

Welcome!

We're excited to learn and grow with your child!

2026-27



little 
buckeyes
Early Learning Center

A SERVICE OF BUCKEYE HILLS CAREER CENTER



Hello!

Thank you for considering Little Buckeyes Early Learning Center for your child's care! We are excited to get to know your child and help them learn and grow!

This packet contains forms for you to complete that will help us know how to best care for your child. **Please complete the forms and return to Little Buckeyes Early Learning Center** (located in the Green Building at Buckeye Hills Career Center) OR **email your completed packet to LittleBuckeyes@buckeyehills.net**.

If you have any questions along the way, please ask us! We want to make the enrollment process easy and simple!

Questions? Call us at 740.245.5334!

Dawn Hall
Early Childcare Facilitator

Forms Checklist

- New Family Intake Form
- Child Enrollment and Health Information for Child Care
- Child Medical/Physical Care Plan for Child Care
Portions must be completed by a physician
- Child Medical Statement for Child Care
Must be completed by a physician
- Request for Administration of Medication for Child Care
- Emergency Medical Authorization
- Payment Plan Form

Supply Checklist

You'll need to bring the following items for your child:

- Blanket & Pillow
- Bookbag
- Lunch
- Seasonally Appropriate Change of Clothes



New Family Intake Form

We're so excited that you're joining our program soon! Please take a few minutes to fill out this form so we can get to know you and your child better.

All about your child

Has your child been in any early learning programs before? If so, please share more details.

How would you describe your child's personality in a few sentences?



What are some things your child does well?

How does your child learn about the world around them?

How does your child feel about starting our program?

What is most comforting to your child when they are upset?

What are your child's favorite toys and games?

Does your child enjoy looking at books or reading at home? What is their favorite book?

All about your family

Tell us about your household (who lives with you, their relationships to your child, and any other details you'd like to share).

Is there any information about your family's culture, religion, or language that is important for us to know?

Do you or your family members have any talents or interests you would like to share with our program?

How else can we support you?

What are your expectations of our program?

Do you have any questions about the facilities, program, or curriculum?

What are your greatest hopes for your child's early education experience?
Do you have any concerns?

Is there any other way our program can support your family (e.g., referrals to community resources)?

Thank you for filling out our intake form! We're thrilled to welcome you to our program.

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?					
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of <u>at least one person</u> 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.					
Name			Name		
City		State	City		State
Telephone Number		Relationship to Child		Telephone Number	
Relationship to Child		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 ____ 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		OR Do not sign both	<u>Do Not Give Permission</u> to Transport	
Program or Home Name			Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			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/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition

Does this health condition require medication or medical food? Yes (If Yes, complete Part II) No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid? Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

Part II: Conditions Requiring Medication or Medical Food

Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

(If no medications or medical foods are required for the condition, skip Part II).

If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name	Date of Birth	Weight <i>(if needed to determine dosage)</i>
Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date
<input type="checkbox"/> Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant		
<p>A. What are the symptoms which require staff to administer medication or medical food?</p> 		
<p>B. What are the specific instructions for administration of medication or medical food?</p> 		
<p>C. What are the actions to be taken if symptoms do not subside?</p> 		
Physician's Signature		Date of Signature

Part III: Administration of Medication or Medical Food Training Authorization
Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)
Part III must be completed

Child's Name _____

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

Medication Supplies Assistance N/A

Parent Provided Training AND grants permission to perform the procedure	Complete Only One Section	Certified Professional Training AND parent grants permission to perform the procedure	
<i>My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>		<i>My signature indicates I have provided instructions for care and/or training for the medical procedure</i>	
Parent Signature		Certified Professional's Name <i>(please print)</i>	
Date of Signature		Certified Professional's Signature	
		Date of Signature	Phone Number
		<i>My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>	
		Parent Signature	
	Date of Signature		

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the procedure for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
<i>My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.</i>	Administrator/Provider Signature	Date of Signature

This 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, a new form must be completed.

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
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

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 (<i>please list in space below</i>):	
<i>Check below, if applicable:</i>	
<input type="checkbox"/> 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
Weight _____	Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
BMI _____	Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	Other: _____
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.

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

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

This form is to be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

Child's Name	Date of Birth <i>(if needed to determine the correct dosage)</i>	Weight <i>(if needed to determine the correct dosage)</i>
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Box 1 The following section must always be completed by the parent/guardian.

Name of medication	Dosage <input type="checkbox"/> See attached
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To be administered at the following times	For the following period of time	Medication expiration date
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I understand:

1. This form expires twelve months from the date of my signature, if box 2 has not been completed.
2. That my child must receive at least one dose of medication at home prior to the program administering the medication (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date
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Box 2 The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant when any of the following apply:

1. The nonprescription medication contains codeine or aspirin;
2. A physician's instruction is needed for a nonprescription medication;
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication;
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen-day period;
5. The intended use differs from the manufacturer's instructions or use

Instructions

See Attached

Possible side effects to watch for are

See Attached

The child is under my care and should receive the above medication as written. I understand this form expires twelve months from the date of my signature.

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

Date of Signature

Phone Number

Emergency Medical Authorization

Revised 5/6/2020

This form meets the requirement for Ohio Revised Code Section 3313.712.

Program

Name _____

Student Name _____

Phone _____

Address _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name _____

Daytime Phone _____

Father's Name _____

Daytime Phone _____

Other's Name _____

Daytime Phone _____

Name of Relative or Childcare

Provider _____

Relationship _____ Daytime Phone _____

Address _____

Emergency Contact #1 _____

Daytime Phone _____

Address _____

Emergency Contact #2 _____

Daytime Phone _____

Address _____

Emergency Contact #3 _____

Daytime Phone _____

Address _____

Emergency contact information is required in accordance with Ohio Administrative Code Rule 3301-37-08 (for preschool programs). Please complete both pages of the form.

PART I MUST BE COMPLETED: PART I - TO GRANT CONSENT I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____

Phone _____

Dentist _____

Phone _____

Medical specialist _____

Phone _____

Local Hospital _____

Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Signature of Parent/Guardian _____ Date _____

Address _____

Little Buckeyes Early Learning Center

2026–2027 School Year Payment Plan

Parent/Guardian Name: _____

Child(ren) Name(s): _____

Phone Number: _____

Email Address: _____

Address: _____

Tuition Selection

Please check one:

- Full-Time Care — \$175.00 per week
- Part-Time Care — \$100.00 per week

Payment Schedule

Please select one payment option:

Weekly Payments

Payments due every Friday for the upcoming week of care.

Bi-Weekly Payments

Payments due every other Friday for the upcoming two weeks of care.

Monthly Payments

Payments due on the 1st business day of each month.

Public Assistance Program

I participate in the **Public Assistance Program**

If known, my weekly/monthly co-pay amount is:

\$ _____

Case Worker Name (if applicable): _____

County Agency: _____

Payment Policies

1. Tuition payments are due according to the selected payment schedule above.
 2. Payments not received by the due date may be subject to late fees.
 3. Parents/guardians are responsible for all tuition balances not covered by public assistance.
 4. A two-week written notice is required for withdrawal from the program.
 5. Returned checks may result in additional fees and future cash-only payments.
 6. Tuition rates are subject to change with advance notice.
-

Accepted Payment Methods

- Cash
 - Check
 - Money Order
 - Electronic Payment
-

Parent/Guardian Agreement

I understand and agree to the tuition payment terms and policies of Little Buckeyes Early Learning Center for the 2026–2027 school year.

Parent/Guardian Signature: _____

Date: _____

Center Use Only

Enrollment Date: _____

Start Date: _____

Staff Initials: _____