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	e of Birth		First Day	at Program/H	ome
Home Address					City		a
State	Zip Code	Hon	ne Telephor	ne Number			
Parent/Guardian Name #1				Relations	hip to Child		
Home Address D Same as Chile	d's		Home Te	lephone N	umber 🗌 Same a	s Child's	
City			1	State	Zip		
Email Address (if applicable)			Cell Phor	ne (if applic	able)		
Parent's Work/School Name			Parent's	Work/School	ol Telephone Num	ber	
Parent's Work/School Address					City		
Please indicate if this name shou for other parents/guardians. If you answered yes, please indic Where can you be reached while	Yes D No ate which informati	on above to inc	clude on the		78 S.55	requests conta	
Parent/Guardian Name #2				Relation	ship to Child		
Home Address ☐ Same as Chile	d's	1	Home Telep	hone Num	ber 🗌 Same as 0	Child's	
City				Stat	ie .	Zip	
Email Address (if applicable)		10	Cell Phone				
Parent's Work/School Name			Parent's Wo	rk/School T	elephone Numbe	г	
Parent's Work/School Address	***************************************				City		
Please indicate if this name shou for other parents/guardians. If you answered yes, please indic Where can you be reached while	Yes No nate which information	on above to inc	clude on the			096 076 - 19 <u>11-19</u> (1911-1911-1911-1911-1911-1911-1911-191	2 14000000000000000000000000000000000000
Emergency Contacts: Parents in the event of an emergency or if one person listed must be able to 18 years of age.	liness if you canno	t be reached.	Any persor	n listed sho	uld be able to assi	st in contacting	you. At least
Name			Name	(1)			
City		State	City			St	tate
Telephone Number	Relationship	to Child	Telepi	none Numb	per	Relationsh	ip to Child
Other numbers where emergence applicable) Name of Physician or Clinic/Hosp		ached (if	Other applic		here emergency o	contact can be i	reached (if
2	2144						***************************************
Street Address							
City		State	Telepi	none Numb	per		

			Medical Conditions, an		
Fill in this section accurately a staff to perform child specific 'Child Medical/Physical Care	care, such as:	to monitor the con	dition, provide treatment	ent health or medical condition re t, care, or to give medication, the ile at the program/home.	equiring child car JFS 01236
oes your child have any food	d, medication	or environmental a	llergies? (check all that	apply)	3
] No		F3		Property and the second	
Yes - check all that apply	☐ Food	☐ Medication	☐ Environmental	Please list and explain:	
Does your child's allergy/aller emergency medication to you			onitor your child for symp	otoms to take action if a reaction	occurs, or give
No					
Yes - a JFS 01236 "Child I	Medical/Physi	cal Care Plan for C	hild Care" must be com	pleted.	
oes your child have a develo	opmental dela	y or special health	or medical condition? (c	heckone)	
] No			633	5.3	
Yes - please explain		15			
nonitor your child for sympto ☑ No	ms or adminis	termedication dur	ing child care hours? (ch	NA AGAMENT	are such as: to
nonitor your child for sympton No Yes - a JFS 01236 "Child	ms or adminis Medical/Physi	ter medication dur ical Care Plan for C	ing child care hours? (ch child Care" must be com	eckone)	are such as: to
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Child's Name				
ist any history of hospit	alization, outpatient surgery, or p	previous health concerns	s that would be needed to a	ssist the staff or medical
ersonnel in an emerge	ency situation.			
				3
Not applicable				
ist any additional inform	mation about your child that would	ld be useful for staff to ki	now, such as fears or ways	that your child prefers to
e comforted.			**************************************	
	45			
☐ Not applicable				
Not applicable	mation about your child that wou	ld be uneful forestoff to k	now guch as nating or sless	ning habite
List any additional infor	nation about your child that wou	nd be dserui for stall to k	now, such as eating of siec	ping nabio.
United States				
Not applicable				
ist any additional infon	mation about your child that wou	ald be useful for staff to k	now, such as special routin	es, or behavior needs.
13				
EMPLOYER REPORTED				
☐ Not applicable				

Child's Name				
	Dia	pering St	atement	
Is your child toilet trained?	skip to Emerger ill out the followin		ortation Authorization section)	3
The program's policy is to check diapers ex program's policy or another:	ery2_hour	s. Please	indicate if you want your child's dia	per checked according to the
☐ I agree with the program's schedule	☐ I do not ag	ree, pleas	se check my child's diaperevery	hours.
23 1-3 - H.O. V. V. P.	Emergency T	ransport	ation Authorization	
Give Permission to Transport	ort		Do Not Give Permiss	sion to Transport
Program or Home Name MIRACLES CHILD CA	RE		Program or Home Name	
has permission to secure emergency tran my child in the event of an illness or injury emergency treatment. The emergency transervice will determine the facility to which not transported.	sportation for which requires asportation	Do not sign both	does not have permission to so transportation for my child in the which requires emergency treatm action to be taken:	event of an illness or injury
Parent's Signature	Date	1	Parent's Signature	Date
I have reviewed and received a copy of the This form, after being completed and signe administrator/designee prior to the child re	e program's or ho	me's poli		
Parent/Guardian Signature(s)				Date
Administrator/Designee Signature				Date
The form is to be initialed and dated, at lear information has stayed the same or change	ast annually, afte les have been no	rit has be ted. If sig	en reviewed by the parent/guardia nificant changes are needed, pleas	n. This is to indicate all se complete a new form.
Parent/Guardian Initials Date of	f Review		Administrator/Designee Initials	Date of Review
Parent/Guardian Initials Date of	f Review		Administrator/Designee Initials	Date of Review
Parent/Guardian Initials Date of	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 formmust 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 CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (print or type)	Date of Birth
Note: Sections A and B must be completed by the example (Physician/Physician's Assistant/Advanced Practice Re	
Section A- EXAMINATION	
√ The above named child has been examined.	
√The above named child is in suitable condition for particip mentally and physically fit to be in group care).	ation in group care (i.e. free of infectious disease,
√ The above named child does not have allergies OR is alle	ergic to the following (please list in space below):
Check below, if applicable: Additional information that will assist the child care programmed child (special health care and developmental co	nsiderations) accompanies this form.
Optional: Measurements and Recommended Assessments/Screen Height Vision Yes Commended Assessments/Screen Weight Hearing Yes Commended Assessments/Screen Height Vision Yes Commended Assessments/Screen Height	enings No Lead Yes No No Hemoglobin Yes No No Other:
Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address C	ty, State and Zip Code
ATTACH A COPY OF THE CHILD'S IMMUNIZ (MM/DD/YYYY FORMAT) OF DOSE	
IMMUNIZATION (Complete ONLY ONE SECTION below Section 5104.014 of the Ohio Revised Code requires in Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatit Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tel	munizations against the following diseases: is A, Hepatitis B, Influenza, Measles, Mumps, Pertussis,
Section B - To be completed by the EXAMINING HEAL PRACTITIONER: The above named child has been immunized against the listed above. If an immunization is medically contraindicated or not medically a	e diseases
for the child's age, note any exceptions by listing the specific immunization(s):	Date
Section C - To be completed by the child's parent ONL WAIVING AN IMMUNIZATION(S): I have declined to have my child immunized for reasons conscience, including religious convictions against all of diseases listed above or against the following disease(s	of the
and a decided and a second and removing discussion	Date

PERSONS AUTHORIZED TO PICK UP MY CHILD

My child,	, may be picked up by the following persons:
Name:	
Telephone #s:	
Name:	
Telephone #s:	
Name:	
Telephone #s:	
Relationship to child:	
Name child calls person:	
Name:	
Name:	
Telephone #s:	
Relationship to child:	
Name child calls person:	
I understand that my child will no also understand I may change this	of the released to anyone whose name is not on this list. It is list in writing at any time.
Parent's Signature	Date

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 incare. 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 MIRACLES CHILD CARE CHILD'S NAME AGE BIRTHDATE (please print) month year CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE Check (V) List hours child normally in care Check (✓) meals child normally receives while in care Days Child AM PM Evening Normally in Arrive Depart Arrive Depart Breakfast Snack Lunch Snack Supper Snack Саге Monday Tuesday Wednesday Thursday Friday Saturday Sunday Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule. SIGNATURE OF DATE DAY PHONE PARENT/GUARDIAN 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

**NAME OF ENROLLED CHILD(REN) AGE BIRTH DATE (The logal responsibility of a welfare agency of court, Attach documentation) CASE NO.	CENTER NAME	MIRACLES	CHILD	CA	RE	A FOSTER CHILD	(SNAP)	OR OWF	ACH CHILD'S F CASE NUMBER CONTAINS 7 DR	R, IF ANY.	
*NAME OF ENROLLED CHILD(REN) AGE BRTH DATE of several Asternation of benefit: 0 OHIO WORKS FIRST (OWF) CASE NO. C	ART 1 - PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER					responsibility of			- 0500000000000000000000000000000000000		
CASE NO. CASE N	* NAME OF ENROLLED CHILD(REN) AGE BIRTH DATE				BIRTH DATE	or court, Attach					
ART 3 - TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household tembers. List all gross income: list how much and how often. If Part 2 is completed, skip to Part I. a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household tembers. List all gross income: list how much and how often. If Part 2 is completed, skip to Part I. B. CHECK INCOME OF ALL HOUSEHOLD MEMBERS INCOME during the last morth (amount deemed before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weekly, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weekly, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Weekly, Every 2 Weekly, Twice Per Month, Monthly, Annuall HOW OFTEN IT WAS RECEIVED. Were 2 were well as annually how often I samount in Washington I was a social Security Now often. I samount / how often I sam	1.						CASE N	0			
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CASE NO. CASE N							CASE N	0			
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HOUSEHOLD MEMBERS INCLUDING CHILDREN NOZERO INCOME IN			T		the second secon	and the second and th		asmad h	hefore tayer & o	ther deduc	tione) and
INCOME before deductions and the part of t			IF								
XAMPLE: JANE SMITH \$ amount / how often \$ / \$ / \$ / \$ / \$ / \$ / \$ / \$ / \$ / \$										4. All Oth	er Income
S / S / S / S / S / S / S / S / S / S /			111	an invitage of the house		and the second second second second			- consideration of the first of the	\$ amour	nt / how ofte
SIGNATURE OF ADULT HOUSEHOLD MEMBER Print Name: Signature April Signature Signat				s		\$/_		\$		\$	
\$ / \$ / \$ / \$ / \$ / \$ / \$ / \$ / \$ / \$ /				\$	1	\$/		\$	1	\$	1
S / \$ / \$ / \$ / \$ / \$ / \$ / \$ / \$ / \$ /	2-180-5-0			\$		\$/		\$		\$	1
SIGNATURE OF ADULT HOUSEHOLD MEMBER Daytime Phone Number: City / State / Zip: County: Work Phone Number: City / State / Zip: County: American Indian or Alaska Native American Indian or Alaska Native Native Hawaiian or Other Pacific Islander Not Hispanic or Latino Indian or Not his	*			\$		\$/		\$		\$	
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" boo I cortify 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 if I purposely give false information. I may be prosecuted. I m				\$		\$/_		\$		\$	
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" boy 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 formation. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted. **I Fart 3 is completed, insert last 4 digits of Social Security Number	•			\$		\$/_		\$		\$	
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HOUSEHOLD LETTER - Dear Parent or Guardian

Please help us comply with the requirements of the U.S. Department of Agriculture's Child and Adult Care Food Program (CACFP) by completing the attached income eligibility application for free and reduced-price meals. All information will be treated with strict confidentiality. The CACFP provides reimbursement to the child care center for healthy meals and snacks served to children enrolled in child care. The completion of the income eligibility application is optional. Complete the application on the reverse side using the instructions below for your type of household. You or your children do not have to be U.S. citizens to qualify for meal benefits offered at the child care center. Households with incomes less than or equal to the reduced-price values listed on the chart at the bottom of this page are eligible for free meal benefits. An application must contain complete information to be considered for free or reduced-price meals. Households are no longer required to report changes regarding the increase or decrease of income or household size or when the household is no longer certified eligible for food assistance (SNAP) or Ohio Works First (OWF). Once approved for free or reduced- price benefits, a household will remain eligible for these benefits for a period not to exceed 12 months. During periods of unemployment, your child(ren) is eligible for meal reimbursement provided the loss of income during this time causes the family to be within eligibility standards for meals. In operation of the CACFP, no person will be discriminated against because of race, color, national origin, sex, age or disability §226,23(e)(2)(iv), If you have questions regarding the completion of this application, contact the child care center. PART 1 – CHILD INFORMATION: ALL HOUSEHOLDS COMPLETE THIS PART ("denotes required info)

Print the name of the child(ren) enrolled at the child care center, All children (including foster children) can be listed on the same application.

List the enrolled child's age and birth date.

Check box indicating if the child is a foster child. Foster children that are under the legal responsibility of the foster care agency or court are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income, Attach documentation to show foster child status.

PART 2 - HOUSEHOLDS RECEIVING FOOD ASSISTANCE OR OHIO WORKS FIRST: COMPLETE THIS PART AND PART 4 - If a child is a member of a food assistance (SNAP) or OWF household, they are automatically eligible to receive free CACFP meal benefits. Circle the type of benefit received: Food Assistance (SNAP) or Ohio Works First (OWF).

List a current food assistance or OWF case number for each child. This will be a 7-digit number. Do not list a swipe card number.

SKIP PART 3 – Do not list names of household members or income if you listed a valid Food Assistance (SNAP) or OWF case number for each child in Part 2. PART 3 – TOTAL HOUSEHOLD SIZE, GROSS INCOME AND HOW OFTEN RECEIVED: ALL OTHER HOUSEHOLDS COMPLETE PARTS 3 & 4.

Write the names of all household members including yourself and the child(ren) that attends the child care center, noting any income received. A household is defined as a group of related or unrelated individuals who are living as one economic unit that share housing and/or significant income and expenses of its members. This might include grandparents, other relatives, or friends who live with you. Attach another piece of paper if you need more space to list all household members.

Check the box for any person listed as a household member (including children) that has no income.

For each household member, list each type of income received during the last month and list how often the money was received.

Earnings from work before deductions: Write the amount of total gross income each household member received the last month, before taxes/deductions or anything else is taken out (not the take-home pay) and how often it was received (weekly, every two weeks, twice per month, monthly, annually), Income is any money received on a recurring basis, including gross earned income. Households are not required to include payments received for a foster child as income. If any amount during the previous month was more or less than usual, write that person's usual monthly income. If you normally get overtime, include it, but not if you only get it sometimes. If you are in the military and your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

List the amount each person got the last month from welfare, child support or alimony and list how often the money was received.

- List the amount each person got the last month from pensions, retirement, Social Security, Supplemental Security Income (SSI), Veteran's (VA) benefits or disability benefits and list how often the money was received,
- List all other income sources, Examples include: Worker's Compensation, strike benefits, unemployment compensation, regular contributions from people who do not live in your household, cash withdrawn from savings, interest/dividends, income from estates/trusts/investments, net royalties/annuities or any other income. Self-employed applicants should report income after expenses (net income) in column 1 under earnings from work. Business, farm or rental property report income should be entered in column 4. Do not include food assistance payments.

PART 4 - SIGNATURE AND LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: ALL HOUSEHOLDS COMPLETE THIS PART (* denotes required info)

All applications must have the signature of an adult household member.

* The adult signing the application must also date the form. b)

* Only an application that lists income in Part 3 must have the last four digits of the social security number of the adult who signs. If the adult does not have a social security number, check the box marked, "I do not have a Social Security Number," if you listed a food assistance or OWF number for each child or if you are applying for a foster child, the last four digits of the social security number are not required.

PART 5 - RACIAL/ETHNIC IDENTITY - OPTIONAL

You are not required to answer this part in order for the application to be considered complete. This information is collected to make sure that everyone is treated fairly and will be kept confidential. No child will be discriminated against because of race, color, national origin, gender, age or disability.

NON-DISCRIMINATION STATEMENT: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form, To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

DEDUCED DRICE INCOME ELICIBILITY GUIDELINES

HOUSEHOLD SIZE	ANNUAL	MONTH	TWICE PER MONTH	EVERY TWO WEEKS	WEEK
1	\$27,861	2,322	1,161	1,072	536
2	\$37,814	3,152	1,576	1,455	728
3	\$47,767	3,981	1,991	1,838	919
4	\$57,720	4,810	2,405	2,220	1,110
5	\$67,673	5,640	2,820	2,603	1,302
6	\$77,626	6,469	3,235	2,986	1,493
7	\$87,579	7,299	3.650	3,369	1,685
8	\$97,532	8,128	4,064	3,752	1,876

PERMISSION TO PHOTOGRAPH

Throughout the year there are opportunities for your child to be photographed/videoed. These photos may be used for classroom activities, holiday displays, or promotional purposes (such as newspaper articles) or video assignment for teachers who are also in college. We must have a parent/guardian's approval to photograph and display these photos/videos. Please check the appropriate box(es).

niias	Name	
	No photos/videos	
	YES - to ALL photos/videos	
	Yes, you may use my child's photos on Miracles C	Child Care Website.
	Yes, you may use my child's photos on social med	dia.
	Yes, you may use my child's photos in classroom	photos.
	Yes, you may use my child's photos on art projec	ts to be given to child's family.
	Yes, you may use my child's photos in newspaper	rs.
	Yes, you may use my child's photos on Miracles (Child Care Newsletters.
	Yes, you may use videos of my child for college st	tudent's assignments.
	Notes:	
	Signature	Date

FAMILY NEEDS ASSESSMENT

25	
Name:	Date:

Do you feel the need for any of the following types of help or assistance?	No Issues	Sometimes an Issue	Often an Issue
Paying for the special needs of my child (ex. Medicines, healthcare needs, immunizations, etc.			
2. Applying for assistance for my child			
 Having enough food on hand for at least two meals for my family 			•
4. Applying for SNAP or assistance			
5. Having a safe and secure place to live		_	
Having working plumbing, lighting and/or heat			
7. Purchasing and obtaining furniture, clothing, toys, diapers			
8. Having special travel equipment for my child (ex. Car seats)			
Finding someone to talk to about my own or my child's development and/or education			
10. Finding a supportive person to talk to about raising my child			
11. Managing the daily needs of my child at home			1/
12. Finding care for my child in the future			

Miracles Child Care 1-2025

Miracles Child Care Agreement

This agreement is made betw and Miracles Child Care for th				(parent/guardian)
Name:		Date of Bir	rth:	
Name:		Date of Bir	rth:	
Name:	1211/07/2019	Date of Bir	rth:	
Parent #1 employment hours	to	_ Parent #2 employme	nt hours	to
Arrival Time:	Departure Time:	(not	t to exceed 9 h	nours per day)
Variations in schedule:			Wellsen 12-12-12	•
Parents are expected to adhe variation from these times m	17.5			
The fees for over 9 hours per	day, with a maximu	m child care limit of 9.5	5 hours/day ar	re as follows:
9:16 – 9:30 hours addit	tional \$1 per child pe	or 16-30 minutes over er minute after 9.5 hou	rs.	out at Miracles
Fees apply to all families incl	uding PFCC.			
We are required by the State require that you follow the a please communicate with the Written work schedules and these times may result in a re	bove times. If circum e administration of N child care schedules e-evaluation of conti	nstances arise that caus Miracles Child Care with may be required for al nued care.	se a change in n at least one v l parents. Fail	your schedule, week notice. ure to adhere to
The Parent Handbook contain and information on holidays, may result in termination of	vacations and other			
Parent/Guardian Printed Nar	ne Parent/G	Guardian Signature	Date	
Administrator Signature	Date			

Miracles Child Care Tuition and Fees Prices effective January 1, 2025

Weekly Rates

Tax ID Available Upon Request

INFANT	TODDLER	R PRESCHOOL	SCHOOL AGE		
\$240	\$220	\$200		Before &/Or After School	Calamity Only*
Income based child care assistance: NOCAC ssp.benefits.ohio.gov		Weekly	140	\$40/day	
		2 Hr. Delay	\$14	\$16	
		No School	\$37	\$40	
		Summer Fun	\$190		

^{*} Calamity day care is only available when school is not in session and we have been informed in advance of your child's schedule.

Initial Registration:

\$30 per family

Materials Fee:

\$35 per child Due August 15th annually (full year students)

Summer Fun Fee:

TBD per child (Summer Fun Students)

Late Payment Fee:

\$5 per week Payment is due on Monday of the current week.

Early/Late Charge:

\$1 per minute per child before 6:30 AM or after 5:30 PM

PFCC Times Missing

\$10 per week, if times are not entered completely

The fees for over 9 hours per day, with a maximum child care limit of 9.5 hours/day are as follows:

9 hours - 9:15 hours

\$10 per child for 1-15 minutes over 9 hours.

9:16 - 9:30 hours

additional \$10 per child for 16-30 minutes over 9 hours.

Over 9:30 hours

additional \$1 per child per minute after 9.5 hours.

School age children's times are calculated based on earliest check in and latest check out at Miracles Child Care.

Fees apply to all families including PFCC.

Holiday Policy

On planned holidays when we are closed, tuition will be prorated and you will not have to pay for the days that Miracles Child Care is closed. If Miracles Child Care closes for any other reason, tuition will be prorated as well.

Other Charges

Diaper or Pull-up \$3 each
Wipes \$1 each
Unreturned item of clothing \$5 per piece

^{*} Repeated violation of policies will result in evaluation of continued care. When payments are two weeks behind, children will not be accepted into care until account is current and the child's place on the roster will be forfeited after one week without full payment.

ITEMS NEEDED FROM HOME

*Please make sure all items are labeled with your child's name

INFANTS

3 Clean, empty bottles/day	
Crib sheet	
Diapers & wipes	
Bibs	
Burp cloths	
Extra clothing	
Pacifier	
Diaper cream (form required)	
Summer- sun hat/sunscreen (form)	

TODDLERS

Diapers/Pull-ups	
Wipes	
Extra clothing	
Small pillow and blanket	
Diaper cream (form required)	
Summer-sunscreen (form required)	
Winter-hat, gloves, snow gear	

PRESCHOOLERS

Extra clothing	
Small pillow, blanket, & sheet	
Summer-sunscreen (form required)	
Winter-hats, gloves, snow gear	

SCHOOL AGERS

Extra Clothing	
Summer-sunscreen (form required)	
Winter-hats, gloves, snow gear	

Parent Activity Ideas for Transitions:

Ideas when transitioning to Miracles -

- Schedule a time to visit the classroom with your child.
- · Read stories about going to school.
- Give your child an item from home or a photo to bring the first few days.

Ideas to prepare your child for a new classroom -

- Visit the classroom with your child and meet the new teacher.
- Discuss your child's new room with them.

Ideas for transitioning out of our program -

- Schedule a goodbye party for child's last day at the program.
- Read stories about making new friends.
- Make a goodbye card with your child.

Ideas for transitioning to a new classroom within our program —

- Decorate a thank you card with your child to give to current teachers and classmates to say goodbye.
- Visit your child's new classroom and meet teacher.
- Work on new expectations with your child at home such as going to an open cup, adjusting activities to prepare your child to go to a new environment.