School's Out Camp 2021-2022

Paperwork Checklist

One Packet per Child Filled Out Yearly

If Currently Registered For Before & After School Do Not Fill Out

- [ ] Health Enrollment Form
- [ ] Administration of Medication
    - ○ If applicable, if not needed put N/A
- [ ] Child Medical/Physical Care Plan
    - ○ If applicable, if not needed put N/A
- [ ] General Permission
- [ ] Permission to Pick-up
- [ ] Routine Trip Permission
- [ ] Permission to Participate in Swimming

All of these forms must be turned in yearly to hold your spot.

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 N/A 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 Lakota Family YMCA		**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.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods.
- Administering procedures which require staff to be trained on those procedures
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication is documented on this form, then a JFS 01217 is not required.

Child's Name	Date of Birth

Special Health Condition

Does the condition require medication?

☐ Yes

☐ No

☐ **Check here if questions 1 through 7 are included on a separate sheet with physician's instructions.**

1. What are the symptoms to watch for?

2. When should the medication or medical food be administered?

3. What are the instructions for administration?

4. What triggers the need for medication or medical foods?

5. What are the expected results of the medication or medical foods?

6. What are the actions to be taken if symptoms do not subside?

7. What are the activities, foods, environmental conditions to avoid? ☐ Not applicable

Training instructions *(include all steps to administer the medication or perform the medical procedure)*

☐ Included on attached physician's instructions

If expected result of medication or medical food does not occur:

☐ Check here if Emergency Medical Services (9-1-1) is to be contacted

NOTE: If Emergency Medical Services (9-1-1) is to be contacted, the parent/guardian is also to be contacted immediately.

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure	**Complete Only One Section**	**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have been trained in performing the procedure for this child.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.

Administrator/Provider Signature	Date of Signature

This 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, a new form must be completed.

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

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

LAKOTA FAMILY YMCA

CHILD CARE GENERAL PERMISSION FORM

- I hereby grant permission for my child to:
  - Use all indoor/outdoor play equipment and participate in all activities at the center.
  - Be included in pictures, media print, electronic media and evaluations connected with any of the other child care programs.
  - Participate in field trips taken by the center. Prior information will be given to the parent/guarding about the trip.
- I hereby grant permission for the Child Care Director, Site Administrator or Camp Arrowhead Directors to take whatever steps that may be necessary to obtain emergency medical/dental care if warranted as state on the Health Enrollment Form.
- I understand that all expenses incurred in obtaining medical/dental treatment are my responsibility and not the Lakota Family YMCA's.
- I understand that the Lakota Family YMCA is not responsible for anything that happens as a result of false information given by the parent/guardian at the time of enrollment.
- I understand the Lakota Family YMCA will not assume responsibility for a child who has not been signed in upon arrival or signed out when they depart for the day. I understand that the person dropping off and/or picking up must be 16 years of age or older and on the Permission to Pick Up Form.

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: ____ / ____ / ____

LAKOTA FAMILY YMCA

CHILD CARE PERMISSION TO PICK UP

I give permission for the following people to pick up my child,

_____

from the Lakota Family YMCA Child Care Programs. I understand that the person picking up my child must be at least 16 years of age or older. They may also be asked for identification when picking up my child.

- Please make us aware of any custody issues.
- Please let us know right away if there are any changes to the above list.

NAME	RELATION TO CHILD	PHONE NUMBER

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: ____ / ____ / ____

Ohio Department of Job and Family Services

PERMISSION TO PARTICIPATE IN WATER AND SWIMMING ACTIVITIES FOR CHILD CARE

Written parental permission is required for the water activities your child will be engaging in when:
(check all that apply for this activity)

- ☐ Water is directly accessible to child (no water activities planned)
- ☐ Child swimming or playing in water 18 inches or more in depth
- ☐ Infants and toddlers using wading pools

The program is providing additional adults or child care staff members that exceed the licensing ratio requirements for the water/swimming activity.
(The program is to meet the minimum ratio requirements outlined in rule).

☐ Yes ☐ No

Swim Site

Date(s)

Departure/Arrival Times from Program

Mode of Transportation *(parents driving, provider vehicle, public transportation, school bus, etc.)*

I give permission for my child to participate in the swimming/water activity listed above.

Child's Name	Child's Date of Birth
My child is a ☐ Swimmer ☐ Non swimmer	
Parent's Signature	Date