Our Lady's Children Our Lady of Perpetual Help B.A.S.E. Program
3730 Broadway, Grove City, Ohio 43123 614.875.7079

CHILD ENROLLMENT AND HEALTH INFORMATION

Child's Name	DOB	Start Date
Home Address		
City/State/Zip	Home Phone	

Parent/Guardian Name		Relationship to Child
Home Address		City/State/Zip
Home Phone	Cell Phone	Email Address
Parent/Guardian Work/School Name	Work/School Phone	
Work/School Address		City/State/Zip

Please indicate if this name should be released to a parent/guardian of a child attending the program requests contact information. ☐ YES ☐ NO

If you answered yes, please indicate which information above may be released.

☐ Home # ☐ Cell # ☐ Work # ☐ Email Address ☐ Other_____

Parent/Guardian Name		Relationship to Child
Home Address		City/State/Zip
Home Phone	Cell Phone	Email Address
Parent/Guardian Work/School Name	Work/School Phone	
Work/School Address		City/State/Zip

Please indicate if this name should be released to a parent/guardian of a child attending the program requests contact information. YES NO

If you answered yes, please indicate which information above may be released.

Home # Cell # Work # Email Address Other_____

Please make sure copies of divorce/custody paperwork are on file with the latchkey office.

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Child's Name

EMERGENCY CONTACTS

Parents cannot be listed as emergency contacts. List the name of at least three adult individuals 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, able to take responsibility for the child in case the parent/ guardian cannot be contacted and should be at least 18 years old.

1. Contact Name		Relationship to Child
Address		City/State/Zip
Phone numbers where emergency contact may be reached (include area codes): Home:	Cell:	Work:

2. Contact Name		Relationship to Child
Address		City/State/Zip
Phone numbers where emergency contact may be reached (include area codes): Home:	Cell:	Work:

3. Contact Name		Relationship to Child
Address		City/State/Zip
Phone numbers where emergency contact may be reached (include area codes): Home:	Cell:	Work:

MEDICAL INFORMATION—EMERGENCY MEDICAL AUTHORIZATION

State of Ohio Revised Code Section 3313.712

Purpose: To enable Parents/Guardians to authorize the provision of emergency treatment for children who become ill or injured while under school/parish/childcare authority, when parents/guardians cannot be reached.

TO GRANT CONSENT:

I hereby give consent for the following medical care providers and local hospital to be called:

Name of Physician/Clinic	Phone
Address	City/State/Zip

Name of Dentist or Dental Clinic	Phone
Address	City/State/Zip

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Child's Name	
Name of Medical Specialist *(if applicable)*	Phone
Address	City/State/Zip
Local Hospital	Emergency Room Phone

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 doctors, 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.

The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent/Guardian Signature	Date

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 JFS01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS01217 "Request for Administration of Medication" form must be completed and kept on file at the center.

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:

_____

_____

_____

Do your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? *(check one)*

- ○ No
- ○ Yes—a JFS01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" form must be completed.

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Child's Name

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?

- ○ No
- ○ Yes—a JFS01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS01217 "Request for Administration of Medication" form must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)?

- ○ No
- ○ Yes—please explain_____
  _____
  _____

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

- ○ No
- ○ Yes—a JFS01217 "Request for Administration of Medication" form 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?

- ○ 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 JFS01217 "Request for Administration of Medication" form.

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 **non medical or health related** information about your child that would be useful for staff to know. This includes fears, eating habits, special routines, etc. Health related information should be listed in the appropriate space.

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Child's Name

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the center's policies and procedures/handbook. ☐ Yes ☐ No

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the Director prior to the child receiving care. After the child is attending the program the Director shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the Director shall initial and date the form in the section below to indicate when the form was last reviewed.

Parent/Guardian Signature	Date
Director Signature	Date

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 will be completed.

Parent/Guardian Initials	Date of Review	Director's Initials	Date of Review
Parent/Guardian Initials	Date of Review	Director's Initials	Date of Review
Parent/Guardian Initials	Date of Review	Director's Initials	Date of Review
Parent/Guardian Initials	Date of Review	Director's Initials	Date of Review
Parent/Guardian Initials	Date of Review	Director's Initials	Date of Review

Please list any other information pertinent to the care of your child:_____

_____

_____

_____

_____

_____

_____

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Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37.