FINANCIAL POLICY AGREEMENT

I HAVE READ THE NEW BEGINNINGS CHRISTIAN DAYCARE POLICIES, UNDERSTAND THEM AND THE SERVICES BEING OFFERED TO ME AND MY CHILD, AND AGREE TO ABIDE BY THEM.

I AM ENROLLING _____FOR _____DAYS PER WEEK AND AGREE TO PAY $_____PER WEEK.

I UNDERSTAND THAT I WILL NOT BE REQUIRED TO PAY TUITION FOR THE TWO WEEKS PER YEAR THAT THE DAYCARE IS CLOSED. THE WEEK OF JULY 4TH AND THE WEEK OF CHRISTMAS.

HOWEVER, I WILL BE REQUIRED TO PAY THE REGULAR CHARGES FOR ANY WEEK WHICH CONTAINS A HOLIDAY. ALSO, IF ANY VACATION TIME IS TAKEN OTHER THAN THE ABOVE MENTIONED TWO WEEKS, I AM REQUIRED TO PAY THE FULL CHARGES FOR DAYCARE.

SCHOOL AGE CHILDREN ONLY:

I AM ENROLLING _____IN THE AM/PM LATCHKEY PROGRAM AND I AGREE TO PAY $_____PER WEEK.

I UNDERSTAND THAT HAVING TWO WEEKS OF UNPAID TUITION FEES IS GROUNDS FOR MY CHILD'S DISMISSAL FROM THE CENTER.

STARTING DATE:_____

SIGNATURE OF PARENT/GUARDIAN:_____

SIGNATURE OF ADMINISTRATOR:_____

NEW BEGINNINGS CHRISTIAN SCHOOL
AUTHORIZATION PICK UP FORM

Please list three people (other than yourself), their names, and telephone numbers that are allowed to sign your child out from school during the school day.

1. **Name** _____

   Address _____

   Phone_____

   Relationship_____

2. **Name** _____

   Address _____

   Phone _____

   Relationship _____

3. **Name** _____

   Address_____

   Phone _____

   Relationship _____

Name of child _____

_____

Signature of parent/guardian

CONFIDENTIAL FAMILY HISTORY

Date: _____

NAME OF CHILD _____DATE OF BIRTH _____

SEX: MALE ___FEMALE___AGE____YEARS ____MONTHS _____

ADDRESS _____PHONE _____
Street City Zip

MOTHER'S NAME _____AGE _____BIRTHPLACE _____

OCCUPATION _____BUSINESS PHONE _____

NAME OF EMPLOYER _____

BUSINESS ADDRESS _____

EDUCATION (yrs. attended) ELEM. ____HIGH SCHOOL____COLLEGE___

FATHER'S NAME _____AGE ___BIRTHPLACE_____

HOME ADDRESS _____ PHONE _____

OCCUPATION _____BUSINESS PHONE _____

NAME OF EMPLOYER _____

BUSINESS ADDRESS _____

EDUCATION (Yrs. attended) ELEM. ___HIGH SCHOOL____COLLEGE____

DO BOTH PARENTS NOW LIVE WITH CHILD? YES ___NO____
IF NO, ARE BOTH PARENTS PERMITTED TO PICK CHILD UP? ____
IF NO, PLEASE EXPLAIN ON BACK OF FORM

LIST NAMES AND BIRTHDATES OF OTHER CHILDREN IN FAMILY:

NAME_____BIRTHDATE_____NAME_____BIRTHDATE ____

NAME_____BIRTHDATE_____NAME_____BIRTHDATE____

NEAREST RELATIVE _____RELATIONSHIP_____

ADDRESS_____PHONE_____

IS CHILD ADOPTED?_____HAS CHILD BEEN TOLD?_____

NAME OF CHURCH _____

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE CENTERS AND TYPE A HOMES

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 Center
Home Address			City
State	Zip Code	Home Telephone Number	
Parent/Guardian Name		Relationship to Child	
Home Address		Home Telephone Number	
City		State	Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Telephone Number		Parent's Work/School Name	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

Parent/Guardian Name		Relationship to Child	
Home Address		Home Telephone Number	
City		State	Zip
Email Address (if applicable)		Cell Phone	
Parent's Work/School Telephone Number		Parent's Work/School Name	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program?

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 within one hour of the center/home, 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

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 JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A 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 child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

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? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

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

☐ No

☐ Yes - please explain

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

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" 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? (*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 the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

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.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

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 center/type A home'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			**_Do Not Give Permission_ to Transport**	
Center or Type A Home Name			Center or Type A 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.		**OR** Do not sign both	**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 center's or type A 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. After the child is attending the program the administrator 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 administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.

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

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT

For Child Care Centers and Type A Family Child Care Homes

Child's Name *(print or type)*	Date of Birth

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) _____

Recommended Immunizations (*enter month, day, and year*)

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

Recommended Assessments/Screenings:

Vision: ☐ Yes ☐ No Date: _____
Dental: ☐ Yes ☐ No Date: _____
BMI: ☐ Yes ☐ No Date: _____
Hearing: ☐ Yes ☐ No Date: _____
Lead: ☐ Yes ☐ No Date: _____
Other: _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination

Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care center or type A home.

Name of Physician /Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State and Zip Code	

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37 of the Administrative Code.

PARENTAL STATEMENT OF COOPERATION

I have read the policies of New Beginnings Christian Daycare, I understand them, and will abide by them.

I will pay all financial obligations on the designated day. I realize tuition is due regardless of absenteeism or holidays. I understand that failure to pay all fees and tuition in a timely manner is grounds for disenrollment. It is my understanding that the policy for the school is to make no refunds on enrollment or entrance fees.

I give New Beginnings Christian Daycare permission to discipline my child using the discipline procedures as outlined in the discipline policy. And I will support or "back up" the school and teachers to my child. And, I will endeavor to work with the school in full cooperation in all areas regarding my child.

I further agree to hold the school and its agents harmless for any liability to my child or any guardian or parent thereof because of any claims on behalf of my child against the school\daycare or any agent thereof because of any injury or alleged injury to my child.

I understand that this statement of cooperation will be in effect for as long as my child attends New Beginnings Christian Daycare and will be kept on file on the premises.

I understand that failure to comply with the policies of New Beginnings Christian School is grounds for disenrollment of my child.

Parent's signatures (both must sign unless only one has guardianship)

Father: _____Date: _____

Mother: _____ Date:_____

Guardian (if other than parent):
_____Date:_____

******* New Beginnings reserves the right to refuse enrollment to any child whose parents or guardian, in the opinion of the administration, indicate the potential for uncooperation.

New Beginnings Christian Daycare Center
492 Williams Roaad
Columbus, Ohio 43207

Parents after reading the handbook please sign and return this page to the Administrator. This is due before the child attends the center. Please feel free to ask questions about any of the policies in the handbook

I acknowledge that I have received a copy of the parent handbook for New Beginnings Christian Daycare Center. I agree to follow all policies outlined within.

_____ _____
Signature of parent/guardian **Date**

_____ _____
Signature of parent/guardian **Date**