parent/Guardian signature: _____	Date: _____

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

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated) or food supplement; or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____		
(name of child)		(name of medication, vitamin, diet)
as follows: _____		
(include dosage and instructions)		
Possible side effects to watch for are: _____		
Expiration date: _____ (May not exceed 12 months from the date of this request for medications or food supplements)		
Signature of physician, dentist or advance practice nurse	Date of signature	Phone number



Ohio Department of Job and Family Services  
**CHILD MEDICAL/PHYSICAL CARE PLAN**  
**FOR CHILD CARE CENTERS & TYPE A HOMES**

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

<b>Child's Name</b>	<b>Date of Birth</b>
<b>Special Health Conditions</b>	
<b>Symptoms to watch for and Emergency Action to be taken if the following symptoms occur</b>	
<b>Activities/Foods/Environmental Conditions to Avoid</b>	
<b>Medical Procedures to be followed and Expected Benefit of Treatment</b>	

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

**If yes, what medications?**

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

Signature of Trainer:		<b>Date:</b>	
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<b>Signature of trained staff members and staff who have been made aware of the condition.</b>	(There must always be a trained staff member present when the child is present.)
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Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained
Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained
Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained
Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained

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

<b>Additional services (educational/therapeutic) child is receiving</b>
Who provides the above services? Name: _____ Phone number: _____ May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____ Phone number: _____ May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes

**I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.**

<b>Parent Signature</b>		<b>Date</b>	
<b>Administrator Signature</b>		<b>Date</b>	

Ohio Department of Job and Family Services  
**REQUEST FOR ADMINISTRATION OF MEDICATION**  
**Child Care Centers and Type A Homes**

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

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

**Check all that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Prescription medication    | <input type="checkbox"/> Topical product or lotion |
| <input type="checkbox"/> Nonprescription medication | <input type="checkbox"/> Food supplement           |
| <input type="checkbox"/> Refrigeration required     | <input type="checkbox"/> Modified diet             |

**Complete all of the following information:**

Name of child: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Weight \_\_\_\_\_

Name of medication: \_\_\_\_\_ Exact dosage: \_\_\_\_\_

To be administered at the following times: \_\_\_\_\_

For the following period of time: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

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

as follows: \_\_\_\_\_  
(include dosage and instructions)

Possible side effects to watch for are: \_\_\_\_\_

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

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

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

