Forms: 1234, 1305, 1236,1217

ST. MARY SCHOOL

Early Childhood - Preschool Daycare
515 Beall Avenue
Wooster, OH 44691
330-262-2752
330-262-0967 FAX
www.stmarywooster.org
stmarydaycarepreschool@gmail.com

☐ Registration begins in February - once you are certain you would like a spot in our program, send in the Registration Form with fee and your spot will be reserved. The remaining papers are not due until Orientation in August (TBA) prior to school opening.

Registration Form - complete and return with fee to reserve spot.

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Thank you for your interest in the Early Childhood program at St. Mary School. A brief description of our program follows to familiarize you with our services. Your child must be 3 and potty trained to attend our program.

Our Early Childhood program is designed to offer the proper discipline and curriculum to prepare your child for school and to assist you as a parent in raising a positive and resilient child. Our curriculum is based on The Creative Curriculum System® for Preschool and includes; Spanish, Language and Literacy, Math, Science, Social Studies, Social and Emotional Development, Physical Well-being and Motor Development with gym class twice a week, development of attention, engagement and persistence.

CHOOSE FROM ONE OF THE FOLLOWING TWO OPTIONS:

OPTION 1)

_____ St. Mary Preschool with extended care - This program is open from 6:30 am to 5:30 pm each weekday during the school year. You may choose from a half day (8:30am -1:30pm) or full day (when pick up is after 1:30) and between 2-5 days per week to fit your schedule

_____ Full Days - list approximate drop off and pick up time _____
_____ Half Days - 8:30 - 1:30

Circle Days of the week needed: M T W TH F

OPTION 2)

_____ St. Mary Afternoon Preschool - Monday Wednesday Friday 12:30pm - 3:00pm

Parent/Guardian(s)
Mother:_____ Father: _____

Child's Full Name:_____DOB_____

Address:_____

Phone Number(s):_____

Email Address:_____

Drop off or mail this Registration Form with $35.00 fee to: St. Mary, ATTN: Preschool, 515 Beall Avenue, Wooster OH 44691.

How did you hear about our program?_____

St. Mary Daycare and Preschool
515 Beall Avenue
Wooster, OH 44691
330-262-2752
stmarydaycarepreschool@gmail.com
Child's name as you would like us to teach them to write it:
Who is in the child's immediate family?(Include siblings' ages if applicable)
Who lives at home with your child?
What is the primary language spoken in your child's home? How many languages are spoken?
Are there any special family arrangements, such as shared parenting, living in two homes, etc?
Are there any changes or transitions that your child has experienced recently?
Are there any cultural or religious practices we should be aware of? (Dietary restrictions, etc)?
Please list person(s) to pick up your child other than parent or guardian: (they must have picture ID)
Please list email address(es) to be used for school communications:
How did you hear about our program?
Do your give permission for your child to use alcohol based wipes (like Purell) to clean dry erase boards?
Parent/Guardian Signature and DATE

Appendix C to rule 5101:2-12-07

Center Parent Information

The center is licensed to operate legally by the Ohio Department of Job and Family Services. This license is posted in a noticeable place for review.

A toll-free telephone number is listed on the center's license and may be used to report a suspected violation of the licensing law or administrative rules. The licensing rules governing child care are available for review at the center.

The administrator and each employee of the center is required, under Section 2151.421 of the Ohio Revised Code, to report their suspicions of child abuse or child neglect to the local public children's services agency.

Any parent of a child enrolled in the center shall be permitted unlimited access to the center during all hours of operation for the purpose of contacting their children, evaluating the care provided by the center or evaluating the premises. Upon entering the premises, the parent, or guardian shall notify the Administrator of his/her presence.

The administrator's hours of availability and child/staff ratios are posted in a noticeable place in the center for review.

The licensing record, including licensing inspection reports, complaint investigation reports, and evaluation forms from the building and fire departments, is available for review upon written request from the Ohio Department of Job and Family Services.

It is unlawful for the center to discriminate in the enrollment of children upon the basis of race, color, religion, sex or national origin or disability in violation of the Americans with Disabilities Act of 1990, 104 Stat. 32, 42 U.S.C. 12101 et seq.

For more information about child care licensing requirements as well as how to apply for child care assistance, Medicaid health screenings and early intervention services for your child, please visit http://jfs.ohio.gov/cdc/families.stm.

St. Mary Catholic School
515 Beall Avenue
Wooster, OH 44691

MEDIA RELEASE AND CONSENT FORM

We recognize the value of audio-visual and digital technologies in providing our child with an effective education and hereby grant permission for our child and/or his/her schoolwork projects to be photographed or recorded as part of an educational program produced by the school or a coalition of schools.

We grant permission for the photographs or recorded work to be used in media presentations that are made available to other educational institutions or through a cable television station or network. We further grant permission for photographs to be used in print media or on the school website and school social media. We understand that our child's image, work product, school and grade may be revealed in the presentation(s), but that no other information about our child or his/her schoolwork will be revealed without prior consent.

Student Name:_____ Grade:_____

Parent(s) Name:_____

Address:_____

City:_____ State: _____ Zip Code:_____

Telephone(home):_____ Work: _____ Cell:_____

Family Internet Address:_____

Date: _____

_____ No, I do not wish to have my child's photo used in any public forum.

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Child Name **Parent Name** **Date**

Please list out two educational goals for us to work on for your child. An example of an Educational Goal: Fine Motor Coordination: Tool and Object Manipulation - Provide multiple fine motor opportunities ie... play doh, legos, chopsticks for snack and art; painting, markers, crayons, pencils.

1)_____

2)_____

Signature:_____

These goals will be discussed during parent meetings.

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	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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) 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	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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) 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 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.

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 family child care 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, 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? ☐ 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			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.		**OR** **Do not sign both**	**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 and 5101:2-13-15. 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.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth

Special Health Conditions

Symptoms to watch for and emergency action to be taken if the following symptoms occur

Activities/foods/environmental conditions to avoid, if applicable

Medical procedures to be followed and expected benefit of treatment, if applicable

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

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?
☐ Yes ☐ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?
☐ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No

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

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

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

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

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

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)* (can be faxed to St. Mary 330 262 2752)	Date of Birth

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination

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

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Optional
Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		

JFS 01305 (Rev. 12/2016)