Date of application: _____ Date child/children will start: _____

Scheduling needs: (please mark age group(s) and days of participation)

☐ 6 wks- 17 mth ☐ 17-30 mths ☐ 30-36 mnths ☐ Preschool ☐ Pre-K ☐ Kindergarten AM ☐ Kindergarten PM

☐ Mon, Wed, Fri ☐ Tues & Thurs ☐ All days

Child's Name: _____ DOB: _____ Age: _____ Sex: M or F

Child's Name: _____ DOB: _____ Age: _____ Sex: M or F

Child's Name: _____ DOB: _____ Age: _____ Sex: M or F

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Social Security#: _____

Work#:_____ Cell#:_____ Home#:_____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Father's Name: _____ Social Security#: _____

Work#:_____ Cell#:_____ Home#:_____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Preferred Pin number for checking in/out 1st Choice _ _ _ _ 2nd Choice _ _ _ _

Ohio Department of Children and Youth

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

Child's Name		Date of Birth	First Day at Program
Address			
City		State	Zip Code
Parent #1 Name		Parent #1 Phone Number	
Parent #1 Address ☐Same as Child's		City	State / Zip Code
Parent #1 Email Address (if applicable)		Parent #1 Cell Phone (if applicable)	
Parent #1 Work/School Name (if applicable)		Parent #1 Work/School Phone Number (if applicable)	
Check here if Not Applicable ☐	Parent #2 Name	Parent #2 Phone Number	
Parent #2 Address ☐Same as Child's		City	State / Zip Code
Parent #2 Email Address (if applicable)		Parent #2 Cell Phone (if applicable)	
Parent #2 Work/School Name (if applicable)		Parent #2 Work/School Phone Number (if applicable)	
Primary Emergency Contact #1 Name (cannot be parent/guardian)		Check here if Not Applicable ☐	Optional Emergency Contact #2 Name (cannot be parent/guardian)
Primary Emergency Contact #1 Phone Number		Optional Emergency Contact #2 Phone Number	
Primary Emergency Contact #1 Other number or email address for emergency contact *(if applicable)*		Optional Emergency Contact #2 Other number or email address for emergency contact *(if applicable)*	
My child may be released to this emergency contact ☐ Yes ☐ No		Optional My child may be released to this emergency contact ☐ Yes ☐ No	

Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication?

☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

Child's Name	Date of Birth

Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes
☐ No

Name of service provider(s) and frequency

☐ N/A

Emergency Transportation Authorization

☐ **The program 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.

☐ **The program 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:

SIGNATURE

This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.

Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures

By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures (parent handbook).

Parent Signature	Date

Program Acknowledgement of Completion

By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.

Program Administrator/Designee Signature	Date

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	
1.Aquaphor 2. Vasoline 3. Banana Boat 50 spf	Pea sized squirt or amount to cover entire area ☐	
To be administered at the following times	**For the following period of time**	**Medication expiration date**
1.When diaper area is red 2. After BM 3. Before Sun Exposure May-Aug	1 year 7/29/26- 7-29-27	

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

Appendix B: Sample Parent/Guardian Agreement

The following provisions constitute an agreement between Young Leaders Learning Center and the parents/guardians of:_____

1. Care is contracted for the following days and times each week:

   _____

2. For the time contracted, a weekly fee of $ _____ will be paid in advance of the first of each week. With each payment I will include the name of my child and what the payment covers. Tuition payments may be left at the front desk or given directly to the director.
3. A completed registration form and medical record must be completed before a child starts.
4. A medical form must be signed by a nurse or doctor at least 30 days after enrollment and updated every 13 months.
5. I understand other fees I may be charged include:
   - A non-refundable registration fee of $80.00 per child (6 weeks-17 months) and $60.00 per child (18 months and older).
   - A $55.00 charge for any checks returned for non-sufficient funds.
   - A $35.00 surcharge for late fees if payment isn't received before the end of the first business day of the week.
   - A late fee of $1.00 per minute for a child picked up after 6:00pm (this is payable to the teacher at the time of lateness).
   - Certain classroom enrichment activities offered through outside vendors.
6. I understand that no refunds are given for absences due to illness, holidays or personal reasons.
7. A written notice of withdrawal from the Center must be given two weeks in advance of the last scheduled day of enrollment.
8. I understand that any changes in this agreement must be negotiated between the Center Director and myself at least two weeks prior to the effective date.
9. I authorize Young Leaders Learning Center to care for my child/ren. ***I have given my consent for emergency medical care and treatment and turned in registration and medical forms.*** I will keep the Center current on all relevant information regarding my child/ren. I will read and abide by the policies outlines in the Parent Handbook and the terms of this agreement.

_____

Parent/guardian signature date

_____

Center official signature date

YOUNG LEADERS
LEARNING CENTER
www.YoungLeadersLearningCenter.com

I give, Young Leaders Learning Center and any entity, affiliate, member or owner of Young Leaders Learning Center the exclusive authorization for the use of my child's photograph.

Check **all** that apply:

☐ I give permission for my child's photograph to be used only in the center.

☐ I give permission for my child's photograph to be used in any & all of the Young Leaders Learning Center marketing brochures, internet advertising and web pages chosen by and on behalf of Young Leaders Learning Center.

☐ I give no photo permission at the center or for Young Leaders Learning Center media purposes.

Child's Name:

_____

Parent/Legal Guardian:

_____

(Print)

_____ _____

(Sign) (Date)

Tuition® Express

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B)**. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

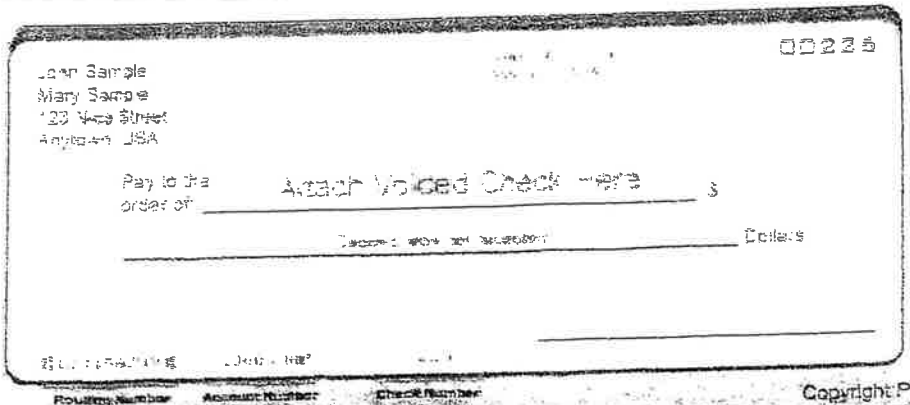
Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received _____

Employee Signature _____



A service of procare SOFTWARE

Family Information Form

Child's Name_____ Nickname (if any) _____

By providing complete information about your child, you will be assisting staff in creating a positive experience while in our care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

Who lives at home with your child and what is the primary language spoken in the home?
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.?
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet)
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)
Do you have any pets at home? If so, what are they and what are their names?
Does your child have any favorite foods or foods he/she dislikes?
Are there any foods your child should not be fed? (ODJFS Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)
Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?
What methods do you use to respond to your child's negative behavior?
Does your child use any special comfort or support items that help him/her go to sleep? If so, what?
Is your child toilet trained? If so, what words or gestures does your child use if he/she needs to use the bathroom?
Does your child need assistance when using the toilet? If so, how?
Circle the words which best describe your child's personality and behavior: active, quiet, curious, happy, excitable, loud, outgoing, sensitive, friendly, easily-angered, hesitant, insecure, shy, shares-well, spontaneous, stubborn, cheerful, calm, cautious, bright, bossy, affectionate, adventurous, jealous, likes structure/routines, other-please list:
What are your expectations of this program and any other information which would be helpful for the staff caring for your child? Please use the back of this form if more space is needed.

Parent/Guardian's Signature	Date