

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?  |                       |  |                           |                       |
| <b>Emergency Contacts:</b> Parents <b>cannot be listed</b> as emergency contacts. List the name of <b>at least one person</b> who can be contacted in the event of an emergency or illness if <b>you cannot be reached</b> . 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   |                       | 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 2 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 <u>Permission</u> to Transport   |      | <b>OR</b><br><br>Do not sign both | Do <u>Not Give Permission</u> to Transport   |      |
|---|------|-----------------------------------|--|------|
| Program or Home Name<br><b>MIRACLES CHILD CARE</b>  |      |                                   | 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. |      |                                   | 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  
**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 (*please list in space below*):

*Check below, if applicable:*

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 | Lead _____       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Weight _____ | Hearing _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemoglobin _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| BMI _____    | Dental _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other: _____     |                              |                             |

Notes:

|   |                          |
|---|--------------------------|
| 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.**

|  |  |
|--|--|
| <b>IMMUNIZATION (Complete ONLY ONE SECTION below)</b>  |  |
| <b>Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:</b><br>Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.  |  |
| <b>Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:</b><br><input type="checkbox"/> The above named child has been immunized against the diseases listed above.<br><br><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> | Initials of Examining Health Care Practitioner<br><br><br>Date |
| <b>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</b><br><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):   | Signature of Parent<br><br><br>Date                            |

**PERSONS AUTHORIZED TO PICK UP MY CHILD**

My child, \_\_\_\_\_, may be picked up by the following persons:

Name: \_\_\_\_\_

Telephone #s: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name child calls person: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone #s: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name child calls person: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone #s: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name child calls person: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone #s: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name child calls person: \_\_\_\_\_

Name: \_\_\_\_\_

Telephone #s: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name child calls person: \_\_\_\_\_

I understand that my child will not be released to anyone whose name is not on this list. I also understand I may change this 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 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

**MIRACLES CHILD CARE**

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 (✓)<br>Days Child<br>Normally in<br>Care | List hours child normally in care |        |        |        | Check (✓) meals child normally receives while in care |             |       |             |        |                  |  |
|--|-----------------------------------|--------|--------|--------|---|-------------|-------|-------------|--------|------------------|--|
|  | Arrive                            | Depart | Arrive | Depart | Breakfast   | AM<br>Snack | Lunch | PM<br>Snack | Supper | Evening<br>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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

Revised 8/2022





**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.
- \* 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](mailto:program.intake@usda.gov). This institution is an equal opportunity provider.

| <b>REDUCED-PRICE INCOME ELIGIBILITY GUIDELINES</b>  |               |              |                        |                        |             |
|---|---------------|--------------|------------------------|------------------------|-------------|
| <b>Guidelines to be effective from July 1, 2024 through June 30, 2025. Households with incomes less than or equal to the reduced-price values below are eligible for free or reduced-price meal benefits.</b> |               |              |                        |                        |             |
| <b>HOUSEHOLD SIZE</b>   | <b>ANNUAL</b> | <b>MONTH</b> | <b>TWICE PER MONTH</b> | <b>EVERY TWO WEEKS</b> | <b>WEEK</b> |
| 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       |
| For each additional family  |               |              |                        |                        |             |

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).

Child's Name \_\_\_\_\_

- No photos/videos
  
- YES - to ALL photos/videos
  
- Yes, you may use my child's photos on Miracles Child Care Website.
- Yes, you may use my child's photos on social media.
- Yes, you may use my child's photos in classroom photos.
- Yes, you may use my child's photos on art projects to be given to child's family.
- Yes, you may use my child's photos in newspapers.
- Yes, you may use my child's photos on Miracles Child Care Newsletters.
- Yes, you may use videos of my child for college student's assignments.

Notes: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## FAMILY NEEDS ASSESSMENT

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 |
|---|-----------|--------------------|----------------|
| 1. Paying for the special needs of my child (ex. Medicines, healthcare needs, immunizations, etc. |           |                    |                |
| 2. Applying for assistance for my child   |           |                    |                |
| 3. 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   |           |                    |                |
| 6. 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)                                   |           |                    |                |
| 9. 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  |           |                    |                |
| 12. Finding care for my child in the future   |           |                    |                |

## Miracles Child Care Agreement

This agreement is made between \_\_\_\_\_ (parent/guardian)  
and Miracles Child Care for the care of the following child(ren):

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent #1 employment hours \_\_\_\_\_ to \_\_\_\_\_ Parent #2 employment hours \_\_\_\_\_ to \_\_\_\_\_

Arrival Time: \_\_\_\_\_ Departure Time: \_\_\_\_\_ (not to exceed 9 hours per day)

Variations in schedule: \_\_\_\_\_

Parents are expected to adhere to arrival/departure times within 10 minutes of this agreement. Any variation from these times must be approved by the administration of Miracles Child Care.

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.

We are required by the State of Ohio to provide staffing to cover specific staff/child ratios; therefore, we require that you follow the above times. If circumstances arise that cause a change in your schedule, please communicate with the administration of Miracles Child Care with at least one week notice. Written work schedules and child care schedules may be required for all parents. Failure to adhere to these times may result in a re-evaluation of continued care.

The Parent Handbook contains policies and procedures that must be followed. It also contains a price list and information on holidays, vacations and other absences. Violation of policies or delinquent payments may result in termination of care.

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent/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 | PRESCHOOL | SCHOOL AGE    |                             |                   |
|--|---------|-----------|---------------|-----------------------------|-------------------|
| \$240  | \$220   | \$200     |               | Before &/Or<br>After School | Calamity<br>Only* |
| Income based child care<br>assistance:<br>NOCAC<br>ssp.benefits.ohio.gov |         |           | Weekly        | 140                         | \$40/day          |
|  |         |           | 2 Hr. Delay   | \$14                        | \$16              |
|  |         |           | No School     | \$37                        | \$40              |
|  |         |           | Summer<br>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 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.