CHILD CARE AGREEMENT-Little Learners, Too

Date: _____

Child Name:_____ DOB_____

Child Name:_____ DOB_____

.Child Name:_____ DOB_____

Mealtimes are; Snack 9am, and 3:00pm. All children must be in attendance at the start of the meal. No food or beverages should be brought to the facility unless advanced arrangements are made. Refer to handbook for more specifics. *meals may be suspended based on, but not limited to availability, staffing, local/state/national crisis, etc.

CARE HOURS ARE BASED ON WHAT IS WRITTEN IN THIS AGREEMENT. HOURS ARE BASED ON CONTRACTED HOURS OF CARE, NOT WHEN THE CENTER OPENS AND CLOSES. LATE FEES BEGIN 1 MIN AFTER YOUR AGREED UPON TIMES AND FRIDAYS ARE DOUBLED.

It is agreed that the owner, administrator any employee or staff member will be held liable for any injury to your child/children while in attendance. You, the parent/guardian, are responsible for any and all medical bills incurred for medical treatment for your child. In the event of emergency, the State of Ohio Emergency Transportation Authorization form, will be relied upon for direction.

PRIVATE PAYMENT; Age Group_____ Payment due weekly at drop off$_____

Age Group_____ Payment due weekly at drop off$_____

I/we agree to pay monthly counting Sundays in the month_____(Initials here)Disc. Discussed in handbook

ODJFS PAYMENT; Age Group_____ CoPayment due weekly at drop off$ _____

Age Group_____ CoPayment due weekly at drop off$_____

Age Group_____ CoPayment due weekly at drop off$_____

I/we agree to pay monthly counting Sundays in the month_____(Initials here)No disc offered for ODJFS

Registration, late fees and other fees apply. Refer to the Policy Handbook.

PARENTAL/GUARDIAN RESPONSIBILITIES

- To allow staff members to discipline according to the State of Ohio Guidelines regarding discipline in a childcare setting. Redirection or timeout will be the main form used.
- Actively participate in the daily activities of your child/children including but not limited to, reading literature and communication from the Provider daily, communicate via text, email, phone, conferences, etc. to discuss concerns, ask questions and give feedback.
- Attend an annual conference, phone discussion or choose to have documents on your child's development sent home with you. This information will include discussion of developmental milestones/goals, concerns, and constructive feedback on how we can work collaboratively. This also includes any renewal of agreements/documents, etc. needed for a smooth annual transition. These are non inclusive
- Communicate in a respectful manner at all times and schedule a private conference if needed for further discussions.
- Pay all tuition, copays, and fees charged when incurred.
- Be sure your child has a good night sleep and will come to school dressed and ready to participate.
- Do not bring your child to school if they violate the illness policy. If an illness is in question, the Provider will make the final decision regarding participation taking into consideration the needs of your child as well as the others and the needs of the caregivers.
- Send extra clothing for accidents, snow play.
- Notify the Program in writing of contractual changes, address or phone changes, etc.
- Only those stated on Child Enrollment form as emergency contacts, will be permitted to pick up your children. In the case of custody or divorce, I must have a copy of the documents outlining visitation agreements.

- Supply the Provider with all necessary dietary supplements such as but not limited to infant formula/breastmilk, soy/lactose free milks, etc. when restrictions apply. *documents necessary at times
- All families must submit a work schedule weekly, biweekly or monthly for all variable schedules and/or college schedule each semester. This helps the Provider plan for employee work schedules and keep in ratio with the licensing rules.
- **All care hours are based on what is written in this agreement. Late fees are based on 1 min after your agreed upon pickup time. *Hours based on contracted hours, NOT center closing time.**

TERMINATION/WITHDRAWALS

This agreement has a 30-day trial period(new clients/agreements only, not including renewals or changes) in which the parent or Provider can cancel at any time during this period, without notice or explanation. No refunds on tuitions or fees paid will be issued. Trial period starts from the date on the Child Care Agreement. After the trial period, this agreement can be terminated immediately or at any time if attempts to rectify a situation haven't been successful by either parent or Provider. No refunds on tuition or fees or days not used will be issued. This agreement can be terminated by Provider or parent if one, some or all of the agreements set forth in the Childcare Agreement and/or Policy and Procedures Handbook, haven't been met. No refunds on tuition and/or fees paid, or days not used will be issued. The advance notice of **two weeks** is required for all families for all other reasons such as but not limited to; change of residence, situation changes such as divorce, job change/loss, family dynamics, change of Providers, work schedule changes, change of hours, status of full-time/part-time, tuition changes, etc.

**Note; if 2 weeks written notice is not given and /or attempts to reach the parent/guardian has failed upon extended absences, the parent/guardian will be billed/charged the tuition rate set forth in the Agreement for two weeks and the county dept. of Job and Family Services plus copays for the care of your child for two weeks. It is in your best interest to give the proper and respectful 2 weeks advance written notice if you intend to leave the facility. Outstanding balances are explained in the Policy Handbook.

Parent/guardian sign_____ **Provider/Admin**_____

HOURS OF CARE

I, _____ (parent/guardian) Can use childcare during the following hours and days for my child/children. If variable(county families) I will send a work and/or school schedule via email, text or paper copy weekly, biweekly or monthly whichever applies, to my Provider so she can plan for staffing for ratio compliance. I understand The facility hours are different from the hours I can use below for childcare.

Monday _____ to _____	Schoolage	Monday _____to_____
Tuesday _____ to _____		Tuesday_____to_____
Wed. _____ to _____		Wed. _____to _____
Thurs. _____ to _____		Thurs. _____to_____
Friday _____ to _____		Friday _____to_____

These are my agreed upon hours and days and anytime earlier or later will result in additional fees set forth by the Provider. I understand these fees are not covered by the ODJFS copay or private tuition payments and/or supply/registration fees. I am responsible for full cash payment within 24 hours(or date agreed upon by both parties) that they are incurred or termination of my childcare may occur. **Please note that all families receiving public assistance, are required to use childcare for work or school hours plus one hour travel time to and from work/school, in this facility.**

_____**Parent/Guardian** _____**Date**

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 2 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 LITTLE LEARNERS TOO			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.

MINOR CHILD PHOTO/MEDIA RELEASE FORM

I, _____the Parent/legal guardian of, _____,

Hereby grant LITTLE LEARNER'S, TOO and any third party whom LITTLE LEARNER'S deems appropriate, my permission to use photographs, videos or other media, for any legal use, including but not limited to: social media, television, publicity, advertising and web content.

Furthermore, I understand that no royalty, compensation or fee shall be paid for said use. This release shall be valid until revoked in writing.

_____Parent/Guardian Signature _____Date

_____Parent/Guardian Printed Name

_____Child/Children Names

_____Phone Number

Must be completed by Dr. + returned w/ Imm. Record attached within 25 days of start.

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:

☐ 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):

Initials of Examining Health Care Practitioner

Date

Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):

☐ 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):

Signature of Parent

Date

SUNSCREEN PERMISSION FORM _____

Child_____ Date _____

I give permission for sunscreen spf 30 or higher to be applied to my child at Little Learner's Too as necessary. Sunscreen supplied by the program

I decline sunscreen for my child_____

Or I will send my own sunscreen to be applied_____

Parent/guardian sign_____

SUNSCREEN PERMISSION FORM ____

Child_____ Date _____

I give permission for sunscreen spf 30 or higher to be applied to my child at Little Learner's Too as necessary. Sunscreen supplied by the program_____

I decline sunscreen for my child_____

or I will send my own sunscreen to be applied_____

Parent/guardian sign_____

Ohio Department of Children and Youth

FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)

We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL
Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.

Child's/Children's Name(s):	Caretaker's Name:	Date Completed:

	TOPICS	Briefly List CONCERN
Child Development and Education- Does anyone in your family have any need for resources or support in the areas listed below?		
Y N	Information on child growth and development.	
Y N	Guiding and supporting a child's behavior.	
Y N	Medical or disabilities or possible conditions for any child or adult in the family.	
Y N	Obtaining toys or activities to use to help any child in your home.	
Y N	Preparing your child for kindergarten.	
Child and Family Health- Does anyone in your family have any need for resources or support in the areas listed below?		
Y N	Health insurance and/or access to regular medical care, dental care, or medications.	
Y N	Medical or health supplies or supports that anyone in your family needs.	
Y N	Accessing immunizations.	
Y N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.	
Y N	Concerns with depression, anger, anxiety, or mental health needs.	
Y N	Concerns with alcohol, drug, or addiction problems.	
Financial and Household Supports- Does anyone in your family have any need for resources or support in the areas listed below?		
Y N	Help paying for child care.	
Y N	Help finding housing or safe housing.	
Y N	Help paying your mortgage or rent.	
Y N	Help with food expenses.	
Y N	Finding household items such as furniture, clothing, or school supplies.	
Y N	Access to transportation or transportation expenses.	
Y N	Attending school (such as a GED, Certifications, or college degrees)	
Y N	Help finding work or job training	

Are there other needs you or your family have that are not listed above:	
Parent Signature	Date:
Administrator or Designee Signature:	Date:

For Staff Use:

Bronze Rating Level	Silver Rating Level	Gold Rating Level
Resources provided to the family:	Resources provided to the family:	Resources provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
	Referrals provided to the family:	Referrals provided to the family:
	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
		Follow-up provided to the family:
		Administrator or Designee Signature & Date:

Ohio Department of Job and Family Services

BASIC INFANT INFORMATION FOR CHILD CARE 0-17mos

This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.

Child's Name	Nickname
Child's Date of Birth	Siblings

What are you feeding your infant? *(Check all that apply)*

☐ Formula (include brand) ☐ Breast milk

Formula preparation *(if center/provider is to prepare.)*

Amount for each feeding	Frequency of feedings

My infant likes a bottle warmed: *(Check one)* ☐ Room temp ☐ Warm ☐ Very warm/NOT HOT

Juice *(type, amount, when?)*

Does child use a cup yet? ☐ No ☐ Yes

Solid foods *(baby food, brand, types, amounts, frequency)*
**you must have written permission from your child's physician if your child is under 4 months and given solid foods.*

Are foods served room temperature or warmed?

Table food *(types, amounts, frequency, special instructions)*

Security items *(pacifier, blankies, etc.)*

Nap schedule

Hints for getting baby to sleep

Sleeping Position ☐ Back ☐ Side* ☐ Tummy*
**You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a JFS 01235.*

Special Precautions

Any additional information about your child that would be helpful or you would like staff to know.

Parent Signature	Date
Primary Caregiver Signature	Date
Date form last updated	