

Welcome to the Vineyard Community Preschool Program. We look forward to an exciting new school year together and getting to know our new students and families. Please complete the attached Preschool Enrollment Packet and contact Kristen Fitterer to schedule an appointment to register for preschool. 740-927-7729 or kfitterer@vineyard05.com .

When you arrive for your registration appointment, please bring the completed Preschool Enrollment Packet, along with the following documents:

- Photo ID of parent or legal guardian
- Custody paperwork, if applicable
- Medical paperwork completed and signed by the physician

Our enrollment packet is also available on our website, vineyard05.com

Reset Form

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	
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.

Child's Name

____/____/____
Date of Birth

Parent/Guardian's Name

____/____/____
Date of Exam

1. General Finding -Significant finding on (describe any abnormalities):

General Physical Examination

Height* _____	Weight* _____	BP _____	Lymphatics _____
Skin _____	Head _____	Eyes _____	Ears _____
Nose _____	Teeth _____	Neck _____	Chest _____
Back _____	Abdomen _____	Genitalia _____	Extremities _____

Lead Screening* _____

Hematocrit Screening* _____

*Required by Ohio Revised Code

2. Specific Findings

General Neurological Examination

Gait _____	Station _____	Muscle Power _____
Muscle Tone _____	Reflexes _____	Cranial Nerves _____

Motor Abnormalities

Gross Motor Coordination _____

Fine Motor Coordination _____

Sensory Abnormalities _____

3. Behavioral Problems (check if observed or reported by informant)

Hyperactive Withdrawn Short attention span Disturbed sleep pattern Distracted

Other (please describe): _____

4. Medical Diagnosis _____

5. Medical Recommendations (include medication as prescribed) _____

This is to certify that the above named child has had a complete physical examination.

Physician Signature

____/____/____
Date

Reset Form

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)		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		
<input checked="" type="checkbox"/> The above named child has been examined.		
<input checked="" type="checkbox"/> 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).		
<input checked="" type="checkbox"/> The above named child does not have allergies OR is allergic to the following (<i>please list in space below</i>): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
Check below, if applicable: <input type="checkbox"/> 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.	
Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER: <input type="checkbox"/> The above named child has been immunized against the diseases listed above. <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>	Initials of Examining Health Care Practitioner Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): <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):	Signature of Parent Date

Please sign and return this page to the Director by the first day of classes.

I have read the Parent Handbook. I understand the expectations for my child(ren), and I will support these policies and procedures in dealing with my son/daughter and the school. If at any time my child(ren) or family cannot support the policies and procedures found in the handbook, I will withdraw my child(ren) from the school.

Signature of Father (or legal guardian)

____/____/____
Date

Signature of Mother (or legal guardian)

____/____/____
Date

Name(s) of students

JULY 2023

Su	M	Tu	W	Th	F	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	16	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

4 Independence Day

JANUARY 2024

Su	M	Tu	W	Th	F	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

1-2 No School

15 Martin Luther King Jr. Day -No School

AUGUST 2023

Su	M	Tu	W	Th	F	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

FEBRUARY 2024

Su	M	Tu	W	Th	F	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

19 President's Day - No School

SEPTEMBER 2023

Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

5 Open House 5:30-7:30 PM
6 First Day of Classes

MARCH 2024

Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

22 In-Service - No School
25-29 Spring Break

OCTOBER 2023

Su	M	Tu	W	Th	F	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

27 In-Service - No School
30 In-Service - No School

APRIL 2024

Su	M	Tu	W	Th	F	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

1 In-Service - No School

NOVEMBER 2023

Su	M	Tu	W	Th	F	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

10 Veteran's Day - No School
22-24 Thanksgiving Break

MAY 2024

Su	M	Tu	W	Th	F	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

21-22 Field Days
23 Graduation

DECEMBER 2023

Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

14 Christmas Program
15 Teacher In-Service - No School
18-29 Christmas Break

JUNE 2024

Su	M	Tu	W	Th	F	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	16	18	19	20	21	22
23	24	25	26	27	28	29
30						