



## **Early Learning Center**

**Jewish Community Center of Youngstown**

505 Gypsy Lane

Youngstown, OH 44504

[jccyoungstown.org](http://jccyoungstown.org)

Dear Families,

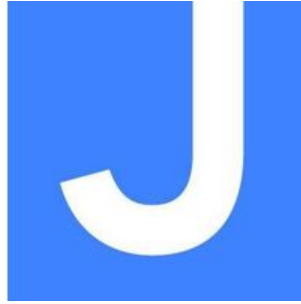
In this packet you will find various forms as required by the State of Ohio.

Before each page is a description of the form, and when the form is needed. If you are unsure on how to complete any section please leave it blank and an administrator will assist you. We appreciate your completion of these forms annually, as they help us better care for your child.

Thank you,

Ben Katz  
Early Learning Director  
330.746.3250 ext 119  
[bkatz@jewishyoungstown.org](mailto:bkatz@jewishyoungstown.org)

Emily Young  
Early Learning Administrator  
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### **Child Medical Statement for Child Care**

This is the “Child Medical Statement for Child Care” form. #1305 as noted in the bottom left corner. It must be completed annually by your child’s physician. Please have the top section completed by your child’s doctor and attach current shot records for your child. If your child is not vaccinated please check mark the box and sign. If you are a returning family to the ELC please confirm with an administrator the date of expiration for your Form #01305.

Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT FOR CHILD CARE**

Child's Name ( <i>print or type</i> )		Date of Birth
<input checked="" type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. <input checked="" type="checkbox"/> This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).		
<b>Signature</b> of Examining Physician/Physician's Assistant/Advanced Practice Registered 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		

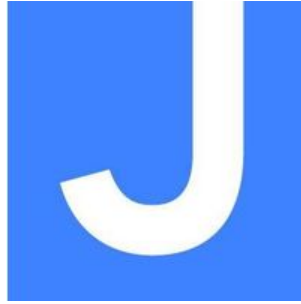
**ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS**

**Exceptions to Immunization requirements pursuant to 5104.014 ORC** (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature
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<b>Optional Recommended Assessments/Screenings</b>			
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
<b>Measurements</b>		<b>Notes</b>	
Height			
Weight			
BMI			



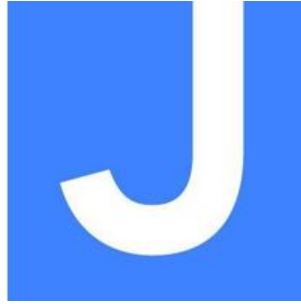
### **Basic Infant Information for Child Care**

This is the “Basic Infant Information for Child Care” form. #01218 as noted in the bottom left corner. If your child is over 18 months old you do not need to complete this form. If your child is under 18 months of age please complete this form and return it to your teacher by the first day of care. It will be updated frequently as your child's needs change.

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

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) <span style="float: right;"><input type="checkbox"/> Breast milk</span>	
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	



## **Request for Administration of Medication for Child Care**

This is the “Request for Administration of Medication for Child Care” form. #01217 as noted in the bottom left corner. This form is used for a variety of different needs for your child including: diaper creams, sun screen, chapstick, milk substitutes, and any medication (prescription or nonprescription) they may need. One form must be completed for each item. In most cases, topical products and lotions that are non prescription only require Box One to be complete. All others must have Box Two completed by your child’s physician. This form must be updated on an annual basis. Please leave Box 3 Blank, as it is to be completed by an ELC Staff member. If you are unsure of any section please leave it blank and seek assistance from an administrator.

Ohio Department of Job and Family Services  
**REQUEST FOR ADMINISTRATION OF MEDICATION  
 FOR CHILD CARE**

<b>Box 1</b>	The following section must always be completed by the parent/guardian.		
Check all that apply and complete all of the information.			
<input type="checkbox"/> Prescription Medication <input type="checkbox"/> Nonprescription Medication <input type="checkbox"/> Food Supplement <input type="checkbox"/> Topical Product or Lotion <input type="checkbox"/> Refrigeration Required <input type="checkbox"/> 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	
<input type="checkbox"/> 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
<b>Box 2</b>	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	

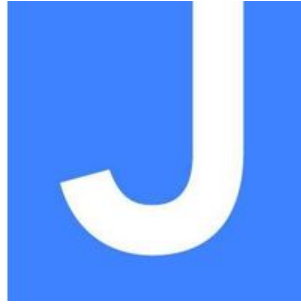
This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

**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.





### **Child Medical/Physical Care Plan for Child Care**

This is the “Child Medical/Physical Care Plan for Child Care” form. #01236 as noted in the bottom left corner. It is imperative that this form be completed with the assistance of an Administrator for any Special Health Condition of your child (Asthma, allergies, etc). This form is **required** for any life threatening medical condition or any life saving medications.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete JFS 01217 "Request for Administration of Medication")</i> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Training Instructions <i>(Trainer must be a parent or certified professional)</i>			
Signature of Trainer		Date	
Signature of trained providers, substitutes or child care staff members who have been made aware of the condition. <i>(There must always be a trained caregiver present when the child is present)</i>			
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
<i>(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)</i>			
Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> 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*