

God's Kidz South

Hours of Operation:

Monday: 6:30am-5:30pm

Tuesday: 6:30 am-5:30pm

Wednesday: 6:30am-5:30pm

Thursday: 6:30am-5:30pm

Friday: 6:30am-5:30pm

***Children must be here by 10am to attend that day**

***Closed major holidays. (refer to family handbook for exact dates)**

***also refer to handbook for late pickup rules and fee's**

Ohio Department of Job and Family Services
ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information	
Routine Trip Destination(s)	
Date of Permission <i>(valid for one year)</i>	
Mode of Transportation <i>(walking, school bus, public transportation, parent vehicles, provider vehicle and driver)</i>	
During this trip children will have access to water that is 18 inches or more in depth. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if yes, a swimming permission slip is required)</i>	
Child's Information	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 8 years and/or over 4' 9"	
Signature	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date

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

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?

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name (Last)	(First)	Nickname (If any)
<p><i>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.</i></p>		
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? <input type="checkbox"/> Yes or <input type="checkbox"/> No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice or <input type="checkbox"/> 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)		

Ohio Department of Education - Office of Integrated Student Supports
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be completed annually and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME
(please print)

AGE

BIRTHDATE

month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE
AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.

SIGNATURE OF PARENT/GUARDIAN

DATE

DAY PHONE NUMBER

**MAILING ADDRESS:
STREET /APT.**

CITY

ZIP CODE

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.aser.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Revised 10/2019

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2020-2021

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME			CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)	PART 2 -- LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.		
PART 1 -- PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER				<input type="checkbox"/>	Check type of benefit: <input type="checkbox"/> FOOD ASSISTANCE (SNAP) or <input type="checkbox"/> OHIO WORKS FIRST (OWF)	
* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE			CASE NO.	
1.					CASE NO.	
2.					CASE NO.	
3.			CASE NO.			

PART 3 -- TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	<input type="checkbox"/>	\$ amount / how often	\$ amount / how often	\$ amount / how often	\$ amount / how often
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

PART 4 -- SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

Signature of Adult Household Member: _____ DATE: _____

* If Part 3 is completed, insert last 4 digits of Social Security Number:
 (Check if applicable) I do not have a Social Security Number

Print Name: _____ Daytime Phone Number: _____ Work Phone Number: _____
 Street / Apt: _____ City / State / Zip: _____ County: _____

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other

Please mark one ethnic identity: Hispanic or Latino Not Hispanic or Latino

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.
 State Distribution: 7/1/2020

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion:
 Weekly x 52, Every 2 Weeks (bi-weekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Total Household Size: _____	Total Household Income: \$ _____ Per: <input type="checkbox"/> week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice per month <input type="checkbox"/> month <input type="checkbox"/> year	Application Certified/Categorized as: <input type="checkbox"/> FREE, based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household size and income <input type="checkbox"/> Foster Child <input type="checkbox"/> REDUCED, based on Household size and income <input type="checkbox"/> PAID, based on <input type="checkbox"/> Income too high <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information
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Signature of Sponsor / Center Representative _____ Date Sponsor Certified/Categorized Form _____
 Note: Effective date is determined by parent or sponsor signature date as selected on CRIS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.
 Effective Date (From the 1st of month of date signed) _____ Expiration Date (Valid until last day of month in which form was signed one year earlier) _____

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)		Date of Birth
<input checked="" type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. <input checked="" type="checkbox"/> This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).		
Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner		Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner		Telephone Number
Street Address		
City, State and Zip Code		

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature
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Optional Recommended Assessments/Screenings			
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
Measurements		Notes	
Height			
Weight			
BMI			

Parent Handbook Acknowledgement

I have received and read all of the information in this handbook for God's Kidz East. I understand that I must follow the policies and procedures of the center and this serves as a contract between me and God's Kidz East. In signing, I agree to adhere to all the guidelines and policies contained therein.

Parent printed name

Parent Signature

Child's Name

Date

GKZ has my permission to take photos of my child or publish my child's artwork for the memory book and other PR publications such as monthly newsletter, newspaper, and advertisements. Photos will be also allowed in the classroom or hallway for displays.

Yes

No

I would like to be listed on the GKZ parent roster.

Yes

No

Director Signature

Date

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.
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.

Diapering Statement

Is your child toilet trained? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> No (If no, fill out the following)
The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport	OR	Do Not Give <u>Permission</u> to Transport
Program or Home Name	OR	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		Parent's Signature
Date		Date

Acknowledgement of Policies and Procedures I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>
--

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 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.

Child's Name

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:

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

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 "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

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

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.

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			Relationship to Child		
Home Address			Home Telephone Number		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name			Relationship to Child		
Home Address			Home Telephone Number		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Emergency Contacts: Parents <u>cannot be listed</u> as emergency contacts. List the name of <u>at least one person</u> 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			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		