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

I wish my child_____to be enrolled in Green-Oak Preschool, 2024-2025.

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

I/We agree to pay the fee of _____ ($155-3 days a week) or ($120-2 days a week)($265-5 days) , 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If my child has to be withdrawn from the school, I/We will give two weeks written notice.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 $50 registration fee the day I/we enroll our child and fully understand this is NON REFUNDABLE. ($90 for two children or $120 for three children)

I/We understand that a $10 late charge will be enforced if monthly tuition is not paid by the tuition due date. (This is usually the first Friday of each month.)

All Children must be fully potty trained. We do no diapering, which includes pull-ups.
All Children must meet the age requirements listed below.
By signing below, you agree to all rules and regulations stated in information packet and addendum.

Parents or Guardian:

_____ Date_____

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

Pre-K 5 year old program (5 by Oct. 1, 2024)

Monday through Friday, 5 days	9:00- 11:30 AM

Pre-K 4-5 year old program (4 by Oct. 1, 2024)

Monday, Wednesday, Friday	9:00 – 11:30 AM
Tuesday, Thursday	9:00 - 11:30 AM

3-4 year old program (3 by Oct 1, 2024)

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

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 _____ 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 Green-Oak Preschool		OR	Program or Home Name Green-Oak Preschool	
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.		**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, 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.

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:

Name& Phone#	Relationship to Child
_____	_____
_____	_____
_____	_____

_____
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

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following (*please list in space below*):

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below*)

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:	**Initials of Examining Health Care Practitioner**
☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):	**Signature of Parent**
☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	Date