
3745 Copley Road, Copley, Ohio 44321 330-666-8293 phone

kidsacademyofcopley@yahoo.com

***Student Information:***

Last Name_____ First Name_____ MI___

Street Adress_____

City_____ State_____ Zip code_____Home phone_____

Sex: M__F__ Date of Birth_____ Place of Birth_____

Social Security #_____ Language Spoken_____

***Enrolling For:*** ( check one)

__ Infant Toddler __ Preschool __ School-age__ Am __ PM__ Both __Summer Camp

(Circle Days Attending)

Monday Tuesday Wednesday Thursday Friday Varied #__

Previous Group Experience_____#of yrs.___

***Parent/Family Information:***

Father's Name_____Birthplace_____Education_____

Occupation_____Employer_____ WK Phone_____

Mother's Name_____Birthplace_____Education_____

Occupation_____Employer_____ WK Phone_____

Parents Seperated __Y__N Parents Divorced__Y__N Father or Mother Deceased__Y__N

If separated who is custodial parent_____ Does noncustodial parent have visitation rights_____

Please list who can pick up your child_____

Student lives with:_____ # of brothers___older___younger #of sisters __older__younger

Language spoken in home_____Religion(optional)_____

I affirm the above information is correct_____Date_____

Date enrolled_____Date Started_____Date Dismissed_____

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 | | 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 [redacted] 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 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 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:

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

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

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.

☐ 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 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 _____ hours.

**Emergency Transportation Authorization**

| **Give *Permission* to Transport** | | | **Do Not Give *Permission* to Transport** | |
|---|---|---|---|---|
| Program or Home Name<br>Kids Acadmey of Copley | | **OR**<br>**Do not sign both** | Program or Home Name<br>N/A | |
| **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 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.

Ohio Department of Job and Family Services

# BASIC INFANT INFORMATION FOR CHILD CARE

This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.

| Child's Name | Nickname |
|---|---|
| Child's Date of Birth | Siblings |

What are you feeding your infant? *(Check all that apply)*

☐ Formula (include brand) ☐ Breast milk

Formula preparation *(if center/provider is to prepare.)*

| Amount for each feeding | Frequency of feedings |
|---|---|

My infant likes a bottle warmed: *(Check one)* ☐ Room temp ☐ Warm ☐ Very warm/NOT HOT

Juice *(type, amount, when?)*

Does child use a cup yet? ☐ No ☐ Yes

Solid foods *(baby food, brand, types, amounts, frequency)*

**you must have written permission from your child's physician if your child is under 4 months and given solid foods.*

Are foods served room temperature or warmed?

Table food *(types, amounts, frequency, special instructions)*

Security items *(pacifier, blankies, etc.)*

Nap schedule

Hints for getting baby to sleep

Sleeping Position ☐ Back ☐ Side* ☐ Tummy*

**You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a JFS 01235.*

Special Precautions

Any additional information about your child that would be helpful or you would like staff to know.

| Parent Signature | Date |
|---|---|
| Primary Caregiver Signature | Date |

| Date form last updated | | | | | |
|---|---|---|---|---|---|

Ohio Department of Job and Family Services

# SLEEP POSITION WAIVER STATEMENT FOR CHILD CARE

## Safe Sleep Practices

Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of an infant under one year of age. Doctors don't know what causes SIDS, but they have found some things that can make babies safer. The American Academy of Pediatrics and the National Institute of Child Health and Human Development state that one of the most important things that can help reduce the risk of SIDS is to put healthy babies on their backs to sleep. State regulations require child care centers, family child care, and in-home aides to place all infants to sleep on their back. A few babies have health or medical conditions that might require them to sleep in an alternative position. At the advice of the infant's physician, the child care program may be authorized to use an alternative sleep position for the infant due to health or medical conditions. If an infant is to be placed in the crib in any other positions than on their back, this form must be completed by the child's physician and signed by the parent.

## To Be Completed by the Infant's Parent/Guardian

| Name of Infant | | Date of Birth |
|---|---|---|
| Name of Primary Care Physician | | |
| Name of Practice | | |
| Address | | |
| Phone | Fax *(optional)* | Email *(optional)* |
| Signature of Caretaker/Parent *(authorizing this instruction)* | | Date |

## To Be Completed by the Infant's Primary Physician

| The above named infant has the following health or medical condition that necessitates an alternative sleep position | |
|---|---|
| Describe the appropriate sleep position for the above named infant | |
| Additional instructions | |
| Signature of Physician | Date |
| This above instruction is effective from *(date)* to *(date)* | |

# Kids Academy of Copley

## General Consent

I hereby grant permission for my child to participate in the program and all activities of this program including transportation to and from fieldtrips and school. I also grant permission to use photographs of my child and put classrooms photos on class emails to parents in the classroom as well as our Instagram page. ( @kids.academy.of.copley) I hereby release, indemnify and hold you and your agents and employees harmless from any and all claims, damages or liabilities to or damage by my child which are not a result of gross negligence by Copley Day Care Center, Inc. DBA Kids Academy of Copley, it's agents or employees.

I hereby warrant to Kids Academy of Copley that I am entitled to legal custody and possession of my child and accordingly am authorized to place my child in your program, care custody and I am further authorized to sign this consent form.

I further warrant that I will pay in advance each week the sum of my child's weekly attendance or the weekly minimum charge and any late fees or other special charges for services rendered by Kids Academy of Copley and I am aware registration fees are non-refundable.

_____ _____ _____

Parent Signature Social Security# Date

_____ _____ _____

Parent Signature Social Security# Date

***Both parents/guardians must sign. Social Security numbers are required.***

# Kids Academy of Copley

## Enrollment Agreement

1. It is my desire to enroll _____ in Kids Academy of Copley. Continued enrollment is at the discretion of Kids Academy of Copley.
2. I hereby agree to pay on Monday of each week the sum of my child's projected weekly attendance. I understand that a three- day minimum is required each week (unless prior arrangements are made with the Director) I will be charged three days if my child is here less than the minimum. I understand any additional services required will adjust the rate and all rates are subject to change without notice as conditions may require.
3. Payment of fees: All fees will be paid at the beginning of each week. If the fee is not paid by noon 12:00 Wednesday, it will be deemed delinquent and will be automatically charged to my credit card on file. A $10 late fee will also be added to my account. I agree and understand that in addition to late charge and unpaid balance on my account will accrue interest at the rate of 20% per annum from the date of delinquency. I give authorization to charge my credit/debit/checking account per the terms stated above.
4. Attendance Requirements: I understand that my child is to attend Kids Academy of Copley at least three times per week, in order to keep my child's place reserved. If my child is discharged or takes a leave of absence, I will be required to pay a re-enrollment fee of $50 prior to readmission providing an available and appropriate opening exists.
5. Late Pick up Fee: I understand that if my child remains at Kids Academy past the closing time of 5:30pm I will be charges and agree to pay $10 for every 10 minutes or part thereof past the 5:30 hour. Any unpaid charges will accrue interest rate stated above from the date incurred.
6. Withdrawal: I understand that my child is absent from Kids Academy of Copley for two weeks and or appropriate fees have not been paid my child will be discharged from Kids Academy of Copley and a $50 reenrollment fee will be charged prior to readmission, provided an available and appropriate opening exists.
7. Returned Check Policy: I understand that for any returned check a $30 fee plus the amount owed will be charged to my card/check on file automatically.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Parent Signature | Social security # | Date |
| _____ | _____ | _____ |
| Parent Signature<br>***(Both Parents Must Sign)*** | Social security # | Date |

# Automated Payment Processing

Procare SOLUTIONS

## 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**

800.338.3884 • procaresoftware.com

myprocare®

Dear parent/guardian,

Kids Academy of Copley is pleased to offer **MyProcare**, a free online portal for you to access account information and easily pay tuition. MyProcare is safe, secure and created with your convenience in mind.

**Log in today!**

1. Go to MyProcare.com.

2. Enter your email address (the email you have on file with Kids Academy) and choose ***Go***.

3. Enter the confirmation code sent to your email, choose a password, and press ***Go***.

4. Then you may:
    a. View your child's schedule, time card, immunizations and more.
    b. Use the ***Pay*** button to make a payment with your card.

Thank you!

Kids Academy of Copley and MyProcare

Ohio Department of Job and Family Services

# FAMILY INFORMATION
# FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

| Child's Name *(Last)* | *(First)* | Nickname *(If any)* |
|---|---|---|
| | | |

*By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in 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 is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

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) Additional Details?

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?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

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?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. *(Check the one that applies.)*

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

| |
|---|
| Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain. |
| What might you and/or your child be anxious about as he/she starts in this program? |
| What are you and/or your child excited about as he/she starts in this program? |
| What are your expectations of this program? |
| What other information would be helpful for the staff caring for your child to know? |

| | |
|---|---|
| Parent/Guardian's Signature | Date |

Ohio Department of Job and Family Services

# 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 child care program in providing appropriate child care 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 |