

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE**

HT-1105A

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name Zac Efron		Date of Birth 3-1-00		First Day at Program/Home 8-17-2020	
Home Address 123 Hopkins St			City Defiance		
State OH	Zip Code 43512	Home Telephone Number 419-112-1234			
Parent/Guardian Name Momma Zac			Relationship to Child Mom		
Home Address 123 Hopkins St			Home Telephone Number 419-112-1234		
City Defiance			State OH	Zip 43512	
Email Address (if applicable) lovezac@gmail.com		Cell Phone 419-412-9234			
Parent's Work/School Telephone Number 419-210-4321		Parent's Work/School Name NOCAC			
Parent's Work/School Address 1933 E Second St			City Defiance		
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input checked="" type="checkbox"/> Work # <input checked="" type="checkbox"/> Cell # <input checked="" type="checkbox"/> Home # <input checked="" type="checkbox"/> Email					
Where can you be reached while your child is in this program/home? work, cell					
Parent/Guardian Name Dad Zac			Relationship to Child Dad		
Home Address 123 Hopkins St			Home Telephone Number 419-112-1234		
City Defiance			State OH	Zip 43512	
Email Address (if applicable) lovezacdad@gmail.com		Cell Phone 419-412-9235			
Parent's Work/School Telephone Number 419-210-4321		Parent's Work/School Name NOCAC			
Parent's Work/School Address 1933 E Second St			City Defiance		
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 checked="" 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/home? cell					
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 Bob Efron			Name Sally Efron		
City Defiance		State OH	City Defiance		State OH
Telephone Number 419-123-1234	Relationship to Child Uncle		Telephone Number 419-112-2345	Relationship to Child Aunt	
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 Dr. Okuley					
Street Address 1400 E Second St					
City Defiance		State OH	Telephone Number 419-784-1414		

Child's Name

Zac Efron

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:

Milk - lactose allergy

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

Lactose allergy

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 Zac Efron
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. None
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. None

Diapering Statement

Is your child toilet trained? <input checked="" type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> 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:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

<u>Give <i>Permission</i> to Transport</u>	OR	<u>Do Not Give <i>Permission</i> to Transport</u>
Program or Home Name	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 Mamma Efron		Parent's Signature
Date 8-17-20		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) Mamma Efron	Date 8-17-20
Administrator/Designee Signature Staff Signature Here	Date 8-17-20

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

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.