Communion of Saints
Early Childhood Enrollment Form

This form meets Ohio Administrative Code.

Section I - Student & Family Information

Child's Name _____ Date of Birth

Family/Guardian Name _____ Please select 1, 2 or 3 to set call order of phone number used to reach you:

Home Address _____ Cell Phone _____ Call Order _____

City _____ State _____ Zip _____ Home Phone _____ Call Order _____

Employer Name _____ Work Phone _____ Call Order _____

Employer Street Address _____ City _____ State _____ Zip _____

Alternate Family Information: Please select 1, 2 or 3 to set call order of phone number used to reach you:

Family/Guardian Name _____ Cell Phone _____ Call Order _____

Family Street Address _____ Home Phone _____ Call Order _____

City _____ State _____ Zip _____ Work Phone _____ Call Order _____

Employer Name _____

Employer Street Address _____ City _____ State _____ Zip _____

Section II - Authorization for Emergencies

List 2 Emergency Contacts for use ONLY if the parents cannot be contacted:

Name _____ Name _____

Street Address _____ Street Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Please select 1, 2 or 3 to set call order of phone number used to reach emergency contact:

Home _____ Call Order _____ Home _____ Call Order _____

Cell _____ Call Order _____ Cell _____ Call Order _____

Work _____ Call Order _____ Work _____ Call Order _____

List Medical Contacts, In Case Of Emergency:

Physician _____ **Dentist** _____

Street Address _____ Street Address _____

City _____ Phone _____ City _____ Phone _____

Local Hospital _____ Phone _____

Section IV - Child's Health Information

Child's Chronic Medical/Health Needs

Please complete both pages of form

EARLY CHILDHOOD PROGAM
STUDENT INFORMATION

You can help us plan for your child's needs and concerns if you provide the following information. This information will remain confidential and is used to better support your child.

Child's Name	
Mother's Name	
Mother's Occupation	
Father's Name	
Father's Occupation	
Marital Status of Parents	☐ married ☐ living together ☐ separated ☐ divorced

Important people in your child's life:

Siblings- name, age, gender, live with your child or separate:

_____ _____

_____ _____

_____ _____

Pets- animal, name

_____ _____

Relative, adults, friends, that play an important role in your child's life and that we may frequently hear about in class:

_____ _____ _____

_____ _____ _____

Describe your child's personality. Is he/she generally happy, outgoing, quiet, curious, etc?

_____

_____

What is the best way to calm your child if he/she is upset? _____

_____

Describe your child's favorite activities and interests. _____

_____

_____

Describe any fears which your child exhibits. _____

_____

What type of experiences has your child had with groups of children (Sunday school, VBS, day care, etc.)

_____

Are there any special concerns which the early learning program staff should be award of with regard to stress in the child's life, family customs, etc.?_____

_____

What are your goals for your child with respect to his/her participation in the COS Early Learning program?

_____

_____

PARENT RELEASE – WALKING FIELD TRIPS

I give permission for my child to participate with Communion of Saints Early Learning Program on walking field trips.

_____ _____

Parent Name Parent Signature

Date_____

MEDIA CONSENT AND RELEASE FORM

I (We) the parent(s) and/or guardian(s) of the minor child identified below hereby grant

Communion of Saints School ("School") and/or its agents consent to record (in writing or otherwise), photograph, audiotape, or videotape my minor child's name, image, likeness, spoken words, schoolwork or school projects, in any form, and to display, release, exhibit, publish, or distribute the same, or any part thereof, for any lawful School use or purpose including, without limitation, use on the School's bulletin boards, websites, social media sites, print and electronic media, marketing publications, public relations and communications materials and/or presentations, and any other uses as may not be contemplated herein, without further notice or compensation as follows:

☐ I consent.

☐ I do not consent.

I further understand that by entering into this informed consent and release, and by granting permission as stated herein, I hereby release the School, affiliated parishes, the Diocese of Cleveland, the Bishop of Cleveland, and their respective officers, directors, agents, employees and/or attorneys from and against any and all liability, loss, damage, costs, claims, and/or causes of action arising out of or related to the above items to which I have consented.

I further understand that the School and its respective officers, directors, agents, employees and/or attorneys have no control over use of photographs, videotapes, audiotapes, or other records made by others and/or outside the scope of this consent and release.

Finally, in signing below I acknowledge that all recordings, audiotape, videotape, photographic proofs, photographic negatives, positives, and prints created pursuant to this Release shall constitute the sole property of the School.

_____ _____

Name of Minor Student- Gr. Signature of Parent or Legal Guardian

_____

Printed Name of Parent or Legal Guardian

_____

Date

Residing at:

_____

Communion of Saints School
Early Childhood Medical Statement
Must be signed by physician.

Section I - Child Medical Information

Child's Name _____

Date of Birth _____ Height _____ Weight _____

Immunizations:			**Exempt from Immunization:**		
Complete for Age	☐ Yes	☐ No	Religious Conviction	☐ Yes	☐ No
In Process	☐ Yes	☐ No	Health	☐ Yes	☐ No
			Other		

Limitations or health conditions, including allergies, medications, and dietary restrictions.

Section II - Child Medical Statement Verification

Physician/Clinic/Hospital Name _____ Provider Address _____

Provider Phone Number _____ Provider City _____ Provider State _____ Provider Zip _____

Check box of examining medical professional:

- ☐ Physician
- ☐ Physician Assistant
- ☐ Advanced Practice Registered Nurse

This child has been examined and is in suitable condition to participate in group care.

Signature of Medical Professional _____ Date of Exam _____

Programs funded through the Ohio Department of Education must have written policies and procedures to ensure that children have received comprehensive health screenings and/or that families are informed of the importance of health screenings and the resources to obtain them.

EARLY CHILDHOOD- AUTHORIZED PICK UP

FOR _____

Student's name

For your child's protection, please fill out the names of people authorized to pick up or bring your child to school other than yourself. Notify the school of any changes immediately.
Inform people on this list that they must be prepared to identify themselves to our staff.

List parent other than the one signing this form if they are authorized to pick up or drop off your child.

1. **Name:**_____**Relationship**_____**Phone:**_____
2. **Name:**_____**Relationship**_____**Phone:**_____
3. **Name:**_____**Relationship**_____**Phone:**_____
4. **Name:**_____**Relationship**_____**Phone:**_____

Carpool Arrangements:

_____

_____

_____

List of Persons NOT PERMITTED to pick up this child (Please print)

	Restraint papers or divorce decree attached
1.	Yes ☐ No ☐
2.	Yes ☐ No ☐

Early Childhood Medication Form

This form meets Ohio Administrative Code.

*A separate medication form is required for each prescription and non-prescription medication administered.

Student Name:_____ DOB:_____

Student address: _____

School _____ Grade: _____ Class: _____

To Be Completed by the Physician/Dentist:

Medication Name:_____

Dose:_____ Dosage Time/s:_____ Reason for

medication:_____

Start date: _____ Stop date: _____

Special Instructions: _____

Potential adverse reactions to be reported:

_____

Physician/Dentist Signature:_____ Date:_____

Physician/Dentist Phone Number:_____ Fax:_____

<u>Parent/Guardian:</u> I give permission for my child to receive this medication at school according to the school district policy and as instructed by my child's physician/dentist.

I agree and am responsible to:

- **Deliver my child's medicine to school in its original container**
- **Ensure prescription medication is labeled by a pharmacist or healthcare provider**
- **Ensure the medication is current within the past 12 months and provide new medication upon expiration**
- **Administer the first dose of any new medication, except in case of emergency**
- **Tell the school as soon as possible if there is a change in the use of my child's medicine**
- **Tell the school if my child gets a new healthcare provider**
- **Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes. I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.**

Parent/Guardian Signature_____ **Date:** _____

Parent/Guardian Phone: _____ **Emergency Alternate Phone:** _____

Student Name:_____ DOB:_____

Grade: _____ Class: _____

Per ORC 3313.713 B (2) - Designated persons employed by the board are authorized to administer to a student a drug prescribed for the student. Effective July 1, 2011, only employees of the board who are licensed health professionals, or who have completed a drug administration training program conducted by a licensed health professional and considered appropriate by the board, may administer to a student a drug prescribed for the student. Except as otherwise provided by federal law, the board's policy may provide that certain drugs or types of drugs shall not be administered or that no employee shall use certain procedures, such as injection, to administer a drug to a student.

Staff Trained and Authorized to Administer Medication: _____

_____ _____

Drug Administration Training Date _____ Length of time _____

Trained by _____

Date	Time	Dosage Amount	Reason Given/Comments	Signature of Person who Administered

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition LIST NA if this form does not apply to your child

Does this health condition require medication or medical food? ☐ Yes (If Yes, complete Part II) ☐ No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid? ☐ Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

Part II: Conditions Requiring Medication or Medical Food

Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

(If no medications or medical foods are required for the condition, skip Part II).

If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) 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

Child's Name	Date of Birth	Weight *(if needed to determine dosage)*

Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date

☐ **Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature

Part III: Administration of Medication or Medical Food Training Authorization

Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)

Part III must be completed

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure	**Complete Only One Section**	**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided instructions for care and/or training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the proced for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.	Administrator/Provider Signature	Date of Signature

This 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, a new form must be completed.

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
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Part IV: Documentation of Administration of Medication or Medical Food

Completed by child care staff member, family child care provider or in-home aide for the child listed on this form

All medication or medical food must be documented when administered. Document each medication or medical food on its own page. Incomplete information elevates the level of risk to children. If more than one medication or medical food is needed, make a copy of this page for each medication or medical food.

This medication or medical food is not to be administered until after the child has received the first dose or application at least once prior to the program administering a dose to avoid unexpected reactions. Emergency medications for the child are exempt from this requirement.

Child's Name	Name of medication/medical food

Date	Time	Dosage	Signature of designated person administering medication

Child's History of Hospitalization:

Child's Disease History:

Child's Allergies/Treatment:

Child's Dietary Needs/Restrictions:

NOTE: A MEDICATION FORM MUST BE COMPLETED FOR EACH MEDICATION ADMINISTERED WHILE IN PROGRAM ATTENDANCE

Child's Medication/s:

Medical Consent: PART I or II MUST be completed

Part I- To Grant Consent I hereby give consent for the above medical care providers and local hospital to be called. In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctor or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medial opinions of two other license physicians or dentist, concurring the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the medical history including allergies, medications being taken , and physical impairments which a physician should be alerted:

_____

_____

Signature of Parent/Guardian_____ Date_____

Address_____

Part II- Refusal to Consent I do not give my consent for emergency medical treatment of my child. In the even to illness or injury requiring emergency treatment, I with the school authorities to take the following action:_____

Signature of Parent/Guardian_____ Date_____

Address_____

Section V - Registration Authorizations

I authorize the following to be listed on the parent roster:

My child's name ☐ Yes ☐ No

Family name ☐ Yes ☐ No

Phone numbers ☐ Yes ☐ No

☐ Cell ☐ Home ☐ Work

Exempt from immunizations because of religious conviction: ☐ Yes ☐ No

Child immunization records attached: ☐ Yes ☐ No

Annual Class Roster: Each year the program prepares a roster for each group of children. This roster will not be furnished to any persons other than parents of children enrolled in our program.

Date

Signature of Parent/Guardain