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.**

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| Child's Name<br>**Simulated Syble Cuthbert** | | Date of Birth<br>**4/13/2019** | | First Day at Program/Home<br>**10/23/2018** |
| Home Address<br>**21525 Ridgetop Circle** | | | | City<br>**Wedonia** |
| State<br>**South Dakota** | Zip Code<br>**98889** | Home Telephone Number<br>**722-886-7839** | | |
| Parent/Guardian Name #1<br>**Addison Cuthbert** | | | Relationship to Child<br>**Father** | |
| Home Address ☐ Same as Child's<br>**2335 Eagle Road** | | | Home Telephone Number ☐ Same as Child's<br>**397-764-9234** | |
| City<br>**Fox Valley** | | | State<br>**Mississippi** | Zip<br>**72784** |
| Email Address (if applicable)<br>**addison.cuthbert@outlook.com** | | Cell Phone<br>**329-673-5818** | | |
| Parent's Work/School Telephone Number<br>**557-561-4355** | | Parent's Work/School Name<br>**Data Networks Corporation** | | |
| Parent's Work/School Address<br>**15932 Greenway Nw** | | | City<br>**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?
**Addison can be reached at Data Networks Corporation**

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|---|---|---|---|
| Parent/Guardian Name #2<br>**Cuthbert** | | Relationship to Child<br>**Mother** | |
| Home Address ☐ Same as Child's<br>**14155 Maple Avenue** | | Home Telephone Number☐ Same as Child's<br>**527-962-4427** | |
| City<br>**Mapleton** | | State<br>**Ohio** | Zip<br>**67757** |
| Email Address (if applicable)<br>**cuthbert.millicent@icloud.com** | Cell Phone<br>**577-845-0902** | | |
| Parent's Work/School Telephone Number<br>**220-790-1330** | Parent's Work/School Name<br>**Soft Tech Consulting, Inc.** | | |
| Parent's Work/School Address<br>**3930 Sweet Woodruff Lane** | | City<br>**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?
**Millicent can be reached at Soft Tech Consulting, Inc.**

**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.

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|---|---|---|---|
| Name<br>**Richard Logue** | | Name<br>**Steve Lehman** | |
| City<br>**West Logan** | State<br>**Utah** | City<br>**Newaygo** | State<br>**Oklahoma** |
| Telephone Number<br>**392-739-6539** | Relationship to Child<br>**Neighbor** | Telephone Number<br>**226-251-7745** | Relationship to Child<br>**Grandparent** |
| Other numbers where emergency contact can be reached (if applicable)<br>**4382669186** | | Other numbers where emergency contact can be reached (if applicable)<br>**345-876-9876, 345-876-9878** | |
| | | | |

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|---|---|---|
| Name of Physician or Clinic/Hospital<br>**Norman Lockshin** | | |
| Street Address<br>**5565 Sterrett Pl Suite 200** | | |
| City<br>**College Park** | State<br>**Oklahoma** | Telephone Number<br>**480-264-4979** |

Child's Name
**Simulated 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 "Child Medical/Physical Care Plan for Child Care" must be completed and 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, 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: cuthbert developmental delay and special health condition

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
**Simulated 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.

**History: Simulated cuthbert Health history**

☐ 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. Simulated cuthbert Fears and comforting**

☐ 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 behaviors. Simulated cuthbert Special routines and habits**

☐ Not applicable

| Child's Name |
|---|
| **Simulated Syble Cuthbert** |

**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 **2 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 5 hours hours

**Emergency Transportation Authorization**

| **Give *Permission* to Transport** | | | **Do Not Give *Permission* to Transport** | |
|---|---|---|---|---|
| Program or Home Name<br>**Guidestar Early Childhood Education** | | **OR**<br>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<br>*Norberto Welch* | Date<br>**11/22/2018** | | 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. (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.

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|---|---|
| Parent/Guardian Signature(s)<br>*Millicent Cuthbert* | Date<br>**6/14/2021** |
| Administrator/Designee Signature<br>*Luvenia Outlaw* | Date<br>**11/18/2015** |

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 |

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.