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# Table of Contents

All forms are required for each participant unless otherwise noted below. Please refer to the table of contents to identify if a form must be completed for your participant's enrollment packet. Some forms are not required based on age, medication needs, and other factors.

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# Registration Form

*Please note applications are processed in the order in which they are received. Spaces are limited and filled on a first-come, first served basis. *

How did you hear about Easterseals? _____

**Camper Information**

Full Name: _____
Preferred Name/Nickname: _____
Date of Birth: _____
Gender: _____

**Household Information**

Who does the child live with?
Parent/Guardian Name #1: _____
Relationship to Child: _____
Parent/Guardian Name #2: _____
Relationship to Child: _____
Siblings (if attending camp): _____

Who is the child's legal guardian if different from above?
Name: _____
Phone Number: _____
Email Address: _____

Diagnosis/Disability
Please list anything that would enable us to provide exceptional care for you child, including any special needs or accommodations they might need at camp:

_____
_____
_____
_____
_____
_____

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# Student Release Authorization

The following individuals are authorized to pick up my child, _____, or be contacted in an emergency, when Easterseals staff are unable to contact an authorized parent/guardian.

| | Name | Cell Phone | Work Phone |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

Do NOT allow the following individuals to pick up my child:

1. _____
2. _____
3. _____

Parent/Guardian Signature: _____ Date: _____

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# Supervision Form

Please review the levels of supervision below.

| | |
|---|---|
| **Level 1**<br>One-on-One Supervision | My child requires a designated staff person. |
| **Level 2**<br>Constant Supervision | My child requires strict guidance but does not require a designated staff person throughout the day. They require full help with daily routines and toileting. |
| **Level 3**<br>Moderate Supervision | My child can work with others but will require guidance to complete most activities. They may need more help with daily routines and toileting but can do some of it independently. |
| **Level 4**<br>Safety Supervision | My child prefers to do things independently. They simply need a friendly face to watch over them throughout the day. They do not need help with toileting. |

Please circle which level of supervision your child will need

Level 1 Level 2 Level 3 Level 4

Please note that Easterseals is unable to provide a one-on-one staff person for any child. We are only able to enroll children that fall within the levels specified below:

**Preschool Age (3 –4 Years Old):** Level 2, Level 3 or Level 4

**Young School Age (5-7 Years Old):** Level 2, Level 3 or Level 4

**Middle School Age (8-11 Years Old):** Level 2, Level 3 or Level 4

**Teenage School Age (12-16 Years Old):** Level 4

***The safety of all campers and staff is our number one priority. Once camp has started, if it is determined that we are unable to provide care for your child while still maintaining the safety of all campers and staff, due to behavior concerns, your child may be released from the program. If a child is unable to complete the camp session because of dismissal or parent withdrawal, your tuition may not be refunded. ***

Parent/Guardian Signature: _____ Date: _____

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# General Publicity Release

I understand and agree that any narratives, depictions, pictures, film, photographs, audio-visual/sound recordings or testimonials of my child made by Easterseals, or its respective employees and agents may be used by Easterseals and those acting with its permission, for illustration, broadcast, or testimonial shared with the public in connection with the work of Easterseals. I assign Easterseals all my child's rights to these materials.

I understand that these materials, made by Easterseals, its employees and agents are owned by Easterseals and that they may copyright them. I further consent to allow Easterseals, their respective employees, agents and those acting with Easterseals' permission, to use my child's protected health information as defined under 45 C.F.R. 164.201 for the purpose of illustration, broadcast or testimonial in connection with any work of Easterseals and to release this information to the public.

I understand that these materials may be published on Easterseals' network of web sites, and this may disclose my child's personal and protected health information online. However, Easterseals' online disclosure of my child's name and residence will be limited to my child's first name and the geographic location of the Easterseals organization where he or she receives services. Easterseals does not need to submit these materials to me for further approval. I understand that these materials may be modified, and that Easterseals may decide not to use them.

I acknowledge that the rights described above are granted to Easterseals on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easterseals will not condition any treatment or funding to my child on the completion of this authorization. I also understand that I may revoke my consent to allow Easterseals to release my child's protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Central and Southeast Ohio Inc. in writing.

I understand and agree that once Easterseals, its respective employees, agents, and those acting with its permission, disclose my child's protected health information, the Health Insurance Portability and Accountability Act of 1996 may no longer protect this information. This release and authorization expires 10 years from the date of my signature below.

_____ I certify that I am over the age of 18 years old. If not, how old are you _____.

_____ AGREE I have read this release and authorization before signing below, and I fully understand and agree to its contents.

_____ DO NOT AGREE I have read this release and authorization before signing below, and I fully understand and do not agree to its contents.

I am the parent or legal guardian of _____, a child under the age of 18 years old.

General Publicity Release must be completed for each individual whose photo will be used.

General Publicity Release for: _____
Name of Individual

| _____ | _____ | _____ |
|---|---|---|
| Printed Name (Parent/ Guardian) | Signature | Date |
| _____ | _____ | _____ |
| Address | City, State, Zip Code | Phone Number |

_____
Email Address

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# Developmental History (Page 1 of 3)

Please complete the following pages to help us learn more about your camper. This information allows us to help them have their best camp experience. Please be sure to include any additional information that is helpful for us to know.

| Does your child have any of the following adaptive medical needs? | |
|---|---|
| ❑ Glasses | ❑ Hearing Aid |
| ❑ Leg Braces | ❑ Wheelchair |
| ❑ Feeding Tube | ❑ Catheter |
| ❑ Communication Devices | ❑ Cochlear Implant |
| ❑ Walker | ❑ Specialized Seating |
| ❑ Orthotics | ❑ Shunt |

| Has your child had any of the following? | Circle One | If YES, please explain |
|---|---|---|
| Behavior Problems | Y or N | |
| Broken Bones or Joint Problems | Y or N | |
| Chicken Pox | Y or N | |
| Clostridium Difficile (C-Diff) Positive | Y or N | |
| Cytomegalovirus (CMV) Positive | Y or N | |
| Diarrhea / Constipation / Stomach Problems | Y or N | |
| Endocrine Problems | Y or N | |
| Hay Fever/Asthma/Allergies | Y or N | |
| Head Trauma | Y or N | |
| Hearing Problems | Y or N | |
| Heart Problems | Y or N | |
| Immune System Problems | Y or N | |
| Kidney Problems / UTIs | Y or N | |
| Lung Problems | Y or N | |
| Measles/Mumps | Y or N | |
| Meningitis | Y or N | |
| Pneumonia | Y or N | |
| Scarlet Fever | Y or N | |
| Seizures (with or without fever) | Y or N | |
| Sensitivity to lights, smells, sounds or tastes | Y or N | |
| Skin Problems | Y or N | |
| Speech Problems | Y or N | |
| Tics or Repeated Movements | Y or N | |
| Treatment for Tuberculosis | Y or N | |
| Trouble touching certain textures | Y or N | |
| Vision Problems | Y or N | |
| Weight Loss/Gain/Trouble with appetite | Y or N | |
| Other | | |

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# Developmental History (Page 2 of 3)

Please list any information that you think might be helpful for us to know about your child:

| | |
|---|---|
| Personality: | |
| Special Talents: | |
| Interests / Hobbies/ Favorites: | |
| Reinforcers: | |
| Dislikes: | |
| Other Important Things to Know: | |

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# Developmental History (Page 3 of 3)

Additional Information:

How closely does your child need to be supervised throughout the day?

_____

_____

Does your child exhibit any behaviors (tantrums, aggressiveness, self-injury, etc.) that staff should be aware of?

_____

_____

How would you describe your child's verbal skills?

_____

_____

Is your child ambulatory?

_____

_____

Does your child wet the bed during naptime?

_____

_____

After toileting, does your child need help with personal hygiene?

_____

_____

Please indicate if your child has any of the following. If so, please include a copy upon submission of the application.

- ❑ Behavioral Plan
- ❑ (IEP) Individualized Education Plan
- ❑ (IFSP) Individual Family Service Plan
- ❑ (ISP) Individual Service Plan

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# Payment Agreement

Registration Fee: $30
*Due at time of application. NON-REFUNDABLE*

Tuition: $2,250

## Please read the following agreement carefully before signing:

The conditions of this agreement are to provide protection for our children and parents/guardians as well as Easterseals. The center's salaries and overhead cannot be reduced because of the absentee losses of income. This agreement is a parent/guardian guarantee to Easterseals that you are financially responsible for the enrollment space guaranteed for your child.

**A deposit of 25% of your child's tuition will be due on May 1st, 2025. If you are unable to submit the deposit by May 1st, your child's spot may be forfeited.**

Please check the requested payment option for the remainder of the tuition below:

- ❑ In full by June 16th, 2025
- ❑ Half on June 16th, 2025, and half on July 7th, 2025

Payments may be made in the form of cash, money order, credit/debit card, or a check made payable to Easterseals. There will be a 3% fee charged for each credit/debit card payment. If a check is returned there will be a $50 fee and Easterseals may request that future payments be made via cash or money order.

*PLEASE NOTE*

- There are no deductions for absence including illness, family vacation, and holidays for which the center is closed.
- Your child may be dropped from the program for non-payment.
- There will be an additional charge if you are late picking up your child. Within the first 15 minutes, the charge is $10. Each minute thereafter will be $1, up to 30 minutes. If we have not heard from the family and Easterseals has exhausted attempts to contact persons on the Emergency Contact Form, your child will be taken to Franklin County Children's Services.
- This agreement is subject to change by Easterseals.

If you would like to place your credit/debit card information for ease of payment please contact Kathy Cordova, School Age Programs Manager at 614-228-5523, ext. 1107.

I agree to the above terms and understand that if my child is unable to complete the 6-week camp session for any reason (including dismissal by Easterseals or parental withdrawal), my tuition may not be refunded.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name of Parent/Guardian | Signature of Parent/Guardian | Date |

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# Facility Dog Waiver of Liability and Release Form

Easterseals has partnered with Canine Companions® and will have a professionally trained dog in the facility. The staff members assigned to the dog have been through extensive training with Canine Companions. The dog will be in the facility on a daily basis and will be on a leash at all times, unless in the trained staff members' office or when accompanied by the trained staff member. The dog will interact with staff and children.

I acknowledge I am the parent/guardian of, _____, a child enrolled in the Summer Camp program at Easterseals. I hereby release and agree for myself and on behalf of all of my family, heirs and assigns to release, indemnify, and hold harmless Easterseals and its successors, heirs and assigns (collectively "Easterseals) from any and all liability, damage, causes of action, or claim of any nature whatsoever and not to sue or otherwise make any claims against Easterseals whatsoever which may arise from, arising out of, or in any way related to our interaction with the Canine Companions Facility dog.

I agree to indemnify and hold Easterseals harmless from any liability associated with any damages caused by me from any interaction with the Canine Companions Facility dog.

My signature below indicates that I have read, understood, and freely signed this release. I expressly agree that this release shall be construed and enforced in accordance with Ohio laws, and I consent to the jurisdiction of said state. I agree that this waiver and release is intended to be as broad and inclusive as permitted under Ohio laws, so that if any portion hereof is held invalid, the balance shall continue in full legal force and effect.

Canine Companion Facility dog facts:

- Facility dogs undergo a two-year, extensive and specialized training program and learn over 40 commands.
- Facility dogs are handled only by facilitators (handlers) who have gone through an extensive training program that includes multiple written and practical tests.
- Each facility dog has been specifically selected for this role because of their comfort being in a public setting interacting with an array of people daily.
- Facility dogs are bred to have a lower than average instinctual drive an reactivity.
- Facility dogs are expected to maintain the same standards as service dogs.
- Facility dogs are never allowed to be roaming the facility unattended.
- Facility dogs are working, even if they may not look like they are.

_____ AGREE I understand that the facility dog is involved in the programming at Easterseals and will be in and out of the classroom, gross motor room and playground. I agree to have my child interact closely with the dog.

_____ DO NOT AGREE I understand that the facility dog is involved in the programming at Easterseals and will be in and out of the classroom, gross motor room, and playground. I do not agree to have my child interact closely with the dog.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name of Parent/Guardian | Signature of Parent/Guardian | Date |

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# Sunscreen Authorization Form

Child's Name _____ Date of Birth _____

Type of Sunscreen _____

Dosage _____

To Be Applied at the Following Times _____

For the Following Period of Time _____

I, _____ (Name of parent/guardian), acknowledge that I am the parent/guardian of a child enrolled in the Easterseals Summer Camp. I give permission for Easterseals staff to apply sunscreen to my child as listed above.

Parent/Guardian Signature _____ Date _____

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# NOTICE OF PRIVACY PRACTICES

**easter seals Central and Southeast Ohio, Inc.**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

You may be assured that Easter Seals has always had policies in place to protect the confidentiality of you and your medical information. This notice is a requirement of the government for your information and protection.

## OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

Individually identifiable information about your past, present or future health or conditions, the provision of health care to you, or payment for health care is considered "Protected Health Information" (PHI). We are required to extend certain protections to your PHI, and to give you this notice about or privacy practices that explains how, when and why we may disclose your PHI. Except in specific circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use of disclosure.

We are required to follow the privacy practices described in the Notice, though we reserve the right to change our privacy practices and the terms of this notice at any time.

## YOUR RIGHTS WITH RESPECT TO YOUR PHI

1. You have the right to see and obtain copies of your PHI.
2. You have the right to a listing of those organizations, agencies or individuals to whom disclosures have been made (unless it is a disclosure that does not require your written consent.)
3. You have the right to request (in writing) an amendment to your file using our amendment process.
4. You have the right to request that we contact you at an alternate site (other than home) or by alternate means (other than phone, mail or fax).
5. You have the right to request a restriction on our uses and disclosures of PHI (but we are not required to agree to your request).
6. You have the right to receive a copy of this notice.
7. Use of your PHI for marketing and publicity purposes can only be done with your authorization.
8. You have the right to communicate electronically with Easter Seals personnel. Doing so, however, may put your transmitted information at risk of unauthorized disclosure. We advise that you avoid or minimize the amount of protected health information that you transmit electronically.

## HOW WE MAY USE AND DISCLOSE YOUR PHI

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Central & Southeast Ohio

1. We may disclose information for treatment, payment and health care operations.
2. We may disclose to the consumer or personal representative.
3. We may disclose to others with proper authorization from consumer or personal representative.
4. We may disclose to Business Associates if a signed written contract exists that protects the PHI.
5. We may refuse to share information if we believe there is danger to the patient if the information is released.

**** Other Uses: For more detailed information about other uses and disclosures allowed by law, please contact our privacy officer.***

## HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think we have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file as follows:

*First contact our Privacy Officer:*

Easter Seals Central and Southeast Ohio, Inc.
**ATTN: Privacy Officer**
3830 Trueman Court
Hilliard, Ohio 43026
PH: 614-228-5523

*Then you may contact the U.S. Office of Civil Rights*

U.S. Office of Civil Rights
Regional Manager
Department of Health and Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Ill 60601
PH: 312-866-1807

**Effective Date: 4/14/03**
Rev. 8/11

# Easterseals

## Receipt of Notice of Privacy Practices

**Consumer Name:** _____

I received the notice of privacy practices, which explains how Easterseals may use or disclose my protected health information, and what my rights are regarding my medical records.

Communication with Easterseals personnel via email is unsecured, and by choosing to communicate in this manner, any transmitted information may be at risk of unauthorized disclosure. I understand that I may choose to communicate electronically with Easterseals personnel, and doing so is at my own risk.

Easterseals values my comments and concerns. If I have any questions, I will call 614-228-5523 to speak with the privacy officer.

Signature: _____ Date: _____

(Consumer/Personal Representative)

_____

(Relationship to Consumer)

Rev. 7/14/08, 8/11 ,1/16

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 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.

| 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 _____ 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** | | | **OR** Do not sign both | ***Do Not Give Permission* to Transport** | |
|---|---|---|---|---|---|
| Program or Home Name | | | | 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 | 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

# 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

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 |
|---|---|---|---|
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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:** | **Initials of 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):* | Date |

| **Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):** | **Signature of Parent** |
|---|---|
| ☐ 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): | Date |