Ohio Department of Children & Youth

CHILD ENROLLMENT & HEALTH INFORMATION FOR CHILD CARE

PRECIOUS YEARS LEARNING CENTER, LTD.

first day at program

*This form shall be completed PRIOR to the child's first day of attendance and must be updated annually as needed

child's legal name	date of birth	home address	city	state & zip	child's phone number

parent/guardian name	relationship to child	☐ check if same as child's	city	state & zip	primary phone number

email	work name & address	city	state & zip	work phone number

Where can you best be reached while your child is in this program?
⇨ ___cell# ___ work # ___email

⇨ can the program release this name to other parents/guardians? __no __ yes
if yes, indicate check what can be released: ___cell # ___ work # ___ email address

parent/guardian name	relationship to child	☐ check if same as child's	city	state & zip	primary phone number

email	work name & address	city	state & zip	work phone number

Where can you best be reached while your child is in this program?
⇨ ___cell# ___ work # ___email

⇨ can the program release this name to other parents/guardians? __no __ yes
if yes, indicate check what can be released: ___cell # ___ work # ___ email address

EMERGENCY CONTACTS *Parents cannot be listed here*

List at least ONE PERSON who can be reached in the event of an emergency/illness if parents/guardians cannot be reached and are able to assist in contacting you. He/She must be able to take responsibility for the child and at least 18 years of age in the event that attempts to reach parents/guardians are unsucessful.

parent/guardian name	relationship to child	primary phone number	city	state	secondary phone number

parent/guardian name	relationship to child	primary phone number	city	state	secondary phone number

PHYSICIAN/CLINIC/HOSPITAL INFORMATION

Name of Physician or Clinic/Hospital	address	phone number	city	state

EMERGENCY TRANSPORTATION

Our program does not accept children unless the school is authorized to transport in the event of an emergency due to liability issues. Please sign below to indicate you agree for us to secure emergency transportation for your child in the event of an illness/injury/or incident. First responders will determine the facility to which my child will be transported.

X _____ date

Parent/Guardian signature indicating acceptance of Emergency Transportation Policy

TOILET TRAINING

Is your child toilet trained? ___ yes ___ no

Our program only accepts children in pullups if there is a developmental delay. Please indicate your child's developmental delay on the next page. Diapers are not accepted in the program and pullups must be parent provided

LIST ANY HISTORY OF HOSPITALIZATION, OUTPATIENT SURGERY OR PREVIOUS HEALTH CONCERNS THAT WOULD BE NEEDED TO ASSIST STAFF/MEDICAL PERSONNEL IN AN EMERGENCY SITUATION

☐ or N/A

LIST ANY ADDITIONAL INFORMATION THAT WOULD BE USEFUL TO KNOW, SUCH FEARS OR WAYS YOUR C CHILD LIKES TO BE COMFORTED ☐ or N/A

LIST ANY ADDITIONAL INFORMATION THAT WOULD BE USEFUL FOR STAFF TO KNOW, SUCH AS EATING OR SLEEPING HABITS

☐ or N/A

DOES YOUR CHILD HAVE ANY SPECIAL ROUTINES OR BEHAVIOR NEEDS? ☐ N/A

ALLERGIES, SPECIAL HEALTH OR MEDICAL CONDITIONS, AND MEDICAL FOODS for

Fill in accurately&completely. Note if your child has a current health/medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatments, care, or to give medication, the DCY form 1236 Child Medical/ Physical Care Plan for Child Care" must be completed and kept on file at the program.

ALLERGIES

Does your child have any food, medication, or environmental allergies? ☐ NO [move to next section]

☐ YES: ☐ food ☐ medication ☐ environmental [check all that apply, list & explain]

Does this require child care staff to monitor child for symptoms, take action if reaction occurs, give emergency medication?

☐ No

☐ Yes - DCY Form 1236 must be completed, contact Adminstrator

DEVELOPMENTAL DELAY or SPECIAL HEALTH or MEDICAL CONDITION

Does your child have a developmental delay, special health or medical condition? [check one]

☐ YES [Please explain] ☐ NO [move to next section]

every ☐ hours

If this condition requires the use of pullups, indicate # of hours staff should check/change pullup

Does this 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 program hours? [check one]

☐ No

☐ Yes - DCY Form 1236 must be completed, contact Adminstrator

MEDICATION or MEDICAL FOOD

Does your child currently using any medication or medical food?[check one]

☐ YES [Please explain] ☐ NO [move to next section]

Does this require child care staff to administer medication or medical food during program hours?

☐ No

☐ Yes - DCY Form 1236 must be completed, contact Adminstrator

DIETARY RESTRICTIONS

Does your child have any dietary restrictions, including medical, religious, or cultural reasons?[check one]

☐ YES [Please explain] ☐ No

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

☐ YES [Written instructions from the child's health care provider must be on file at the program]

ACKNOWLEDGEMENT OF POLICIES & PROCEDURES

By signing below, I acknowledge that I have received a copy of the program's policies and procedures handbook.

X _____ ☐☐☐ date

Parent Signature

X _____ ☐☐☐ date

Administrator Signature

This section reserved for recording updates