SYLVANIA Child Care
A PROGRAM OF SYLVANIA COMMUNITY SERVICES

Woodrow Preschool through Sylvania Community Services
POLICY ON RELEASE OF CHILDREN

Child's Name:_____DOB_____

Woodrow Preschool through Sylvania Community Services will not release a child to anyone other than the designated adults listed below. All children must be picked up by a parent or someone on this list.

We must have a written authorization for the release of your child to anyone other than these designated adults. If the parent or guardian needs to change the designated adults for release of the child, it must be done in writing. Please list the authorized adults who have your permission to pick up your child.

1. Name:_____Phone:_____

Address:_____City:_____State:_____

Zip:_____ Relationship:_____

2. Name:_____Phone:_____

Address:_____City:_____State:_____

Zip:_____ Relationship:_____

3. Name:_____Phone:_____

Address:_____City:_____State:_____

Zip:_____ Relationship:_____

4. Name:_____Phone:_____

Address:_____City:_____State:_____

Zip:_____ Relationship:_____

5. Name:_____Phone:_____

Address:_____City:_____State:_____

Zip:_____ Relationship:_____

6. Name:_____Phone:_____

Address:_____City:_____State:_____

Zip:_____ Relationship:_____

Parents Signature:_____Date:_____

Adults unrecognized by staff will be asked to show I.D.

Child's Name:_____DOB_____

PBS Show: My child has permission to watch a suitable PBS Show

☐ Yes ☐ No

G Movie: My child has permission to watch a suitable G rated show/movie

☐ Yes ☐ No

Walking: My child may walk from the Woodrow Preschool Program to:
Memorial Field, downtown Sylvania destinations such as the Bakery, Sylvania Library, Burnham Park, Haroun Park, Plummer Pool, and various walking tours that may be determined later.

☐ Yes ☐ No

Photograph/Videotape: I give consent for my child to be photographed or videotaped. This is for Sylvania Community Services purposes (i.e. Website, Facebook, Instagram, and printed collateral) or any local newspaper/television station coverage. ☐Yes ☐ No

Photograph/Videotape: In addition to a class website, social media (e.g., Facebook, Twitter or Instagram) may be used for sharing information relating to the education of children at Woodrow Preschool. This may include photographs, videos, childcare-related news posts, and child activity updates. The use of such social media is considered an extension of the preschool program's form of communication and will not be used for personal communication for staff, students or parents. Children's names will not be posted with their photographs.

☐ Yes, I give consent to have my child photographed and videotaped for educational use on the preschool program's social media.

☐ No, I do not give consent to have my child photographed and videotaped for educational use on the preschool program's social media.

Annual Class Roster

Each year we prepare a roster for each group of children in our program. This roster will not be furnished to any persons other than parents of children enrolled in our program.

I authorize my child's name, my name and phone number to be listed on the parent roster.

☐ Yes ☐ No

Notice: For children of divorced parents, the Ohio Revised Code provides that non-residential parents are entitled to: access to the day care facilities during SCS child care hours for the purposes of contacting their children; access to records such as child care time and attendance; and to have a parent-teacher conference UNLESS there is an agreement to the contrary between the parents or a court order or divorce decree stating otherwise. If this situation applies to me, I agree to provide SCS with copies of the appropriate paperwork.

Parent/Guardian Signature _____ Date_____

Due to state policy, all registration packets MUST be completed in their entirety prior to your child's first day of attendance. All medications and medical forms must be on site and verified. If a child arrives at the Preschool Program without a completed registration or medical forms and medications, the Parent/ Guardian will be called, and the child will need to be picked up.

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 childcare 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:

Do your child's allergy/allergies require childcare 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 childcare staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during childcare 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 childcare 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.

☐ 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 hour. 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		OR	***Do Not Give Permission*** to Transport	
Program or Home Name **Sylvania Community Services - Woodrow Child Care Center**		Do not sign both	Program or Home Name **Sylvania Community Services - Woodrow Child Care Center**	
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 childcare 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 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 childcare program in providing appropriate childcare 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: ☐ 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):*	**Initials of Examining Health Care Practitioner**
	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ 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):	**Signature of Parent** Date:

Ohio Department of Children and Youth

FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)

We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL

Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.

Child's/Children's Name(s):	Caretaker's Name:	Date Completed:

	TOPICS	Briefly List CONCERN
Child Development and Education- Does anyone in your family have any need for resources or support in the areas listed below?		
Y N	Information on child growth and development.	
Y N	Guiding and supporting a child's behavior.	
Y N	Medical or disabilities or possible conditions for any child or adult in the family.	
Y N	Obtaining toys or activities to use to help any child in your home.	
Y N	Preparing your child for kindergarten.	
Child and Family Health- Does anyone in your family have any need for resources or support in the areas listed below?		
Y N	Health insurance and/or access to regular medical care, dental care, or medications.	
Y N	Medical or health supplies or supports that anyone in your family needs.	
Y N	Accessing immunizations.	
Y N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.	
Y N	Concerns with depression, anger, anxiety, or mental health needs.	
Y N	Concerns with alcohol, drug, or addiction problems.	
Financial and Household Supports- Does anyone in your family have any need for resources or support in the areas listed below?		
Y N	Help paying for child care.	
Y N	Help finding housing or safe housing.	
Y N	Help paying your mortgage or rent.	
Y N	Help with food expenses.	
Y N	Finding household items such as furniture, clothing, or school supplies.	
Y N	Access to transportation or transportation expenses.	
Y N	Attending school (such as a GED, Certifications, or college degrees)	
Y N	Help finding work or job training	

Are there other needs you or your family have that are not listed above:	
Parent Signature	Date:
Administrator or Designee Signature:	Date:

For Staff Use:

Bronze Rating Level	Silver Rating Level	Gold Rating Level
Resources provided to the family:	Resources provided to the family:	Resources provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
	Referrals provided to the family:	Referrals provided to the family:
	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
		Follow-up provided to the family:
		Administrator or Designee Signature & Date: