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	**Marsha Syble Cuthbert**				
Date of Birth	**09/26/2014**	First Day at Program/Home	**04/07/2017**		
Home Address	**21525 Ridgetop Circle**				
City	**Wedonia**	State	**South Dakota**	Zip Code	**20002**
Home Telephone Number	**722-886-7839**				
Parent/Guardian Name	**Addison Cuthbert**	Relationship to Child	**Father**		
Home Address	**2335 Eagle Road**				
Home Telephone Number	**397-764-9234**				
City	**Fox Valley**	State	**Mississippi**	Zip Code	**20002**
Email Address (if applicable)	**Addison.Cuthbert@outlook.com**				
Cell Phone	**329-673-5818**				
Parent's Work/School Telephone Number	**557-561-4355**				
Parent's Work/School Name	**Data Networks Corporation**				
Parent's Work/School Address	**15932 Greenway Nw**				
City	**Silver Spring**				

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. ☑ **Yes** ☐ **No**

If you answered yes, please indicate which number(s) above to include on the list: ☐ **Work #** ☑ **Cell #** ☑ **Home #** ☑ **Email**

Where can you be reached while your child is in this program/home?	**Work Phone**		
Parent/Guardian Name	**Millicent Cuthbert**	Relationship to Child	**Mother**
Home Address	**14155 Maple Avenue**		
Home Telephone Number	**527-962-4427**		
City	**Mapleton**	State	**Ohio**	Zip Code	**20002**
Email Address (if applicable)	**Addison.Cuthbert@icloud.com**		
Cell Phone	**577-845-0902**		
Parent's Work/School Telephone Number	**220-790-1330**		
Parent's Work/School Name	**Soft Tech Consulting, Inc.**		
Parent's Work/School Address	**3930 Sweet Woodruff Lane**		
City	**Silver Spring**		

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. ☑ **Yes** ☐ **No**

If you answered yes, please indicate which number(s) above to include on the list: ☑ **Work #** ☑ **Cell #** ☑ **Home #** ☑ **Email**

Where can you be reached while your child is in this program/home?	**Work Phone**

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	**Richard Logue**	Name	**Steve Lehman**
City	**West Logan**	City	**Newaygo**
State	**Utah**	State	**Oklahoma**
Telephone Number	**392-739-6539**	Telephone Number	**226-251-7745**
Relationship to Child	**Neighbor**	Relationship to Child	**Grandparent**
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)	
4382669186		**4382669186**	

Name of Physician or Clinic/Hospital **Norman Lockshin**

Street Address **5565 Sterrett Pl Suite 200**

City **College Park** State **Oklahoma** Telephone Number **480-264-4979**

Child's Name	**Marsha Syble Cuthbert**

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: **Cow's milk, Dairy products, pollen, trees, cats**

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

Attention-deficit/hyperactivity disorder

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 - 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

Astelin, Zyrtec, Dexedrine

If yes, does this medication, food supplement, or medical food need to be administered at the child care center or family child care 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

Marsha is a vegitarian

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	**Marsha Syble Cuthbert**

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.

Kidney transplant surgery

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.

Eats slowly. Needs rest after playground.

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 **3 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 2 hours

Emergency Transportation Authorization

Give Permission to Transport		**OR** Do not sign both	Do Not Give Permission to Transport	
Program or Home Name			Program or Home Name **Guidestar Center of Silver Spring**	
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: **Call Manny's ambulance service at 256-658-9988**	
Parent's Signature	Date		Parent's Signature **Millicent Cuthbert**	Date **12/28/2016**

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. (check one) ☐ Yes ☑ No

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) **Millicent Cuthbert**	Date **04/14/2017**
Administrator/Designee Signature **Albert Einstein**	Date **11/02/2016**

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
RIQ	**06/11/2017**	**NQW**	**02/03/2017**
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
PDD	**12/08/2016**	**PNJ**	**10/16/2016**
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
MHX	**05/27/2017**	**YOF**	**11/26/2016**

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.