Ohio Department of Children and Youth

DYVOSVIT SCHOOL AND CHILDCARE

(Ohio License # 2170014767)

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATIONAL PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may request additional information from the parent/guardian.

Child's Full Name		Date of Birth	First Day at Program
Address			
City		State	Zip Code
Parent #1 Full Name (will be used for billing purposes)		Parent #1 Cell Phone Number	
Parent # 1 Address ☐ Same as Child's		City	State / Zip Code
Parent #1 Email Address (will be used for billing purposes)		Parent #1 Work/School Name (if applicable)	
Check here if not applicable ☐	Parent #2 Full Name	Parent #2 Cell Phone Number	
Parent # 2 Address ☐ Same as Child's		City	State / Zip Code
Parent #2 Email Address		Parent #2 Work/School Name (if applicable)	
Primary Emergency Contact #1 Name (cannot be parent/guardian)		Check here if not applicable ☐	Optional Emergency Contact #2 Name (cannot be parent/guardian)
Primary Emergency Contact #1 Phone Number		Optional Emergency Contact #2 Phone Number	
My child may be released to this emergency contact: ☐ Yes ☐ No		My child may be released to this optional emergency contact: ☐ Yes ☐ No	

Does your child have a chronic health condition or diagnosis that requires the program to observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school-age child to carry and administer their own medication?

☐ Yes (complete or provide a Health care plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

Please complete the opposite side too.

Child's Full Name	Date of Birth

Information on my child's development (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodations may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes ☐ No

Name of service provider(s) and frequency:

☐ N/A

Emergency Transportation Authorization

☐ **The program has permission** to secure emergency transportation for my child in the event of an illness or injury requiring emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.

☐ **The program does not have permission** to secure emergency transportation for my child in the event of an illness or injury requiring emergency treatment. I wish for the following action to be taken:

SIGNATURE

This form should be reviewed 12 months from the date the parent/guardian acknowledges accuracy and receipt of policies and procedures.

Parent/Guardian Acknowledgment of Accuracy and Receipt of Policies and Procedures

By signing this form, I attest that the information is accurate and that I have a copy of the program's policies and procedures (Parent Handbook).

Parent/Guardian Signature	Date

Program Acknowledgment of Completion

By signing this form, I attest that I have reviewed it for completeness and that this form has been signed by the parent/guardian.

This form is to be completed prior to the child receiving care.

Program Administrator/Designee Signature	Date

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