

GREEN-OAK PRESCHOOL
1921 Woodman Dr.
Kettering, Ohio 45420
252-7840

I wish my child _____ to be enrolled in Green-Oak Preschool.

I/We agree to follow all rules and regulations of said school.

I/We agree to pay the fee of _____ (\$107-3 days a week or \$88-2 days a week) per month, monthly regardless if my child is present or not.

If my child has to be withdrawn from the school, I/We will give two weeks written notice. Failure to give two weeks written notice, I/We will be charged for the full month.

If written notice is given any fees paid beyond time of notice of withdrawal will then be refunded.

I/We agree to pay the \$35 registration fee the day I/we enroll our child and fully understand this is NON REFUNDABLE. (\$60 for two children or \$80 for three children)

I/We understand that a \$5 late charge will be in force if monthly tuition is not paid by the tuition due date. (This is usually the first Friday of each month.)

Parents or Guardian:

_____ Date _____

Please circle the days and times that you would prefer for your child:

Pre-K 5-6 year old program (5 by Oct. 1, 2012)

Monday, Wednesday, Friday	9:00 – 11:30 AM
Monday, Wednesday, Friday	12:00- 2:30 PM

Pre-K 4-5 year old program (4 by Oct. 1, 2012)

Monday, Wednesday, Friday	9:00 – 11:30 AM
Monday, Wednesday, Friday	12:00 – 2:30 PM
Tuesday, Thursday	9:00 – 11:30 AM

3-4 year old program (3 by Oct 1, 2012)

Tuesday, Thursday	9:00 – 11:30 AM
Monday, Wednesday, Friday	9:00 – 11:30 AM
Monday, Wednesday, Friday	12:00 – 2:30 PM

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				
Where can you be reached while your child is in this program?				
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				
Where can you be reached while your child is in this program?				
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name <u>of at least one person</u> 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 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 _____ NICKNAME _____ GENDER M F
(Circle one)

PLEASE LIST ALL OTHER MEMBERS OF YOUR HOUSEHOLD:

Name _____ Name _____ Name _____ Name _____ Name _____

Age _____ Age _____ Age _____ Age _____ Age _____

PICK-UP PERMISSION

I give permission for the following people to pick-up my child, _____ at Green-Oak Preschool:

<u>Name</u>	<u>Relationship to Child</u>
_____	_____
_____	_____
_____	_____

Signature Date

HOW DID YOU FIND OUT ABOUT GREEN-OAK?

____ Friends or Family ____ Newspaper Ad ____ Phone Book ____ Website ____ Other

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
-------------------------------------	---------------

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) _____

Immunizations <i>(enter month, day, and year)</i>					
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
--	---------------------

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