February 25, 2020

Welcome Jeffrey Mansion Preschool Families,

My name is Catie Swendal and I am the Director at Jeffrey Mansion Preschool (JMP). I am thrilled that you have chosen JMP for your child's 2020-2021 school year.

Attached to this letter is the packet of paperwork that must to be filled out and returned to me no later than **Friday March 27, 2020.** Please note that the Child Medical Statement for Child Care form has to be filled out and signed by your child's doctor's office. Also, if your child will need to be administered medication while at school (inhaler, epi pen, ect) then the Request For Administration of Medicine for Child Care form must also be filled out and signed by your child's doctor's office.

Because these forms are required by the State of Ohio and are sensitive to a deadline, if forms are not filled out and returned to me by **Friday March 27, 2020** your registration will be voided and your spot filled from the wait list.

If you have any questions, please feel free to contact me at 614-559-4311 or cswendal@bexley.org.

Thank you,

Catie Swendal, Director Jeffrey Mansion Preschool

Registration Form

Child's Name _____ DOB _____
First Middle Last

Program enrolled: **3-4yr. old:** ___ 3 ½ day ___5 ½ day ___3 Full Day ___5 Full Day

4-5yr. old: ___ 5 ½ day ___5 Full Day

Parent's Name _____

Address _____
Street City State Zip

Parent Phone - Cell _____ Home _____

Work _____ Provider _____
(At&t, Verizon, Sprint, etc.)

Please check ☐ if you wish to receive preschool related text messages.

Other parent (if different than above)

Parent's Name _____

Address _____
Street City State Zip

Parent Phone - Cell _____ Home _____

Work _____ Provider _____
(At&t, Verizon, Sprint, etc.)

Please check ☐ if you wish to receive preschool related text messages.

Roster Release

I do/do not wish my information to be printed in the preschool parent roster.
Preferred number to be released: _____ Email: _____

Photo Release

I do/do not give permission for my child's picture to be and used in monthly preschool newsletters, displayed in the preschool classroom, put on the JMP Facebook page, and/or used the Bexley Recreation Brochure.

Release/Permission

I, as parent or legal guardian representing this minor, agree to release the City of Bexley, its officers, employees and volunteers from any and all liability for accidents, injuries, loss of and / or damage to my / our person or property that may arise out of my child's participation in or at the listed activity / activities. I / we are aware that participating in activities or use of facilities involves certain risk of injury despite safety precautions. I give permission for my child to take part in all preschool activities, including use of playground equipment and trips off the preschool grounds. In the event of an accident or emergency, if my child's physician is not available, I grant permission to call another licensed physician. I authorize the preschool staff to act for me according to their best judgment.

_____ **08.01.2020**

Signature of Parent, Custodian, or Guardian **Date**

Security Deposit & Direct Withdrawal Form

Name of Child/Children:

1. _____

3 & 4 Year Old Program	4 & 5 Year Old Program
__ 3-Day Half ($260) __ 3-Day Full ($570) __ 5-Day Half ($365) __ 5-Day Full ($715)	__ 5-Day Half ($365) __ 5-Day Full ($715)

2. _____

3 & 4 Year Old Program	4 & 5 Year Old Program
__ 3-Day Half ($260) __ 3-Day Full ($570) __ 5-Day Half ($365) __ 5-Day Full ($715)	__ 5-Day Half ($365) __ 5-Day Full ($715)

Name on Card: _____ **Credit Card Type:** ____**VISA** ____**MC**

Account #_____ - _____ - _____ - _____ **Exp. Date:** ____ / ____ **3-Digit Code:** _____

All credit card numbers will be kept on file as a security deposit. Cards <u>will not</u> be charged unless a child drops from the program or the MONTHLY box is checked below for automatic withdrawal. If a child drops, the card listed above will be charged immediately. Monthly payments will be charged on the 1st of each month.

DEPOSIT **<u>Cost of one month's tuition (not charged)</u>** ☐ **MONTHLY**

By signing this form, you are giving permission to the Bexley Recreation & Parks Department to charge to the above listed credit card and/or account number the amount owed each week for Jeffrey Mansion Preschool. All late fees, cancellation charges, and outstanding payments will be assessed to this card. Payment for any other Bexley Recreation sponsored program may NOT be charged as a result of this form.

Signature: _____ **Date:** _____

<u>Month Attending</u>	**<u>Account to be Charged on:</u>**
September 2020	September 1, 2020
October 2020	October 1, 2020
November 2020	November 1, 2020
December 2020	December 1, 2020
January 2021	January 1, 2021
February 2021	February 1, 2021
March 2021	March 1, 2021
April 2021	April 1, 2021
May 2021	May 1, 2021

Revised January 16

Dismissal Form

My Child has permission to be picked up at preschool by any of the following people:

Name of Child/Children: _____

Name of Authorized Person(s)	**Relationship to Child** (friend, relative, ect.)
_____	_____(parent)
_____	_____(parent)
_____	_____
_____	_____
_____	_____
_____	_____

_____ 08.01.2020

Parent Signiture **Date**

Comments:

_____

_____

_____

JMP COMMUNICABLE DISEASE POLICY

The following is a list of common preschool age illnesses. Many of the illnesses require the student to stay at home. Sending an ill student to school puts other students and staff at risk. A sick child is uncomfortable and unable to concentrate during the school day.

- Parents/guardians must contact the Directors Office (614-559-4311) when a student is absent for any reason.
- Parents/guardians must inform the school if the student is diagnosed by a physician/NP with Varicella (chicken pox), strep throat, conjunctivitis (pink-eye), impetigo, head lice, pertussis (whooping cough), ringworm, fifth's disease, measles, mumps, rubella (German measles), influenza (flu), meningitis, hepatitis, scabies, or other communicable disease. Informing the school of this information allows it to communicate this information -- without mentioning the student's name -- to the other members of the school community. This is very important for the health of all students and staff.
- A student with a temperature of 99.0 or above needs to be kept home. He or she may return to school when free of fever for 48 hours without the use of anti-fever medication.
- A child who is vomiting or suffering from diarrhea needs to remain at home until he/she is symptom-free for 24 hours.
- Any child who is on antibiotics for strep throat, impetigo, ringworm, bacterial infection or other condition needs to stay home until 48 hours after antibiotics/anti-fungals are started.
- Any child who is complaining of headache, sore throat, cough, extreme fatigue, stomach ache, earache or injury that is severe enough to decrease the child's ability to participate in class needs to stay home.
- Any child diagnosed with pertussis (whooping cough) must remain home for five (5) days after antibiotic treatment has been started.
- Any child with yellow or green drainage from the eye(s) should be seen by a doctor and needs to stay home for 48 hours after antibiotic drops are started, if they are prescribed. The child should have no drainage from eye(s) when returning to school.
- A child with a rash of unknown cause should stay at home until a doctor confirms the rash is not contagious. Students with chicken pox need to stay at home for seven (7) days or until all the lesions are crusted.
- Children with head lice must be treated and have no live lice. Nits are to be removed prior to coming back to school.

I have read the above and understand the Communicable Disease Policy.

Name:_____ Date: 08.01.2020

JMP Potty Training Policy

All students must be fully potty trained in order to attend Jeffrey Mansion Preschool (JMP). Fully Potty Trained is defined as: a child knowing when he or she has to use the bathroom and does not need assistance in the bathroom (ex. Wiping, Clothes Management, Hand Washing). If a child has more than one accident after the first week of school, JMP has the right to terminate the child's enrollment.

I have read and understand JMP's Potty Training Policy.

Name: _____ Date: 08.01.2020

JMP Behavior Policy

The teaching staff at Jeffrey Mansion Preschool is committed to providing a safe and secure learning environment for our students. All participants in our program have the right to learn in an environment where they are respected and safe. Teachers intervene when needed, as quickly as possible to ensure the safety of all children. We follow and adhere to the guidelines in accordance with the Ohio Revised code of conduct 5101:2-12-22. We do not use any form of physical punishment.

Safety is our primary concern; therefore, respect is the core of how students and staff are expected to conduct themselves: respect for each other, themselves, their classroom, and materials. When a problem does arise, we believe in a positive approach to discipline where we would mutually discuss the situation with involved students and parents if need be. If the problem does persist and/or the child's behavior may endanger themselves or others, the staff will address such behaviors following these guidelines:

Guidelines:

- A first incident will be reported to the parent(s)/caregiver. Per parent/caregiver request, a copy of the incident report can be made.

- A second incident will result in a parent-teacher conference to discuss the behavior and establish a plan of action.

- A third incident will result in the parent being called and another conference will be set up with the teacher(s) and the director. Referral for outside advice may be suggested (ex. Nationwide Children's Hospital, Home School District, Physician)

- Jeffrey Mansion Preschool (JMP) reserves the right to terminate any child's enrollment if any further incident occurs, or if we feel any of the following conditions exist:

    1. The school cannot meet the child's needs.
    2. The parents are not able to work with the school to find an acceptable solution.
    3. The continuing behavior endangers the well-being of other children/staff, and/or the child in the behavior.
    4. An excessive amount of the teacher's time is needed to attend to a particular child's special situation, to the extent that it is depriving the other children in the classroom the level of care and concern to which they are entitled.

*JMP reserves the right to operate outside these guidelines and to discontinue student/school relationship deemed necessary to maintain a safe and effective function of the school at any given time. Be it the best interest of the student and/or school.

I have read and understand JMP Behavior Policy.

Name: _____ Date: 08.01.2020

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			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/home?

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/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 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

Child's Name

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 family child care 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, 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 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 *Permission* to Transport			**_Do Not Give Permission_ 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.		**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 8/1/20		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 08.01.2020
Administrator/Designee Signature	Date 08.01.2020

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 and 5101:2-13-15. 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

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage

To be administered at the following times	For the following period of time

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.		
Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth

Special Health Conditions

Symptoms to watch for and emergency action to be taken if the following symptoms occur

Activities/foods/environmental conditions to avoid, if applicable

Medical procedures to be followed and expected benefit of treatment, if applicable

Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")*
If yes, what medications?

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?
☐ Yes ☐ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?
☐ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth
☐ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.	
Signature of Examining Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number
Street Address	
City, State and Zip Code	

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

	PHYSICIAN /PHYSICIAN'S ASSISTANT/ADVANCED PRACTICE NURSE/CERTIFIED NURSE PRACTITIONER COMPLETES *check all that apply for each disease*		
Diseases for Immunization	**Immunized**	**In Process of Immunization**	**Medically Contraindicated/ Not Age Appropriate**
Chicken pox	☐	☐	☐
Diphtheria	☐	☐	☐
Haemophilus influenzae type b	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B	☐	☐	☐
Influenza ☐ Seasonal Vaccine Not Available	☐	☐	☐
Measles	☐	☐	☐
Mumps	☐	☐	☐
Pertussis	☐	☐	☐
Pneumococcal disease	☐	☐	☐
Poliomyelitis	☐	☐	☐
Rotavirus	☐	☐	☐
Rubella	☐	☐	☐
Tetanus	☐	☐	☐

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Initial beside the disease(s) being declined above and sign below.

Signature of Parent	Date of Signature

Recommended Assessments/Screenings			
Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements:		**Notes:**
Height		
Weight		
BMI		

JFS 01305 (Rev. 6/2015)