

Summer Camp 2024 Enrollment Forms

This paperwork must be submitted with a check for \$175 per student. Forms will not be accepted without payment. Please pay your registration fee via check made out to Bethesda Childcare Center. Please complete a separate set of forms for each child. If your child is currently attending, you do not need to complete the attached ODJFS enrollment paperwork, but everyone must complete a swimming permission form and a routine trip form (keeping in mind preschool does water play at the center, and school-agers go to the pool) Camp runs from Tuesday, June 4th through Wednesday, August 14th. The schedule you choose for your child upon enrollment is what you will be charged each month. Each child is granted a one week unpaid vacation. **Please note on your form when you have a vacation planned, in order for us to omit that week from your invoice.** Please see the summer camp handbook for more details.

Enrollment is for the entire summer, we do not accept enrollment for specific weeks only. If you have questions, please reach out to Jenna or Kelly **prior** to completing and submitting paperwork. **Please submit enrollment & payment in a sealed envelope to either the black mailbox or to the office at pick up.**

Parent/Guardian(s) Full Name(s): _____

Child's First & Last Name: _____

Date of birth: _____ Current grade level (23-24 school year) _____

Schedule: (Please note your child's schedule must remain the same week to week)

My child will attend on the following days: (Please circle)

Mondays Tuesdays Wednesdays Thursdays Fridays

Child's Approximate drop off and pick up time each day: _____

Dates of your families vacation week (**Must be included in order to receive the 1 week vacation**):

*Please note: if your school-aged child attends on Tuesdays or Thursdays, you will need to purchase them a Bay Village Pool pass. Please contact the Bay Rec Dept. in order to do so.

*Sunscreen forms will be emailed out prior to the start of camp. Your child must have a sunscreen form on file in order to attend. Sunscreen forms must be completed with the exact name/brand of sunscreen that your child will be bringing and using. If you change sunscreens throughout summer, a new form will need to be completed.

You will receive an email confirming your child's spot in the program once we have had a chance to process enrollment applications and place students in classrooms.

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 <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information 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 #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information 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 cannot be listed 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 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		City		State	
Telephone Number		Relationship to Child		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 <u>Permission</u> to Transport		OR Do not sign both	Do Not Give <u>Permission</u> 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 STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)	Date of Birth
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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 _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lead _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight _____	Hearing _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemoglobin _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BMI _____	Dental _____	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

<p>Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:</p> <p><input type="checkbox"/> The above named child has been immunized against the diseases listed above.</p> <p><i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i></p>	<p>Initials of Examining Health Care Practitioner</p> <hr/> <p>Date</p>
<p>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</p> <p><input type="checkbox"/> 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):</p>	<p>Signature of Parent</p> <hr/> <p>Date</p>

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

Routine Trip Information	
Routine Trip Destination(s) Walks around the our block including the Metro Parks	
Date of Permission (<i>valid for one year</i>) 6/4/2024	
Mode of Transportation (<i>walking, school bus, public transportation, parent vehicles, provider vehicle and driver</i>) Walking	
During this trip children will have access to water that is 18 inches or more in depth. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? (if yes, a swimming permission slip is required) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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

Ohio Department of Job and Family Services
**PERMISSION TO PARTICIPATE IN WATER AND SWIMMING ACTIVITIES
 FOR CHILD CARE**

Written parental permission is required for the water activities your child will be engaging in when: <i>(check all that apply for this activity)</i>	
<input type="checkbox"/> Water is directly accessible to child (no water activities planned) <input checked="" type="checkbox"/> Child swimming or playing in water 18 inches or more in depth <input type="checkbox"/> Infants and toddlers using wading pools	
The program is providing additional adults or child care staff members that exceed the licensing ratio requirements for the water/swimming activity. <i>(The program is to meet the minimum ratio requirements outlined in rule).</i>	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Swim Site Bethesda Childcare Center - Preschool/Pre-k water play	
Date(s) 6/4/24-8/14/24	
Departure/Arrival Times from Program N/A water play is on-site at the center	
Mode of Transportation <i>(parents driving, provider vehicle, public transportation, school bus, etc.)</i> N/A water play is on-site at the center	
I give permission for my child to participate in the swimming/water activity listed above.	
Child's Name	Child's Date of Birth
My child is a <input type="checkbox"/> Swimmer <input type="checkbox"/> Non swimmer	
Parent's Signature	Date

Ohio Department of Job and Family Services
**PERMISSION TO PARTICIPATE IN WATER AND SWIMMING ACTIVITIES
 FOR CHILD CARE**

<p>Written parental permission is required for the water activities your child will be engaging in when: <i>(check all that apply for this activity)</i></p> <p><input type="checkbox"/> Water is directly accessible to child (no water activities planned) <input checked="" type="checkbox"/> Child swimming or playing in water 18 inches or more in depth <input type="checkbox"/> Infants and toddlers using wading pools</p>	
<p>The program is providing additional adults or child care staff members that exceed the licensing ratio requirements for the water/swimming activity. <i>(The program is to meet the minimum ratio requirements outlined in rule).</i></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Swim Site 310 Dover Center Road Bay Village Ohio, 44140</p>	
<p>Date(s) 6/14/24-8/14/24</p>	
<p>Departure/Arrival Times from Program 11:40am -2:00pm</p>	
<p>Mode of Transportation <i>(parents driving, provider vehicle, public transportation, school bus, etc.)</i> Walking</p>	
<p>I give permission for my child to participate in the swimming/water activity listed above.</p>	
<p>Child's Name</p>	<p>Child's Date of Birth</p>
<p>My child is a <input type="checkbox"/> Swimmer <input type="checkbox"/> Non swimmer</p>	
<p>Parent's Signature</p>	<p>Date</p>