

Ohio Department of Children and Youth  
**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: 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 able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.</b>					
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 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 DCY 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 DCY 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 DCY 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 DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 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>  Do not sign both	<u>Do Not Give Permission</u> to Transport	
Program or Home Name BLOSSOM ACADEMY			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: VOID VOID VOID VOID VOID VOID	
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 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.  
 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.

**Reset Form**

Ohio Department of Children and Youth  
**BASIC INFANT INFORMATION FOR CHILD CARE**

<p>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.</p>					
Child's Name			Nickname		
Child's Date of Birth			Siblings		
<p>What are you feeding your infant? <i>(Check all that apply)</i></p> <p> <input type="checkbox"/> Formula (include brand)             <span style="float: right;"><input type="checkbox"/> Breast milk</span> </p>					
Formula preparation <i>(if center/provider is to prepare.)</i>					
Amount for each feeding			Frequency of feedings		
<p>My infant likes a bottle warmed: <i>(Check one)</i></p> <p style="text-align: center;"> <input type="checkbox"/> Room temp             <input type="checkbox"/> Warm             <input type="checkbox"/> Very warm/NOT HOT           </p>					
Juice <i>(type, amount, when?)</i>					
<p>Does child use a cup yet?      <input type="checkbox"/> No      <input type="checkbox"/> Yes</p>					
<p>Solid foods <i>(baby food, brand, types, amounts, frequency)</i></p> <p><i>*you must have written permission from your child's physician if your child is under 4 months and given solid foods.</i></p>					
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					
<p>Sleeping Position      <input type="checkbox"/> Back      <input type="checkbox"/> Side* <input type="checkbox"/> Tummy*</p> <p><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 DCY 01235.</i></p>					
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					

**Reset Form**

# Blossom Academy

## Child Pick-Up

### Authorization Form

In the event that I am unable to pick up my child \_\_\_\_\_,  
I \_\_\_\_\_, authorize Blossom Academy to release my child/ren to the  
following people below. Child/ren will only be released to individuals that is 16 years of age or older  
and with a valid picture identification card. Parent/Guardian must contact Blossom Academy one (1)  
hour in advance of the scheduled pick-up time to inform the staff of who will be picking up your  
child/ren. Your child/ren will only be released to the following persons:

Name	Relationship to child	Phone number

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Photo Releases

I (parent's name) \_\_\_\_\_ grant Blossom Academy the right to use any photographs/video taken of my child(ren) for the purposes of advertising, marketing, illustration and or any other purpose with Blossom Academy. When using such photo, Blossom Academy:

- \_\_\_\_\_ may use my child's full name in conjunction with the photo/video
- \_\_\_\_\_ may use my child's first name in conjunction with the photo/video
- \_\_\_\_\_ shall not use my child's name in conjunction with the photo/video
- \_\_\_\_\_ may use my child's photo in group pictures only.

Name of Child: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_





Main Office: 222 East Central Parkway • Cincinnati, Ohio 45202-1225  
 General Information: (513) 946-1000  
 General Information TDD: (513) 946-1295  
 www.hcjfs.org

## Child Care Co-Payment Agreement Form

Ohio Administrative Code 5101:2-16-39 (H) requires Child Care providers to establish a written agreement for payment of the co-payment and fees, signed by the provider and caretaker. Providers must retain the original form in their records and submit a copy to HCJFS only when advising HCJFS of the consumer's non-payment of fees.

Caretaker:	Provider: Blossom Academy
Address:	Address: 2828 Highland Ave
Telephone:	Telephone: (513)978-0004

I, \_\_\_\_\_, agree to pay the assigned weekly co-payment (fee determined by HCJFS) to the provider. The due date for payment is:

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Failure to pay the co-payment by the agreed upon date, will result in notifying the HCJFS of the delinquent co-payment and possible termination of services.

The signatures below signify agreement with the statements above.

Signature of Caretaker:	Date:
Signature of Provider:	Date:

\*\*\*\*\*  
 If the consumer's co-payment fee is delinquent more than ten calendar days from the due date established in this written co-payment agreement, submit a copy of this document and the HCJFS 4671 – Delinquent Fee Form by fax or mail to:

Hamilton County Job & Family Services  
 Child Care Department  
 222 E. Central Parkway  
 Cincinnati OH 45202  
 Fax: 513-946-1830



## Consent Form

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

- I have read the information provided about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/ monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.
- I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

\_\_\_\_\_  
Parent or guardian's signature

\_\_\_\_\_  
Date

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

Child's date of birth: \_\_\_\_\_

If child was born 3 or more weeks prematurely, # of weeks premature: \_\_\_\_\_

Child's primary physician: \_\_\_\_\_

## Media Policy

Blossom Academy will not show or take any children enrolled in our program to any "R" rated or "X" rated movies. All films are to be reviewed by the staff, before any children view programming, to ensure the material is satisfactory for the viewing audience. Children will have access to "G" rated, "TV-Y", "TV-7" and "PG" rated movies and stations that may be viewed at the center or on field trips to the movie theater. Children will only have access to this with written parent permission.

I give my permission for my child \_\_\_\_\_ to watch "G" rated, "TV-Y" rated, "TV-7" rated and "PG" rated movies and television shows when my child/ren are under the care of Blossom Academy.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

# Billing Policy Agreement

10/31/25

RE: Billing Policy

Dear Parents

Beginning November 1, 2025 Blossom Academy will be enforcing our billing policy. Full-time clients must attend a minimum of 33 attendance hours per week, in order to receive full credit from Jobs and Family Services. Part-Time clients must attend a minimum of 10 hours in order to receive the full credit. Those parents not meeting the minimum requirements will now be responsible for the remaining balance, when the minimum requirement is not met.

Example:

Pre-School Rate =	\$283.80 per week.
Attendance Hours (24.99): JFS Credit	- \$187.00 per week
Parent Fee:	<u>- \$5.00 per week</u>
Remaining Balance:	\$ 91.80

Parents with children in the After-School program will need to pay close attention to this policy. Please make sure that your child is meeting the required minimum hours assigned:

In the past, we have been very lenient with attendance, this policy will not affect the majority of our parents. The majority of parents are already meeting the necessary minimum requirements. Please stay on top of the number of absent days you have, back swipe list, both will assist you in making sure you hit your minimum requirement.

If you have any questions, please see the Enrollment Specialist whom will be able to assist you with your number of hours of attendance.

I understand that I must meet the assigned minimum requirements per my voucher status assigned by Job and Family Service. If hours are not met I understand that I will be responsible for all remaining fees that were not paid by Job and Family Services. If fees are not paid this could result in losing your space at the childcare center until fees are paid in full.

Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Management staff: \_\_\_\_\_

Date: \_\_\_\_\_