



WELCOME LETTER



Carnival Child Development Center staff extends a cordial welcome to you. We are honored that you have chosen us to care for your children. Our goal is to impact our students' lives educationally, emotionally, and socially so they are provided with a strong foundation for their educational career. We look forward to working as a family to help each child reach goals that are set for them throughout their time at Carnival Child Development Center. We strive not only to provide a challenging academic program but a secure, personal environment of care to each individual student. We hope that we can exceed all of our families' expectations and want to take this time to personally welcome you and your family!



PLEASE READ THE FOLLOWING



Upon successful enrollment, all parents will receive an invitation from Brightwheel. Brightwheel is a tool for classroom management, communication, photos, videos, online bill pay, and much more. Brightwheel is the industry leader in early education, proven to save time for staff, allowing for measurably more time with students, while also delivering a much better experience for parents. This is a private group just for our Carnival families. It's vital that all parents use this app because this is going to be our main source of broadcasting important messages and updates with our families! (examples: school closing, delays, daily activities etc....)

If you need any assistance with downloading the app or if your current phone doesn't support brightwheel please stop in the office and we will be glad to assist you.

Thanks,
Carnival Management

Stay connected with us on:

 @carnivalchildcare

 @carnivalcdc





OFFICE USE ONLY:

Assigned Classroom: _____

Start Date: _____

Private Pay County

General Information

Childs Name: _____ Date of Birth: _____

Mother Name: _____ Father Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Siblings (Names & Ages): _____

Any Special Food Habits: _____ Any Special Medical Needs: _____

Any Allergies: _____ Any Special Conditions: _____

Has Your Child Previously Attended Child Care: _____

If Yes, Which Center Did They Most Recently Attend: _____

Authorization

In order to ensure the safety of your child(ren), we would like to know exactly who's picking up the child(ren).

Please print all information:

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Our staff will be authorized to request photo ID from everyone on the pick up list. The ID will be photocopied and placed in the child's folder.

I _____ authorize the people I've listed to pick-up my child(ren).

Parent/Guardian Signature _____ 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 <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 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 _____ 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

<u>Give Permission to Transport</u>	OR	<u>Do Not Give Permission to Transport</u>
Program or Home Name Carnival Child Development Center 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.	Do not sign both	Program or Home Name Carnival Child Development Center 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.

Ohio Department of Job and Family Services
FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name <i>(Last)</i>	<i>(First)</i>	Nickname <i>(if any)</i>
<i>By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.</i>		
Who is in the child's immediate family?		
Who lives at home with your child?		
What is the primary language spoken in your child's home?		
Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?		
Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?		
Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)		
Do you have any pets at home? If so, what are they and what are their names?		
Has your child had a previous care arrangement? <input type="checkbox"/> Yes or <input type="checkbox"/> No Additional Details? (Center based, in home, with family, with parents, etc.)		
My child drinks <input type="checkbox"/> milk, <input type="checkbox"/> formula, <input type="checkbox"/> juice or <input type="checkbox"/> water. <i>(Check all that apply)</i> How much and how often?		
Does your child have any favorite foods?		
Does your child dislike any foods?		
Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)		

Please check all of the words that best describe your child's personality and behavior

- active adventurous affectionate anxious bossy bright busy calm cautious cheerful
 content creative curious easily-angered emotional energetic excitable friendly gives-in-easily
 happy hesitant insecure jealous likes structure/routines loud loving mellow outgoing
 prefers adult attention quiet sensitive serious shares-well social spontaneous stubborn tentative
 other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a high chair, booster, child size chair or adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature

Date

Parent Handbook Acknowledgement

I, the undersigned, acknowledge that I have unlimited access to the Parent Handbook for Carnival Child Development Center on their website www.carnivalcdc.org on the parent resource tab and agree to all the terms, conditions, and policies of CCDC. I recognize that it is my responsibility to read and understand the policies, provisions, and procedures contained in the Parent Handbook.

In addition, I understand that the contents of the Parent Handbook are subject to change. I acknowledge that the Parent Handbook will be revised in accordance with the rules or regulations of state, federal, and accrediting entities, best practices for child care service providers, or at the discretion of Carnival Child Development Center. I recognize that any such revisions will supersede, modify, or eliminate the current contents of the Parent Handbook.

I acknowledge that it is my responsibility to stay informed of policy and procedure revisions to the Parent Handbook, which will be posted on Carnival Child Development Center web site at www.carnivalcdc.org under the parent resource tab. In the event I do not have internet access, I understand that I can obtain a hard copy of the updated Parent Handbook upon request to Carnival Child Development Center.

Moreover, I recognize that it is my responsibility to contact Carnival Child Development Center Director for any questions I might have about the contents of the Parent Handbook now and in the future.

Some Handbook Highlights:

- ✓ We have a 10:00am cut off time
- ✓ Breakfast is cut off at 9:00am sharp. Lunch is served at 11:00am
- ✓ No outside toys allowed (unless for a scheduled show-and-tell day)
- ✓ No outside food is allowed in the center (unless authorized by the office for birthdays or special occasions)
- ✓ We're closed all major holidays; you will receive a memo before we're closed.
- ✓ We now require a holding fee of \$100/weekly for extended absences longer than one week.
- ✓ To ensure the utmost safety and create a secure environment for all our children, we have made the decision to no longer allow beads and barrettes in the children's hair while they are here at Carnival.

Parent/Guardian Signature

Date

Ohio Department of Job and Family Services
ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information	
Routine Trip Destination(s) Routine walks to the playground and around the building	
Date of Permission (<i>valid for one year</i>)	
Mode of Transportation (<i>walking, school bus, public transportation, parent vehicles, provider vehicle and driver</i>)	
During this trip children will have access to water that is 18 inches or more in depth. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, a swimming permission slip is required)	
Child's Information	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 8 years and/or over 4' 9"	
Signature	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date

Ohio Department of Job and Family Services
BASIC INFANT INFORMATION FOR CHILD CARE

* This Form is for "INFANTS ONLY"

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? <i>(Check all that apply)</i>					
<input type="checkbox"/> Formula (include brand)				<input type="checkbox"/> Breast milk	
Formula preparation <i>(if center/provider is to prepare.)</i>					
Amount for each feeding			Frequency of feedings		
My infant likes a bottle warmed: <i>(Check one)</i> <input type="checkbox"/> Room temp <input type="checkbox"/> Warm <input type="checkbox"/> Very warm/NOT HOT					
Juice <i>(type, amount, when?)</i>					
Does child use a cup yet? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Solid foods <i>(baby food, brand, types, amounts, frequency)</i> <i>*you must have written permission from your child's physician if your child is under 4 months and given solid foods.</i>					
Are foods served room temperature or warmed?					
Table food <i>(types, amounts, frequency, special instructions)</i>					
Security items <i>(pacifier, blankies, etc.)</i>					
Nap schedule					
Hints for getting baby to sleep					
Sleeping Position <input type="checkbox"/> Back <input type="checkbox"/> Side* <input type="checkbox"/> Tummy* <i>*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.</i>					
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					

Ohio Department of Education - Office of Nutrition
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME
(please print)

AGE

BIRTHDATE

month / day / year

**CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE
AND THE MEALS RECEIVED WHILE IN CARE**

Check (✓) Days Child Normally in Care	List hours child normally in care				Check (✓) meals child normally receives while in care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.

**SIGNATURE OF
PARENT/GUARDIAN**

DATE

**DAY PHONE
NUMBER**

**MAILING ADDRESS:
STREET /APT.**

CITY

ZIP CODE

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;

(2) fax: (833) 256-1665 or (202)690-7448; or (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Revised 8/2022

CHILD AND ADULT CARE FOOD PROGRAM: CHILD CARE COMPONENT
INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2024-2025

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and instructions on backside of this form. Complete application and return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used only for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 is completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME				CHECK IF A FOSTER CHILD <small>(The legal responsibility of a welfare agency or court. Attach documentation)</small>	PART 2 – LIST EACH CHILD’S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER, IF ANY. A VALID CASE NUMBER CONTAINS 7 DIGITS.	
PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER						
* NAME OF ENROLLED CHILD(REN)		AGE	BIRTH DATE	<input type="checkbox"/>	Check type of benefit:	<input type="checkbox"/> FOOD ASSISTANCE (SNAP) or <input type="checkbox"/> OHIO WORKS FIRST (OWF)
1.				<input type="checkbox"/>	CASE NO.	_____
2.				<input type="checkbox"/>	CASE NO.	_____
3.				<input type="checkbox"/>	CASE NO.	_____
4.				<input type="checkbox"/>	CASE NO.	_____

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annually			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	<input type="checkbox"/>	\$ amount / how often	\$ amount / how often	\$ amount / how often	\$ amount / how often
1.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
2.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
3.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
4.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
5.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
6.	<input type="checkbox"/>	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed, the adult signing the form must also list last 4 digits of his/her Social Security Number or check the “I do not have a Social Security Number” box. I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* _____ SIGNATURE OF ADULT HOUSEHOLD MEMBER	* _____ DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> (Check if applicable) I do not have a Social Security Number
Print Name: _____	Daytime Phone Number: _____	Work Phone Number: _____
Street / Apt: _____	City / State / Zip: _____	County: _____

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other
Please mark one ethnic identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program. State Distribution: July 2024

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3. Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion: Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12	Application Certified/Categorized as: <input type="checkbox"/> FREE, based on <input type="checkbox"/> Food Assistance/OWF Case No. <input type="checkbox"/> Household size and income <input type="checkbox"/> Foster Child <input type="checkbox"/> REDUCED-PRICE, based on Household size and income <input type="checkbox"/> PAID, based on <input type="checkbox"/> Income too high <input type="checkbox"/> Incomplete <input type="checkbox"/> Invalid case number or information
Total Household Size: _____ Total Household Income: \$ _____ Per: <input type="checkbox"/> week <input type="checkbox"/> every two weeks <input type="checkbox"/> twice per month <input type="checkbox"/> month <input type="checkbox"/> year	

Signature of Sponsor / Center Representative _____	Date Sponsor Certified/Categorized Form _____	Effective Date _____ <small>(From the first of month of date signed)</small>	Expiration Date _____ <small>(Valid until last day of month in which form was signed one year earlier)</small>
<small>Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.</small>			

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	
√ 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 (<i>please list in space below</i>):	
<i>Check below, if applicable:</i>	
<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
Weight _____	Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
BMI _____	Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	Other: _____
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:	Initials of 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>	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):	Signature of Parent
<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):	
	Date