

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

Child Enrollment and Health Information - Page 1			First day at the center
Child's Name		Date form completed/ updated	
Date of Birth	Home address	City, State, Zip Code	Home Telephone Number
Parent/Guardian Name	Relationship to Child	Parent/Guardian Name	Relationship to Child
Home Address	Employer/ School	Home Address	Employer/ School
City, State, Zip Code	Address & City	City, State, Zip Code	Address & City
How can you be reached: Home telephone #: _____ Work/ School telephone #: _____ Cell phone: _____ Pager: _____		How can you be reached: Home telephone #: _____ Work/ School telephone #: _____ Cell phone: _____ Pager: _____	
Where can you be reached most of the time when your child is at this program:		Where can you be reached most of the time when your child is at this program:	
Emergency Contacts: List the names of <u>other local persons</u> who you want to be contacted in the event of an emergency or illness if the parent/ guardian cannot be reached. Persons listed should be able to assist in locating the parent/ guardian and at least one person listed must be able to take responsibility for the child in cases where the parent/ guardian can not be located.			
Name		Name	
City/ State		City/ State	
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child

Emergency Transportation
(Complete only 1 OR 2)

<p>1. Give Permission to Transport</p> <p>I give (Center/Type A Home Name) _____ my permission to have my child _____ transported to (Hospital, Clinic) _____ for emergency medical care or to (Dentist- if applicable) _____ for emergency dental care, or to the nearest available source of assistance.</p>	<p>2. Do not give Permission to Transport</p> <p>I do not give (Center/Type A Home Name) _____ my permission to have my child _____ transported for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following action be taken _____</p> <p>_____</p> <p>_____</p>		
Parent/ Guardian 's signature	Date	Parent/ Guardian's signature	Date

Name of Physician or Clinic/ Hospital		Name of Dentist (recommended for children over 18 months of age)	
Street Address		Street Address	
City, State	Telephone Number	City, State	Telephone Number

Note: This is a prescribed form provided by JFS which must be used by centers and type A homes to meet the requirements of Rules 5101:2-12-37 and 5101:2-13-37. This form must be completed and on file at the center or type A home on or before the child's first day of attendance.

Child Health and Enrollment Information - Page 2

Child's Name	Date form completed, updated
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Health Information

Check if not applicable

Allergies (food, medication, & environmental) and precautions, reactions, and treatment:	
Medications, food supplements, modified diet currently being administered:	
Chronic Physical Problems:	
History of Hospitalization:	
History of diseases the child has had:	
Any additional health or enrollment information you feel we should know about your child:	

Immunization Record

Not required to be completed for school age children

(Indicate Dates by entering: month/day/year for each immunization)

Immunizations:	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Pertussis, Tetanus (DPT)					
Hepatitis B (Hep B)				X	X
Haemophiles Influenza type b (HIB)				X	X
Measles, Mumps, Rubella (MMR)			X	X	X
Polio			X	X	X
Varicella (chicken pox)			X	X	X
Hepatitis A			X	X	X

Parent Roster

YES	NO	
		I agree to have my name and telephone number included on the center, type a home's parent roster which will be made available upon request to any parent whose child is enrolled in the center or type a home.
Parent/Guardian Signature		Date

Note: This is a prescribed form provided by JFS which must be used by centers and type A homes to meet the requirements of Rules 5101:2-12-37 and 5101:2-13-37. This form must be completed and on file at the center or type A home on or before the child's first day of attendance.