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

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Early Learning Center

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 Children and Youth

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

Child's Name		Date of Birth	First Day at Program
Address			
City		State	Zip Code
Parent #1 Name		Parent #1 Phone Number	
Parent #1 Address ☐Same as Child's		City	State / Zip Code
Parent #1 Email Address (if applicable)		Parent #1 Cell Phone (if applicable)	
Parent #1 Work/School Name (if applicable)		Parent #1 Work/School Phone Number (if applicable)	
Check here if Not Applicable ☐	Parent #2 Name	Parent #2 Phone Number	
Parent #2 Address ☐Same as Child's		City	State / Zip Code
Parent #2 Email Address (if applicable)		Parent #2 Cell Phone (if applicable)	
Parent #2 Work/School Name (if applicable)		Parent #2 Work/School Phone Number (if applicable)	

Primary Emergency Contact #1 Name (cannot be parent/guardian)	Check here if Not Applicable ☐ Optional Emergency Contact #2 Name (cannot be parent/guardian)
Primary Emergency Contact #1 Phone Number	Optional Emergency Contact #2 Phone Number
Primary Emergency Contact #1 Other number or email address for emergency contact *(if applicable)*	Optional Emergency Contact #2 Other number or email address for emergency contact *(if applicable)*
My child may be released to this emergency contact ☐ Yes ☐ No	Optional My child may be released to this emergency contact ☐ Yes ☐ No

Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication?

☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

Child's Name	Date of Birth

Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes
☐ No

Name of service provider(s) and frequency

☐ N/A

Emergency Transportation Authorization

☐ **The program 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.

☐ **The program 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:

SIGNATURE

This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.

Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures

By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures (parent handbook).

Parent Signature	Date

Program Acknowledgement of Completion

By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.

Program Administrator/Designee Signature			Date
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 Children and Youth

HEALTH CARE PLAN DOCUMENTATION & PERMISSION TO ADMINISTER MEDICATION FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance and update annually and as needed when a child has a special chronic health condition that may require the program to perform a medical procedure or administer medication. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

HEALTH CARE PLAN DOCUMENTATION

Child's Name	Date of Birth

If the child does not have a special chronic health condition or diagnosis check here: ☐
Skip to page 2 to give permission to administer medication/medical food.

Complete a new form or provide separate documentation for each condition that requires different actions to be taken.

☐ **Check here if additional information/documentation is attached from a licensed dentist, licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN).** This documentation may serve as a substitute for page 1.

Special Chronic Health Condition

What are the signs, symptoms, or situations which require staff to take action, perform a medical procedure and/or administer medication or medical food?

What are the activities, foods, conditions, etc. to avoid? ☐ Not Applicable

What are the instructions to care for the child or perform a medical procedure?

If the child's health condition does not improve or side effects to medication appear, trained staff will do one or more of the following:

☐ Call 9-1-1

☐ Call Parent

☐ Other:

Additional Information and/or what is needed if the child care program must be evacuated:

If the special health condition does not require administering medication/medical food: STOP HERE AND SKIP TO PAGE 3

Page 1 is completed to provide instructions for performing a medical procedure.

PERMISSION TO ADMINISTER MEDICATION

Instructions from a licensed dentist, licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) are required for administering:

- Medical foods.
- Prescription medications, including samples.
- Non-prescription medicines containing aspirin.
- Topical preventative products and lotions or non-prescription medications, when the instructions for use exceed or do not match the manufacturer's instructions or are not stored in original container.

Child's Name	Date of Birth	Weight (if needed to determine dosage)

What are the instructions to administer medication or medical food?

☐ **Not Applicable: Instructions are not required if the prescription medication is stored in the original container with prescription label that includes the child's full name, exact dosage, and directions for use.**

What actions are to be taken if the medication or medical food is not available?

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 ☐ Administer because symptoms are present	Time of Medication/Medical Food Administration ☐ Administer because symptoms are present	Time of Medication/Medical Food Administration ☐ Administer because symptoms are present

SIGNATURE PAGE

Child's Name

PARENT/GUARDIAN

By signing this form I attest that: (check all that apply)

- ☐ I have provided information for care or implementing a medical procedure
- ☐ I have trained staff and have given permission to perform the procedure
- ☐ I have trained staff and have given permission to administer medication to my child

Parent Signature	Date of Signature

LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE REGISTERED NURSE, LICENSED DENTIST

Health Care Professional's signature is only required in this box if their instructions have been provided on this form, prescribed medication does not have a prescription label, or as directed by the manufacturer's instructions.

Physician Signature	Date of Signature

CERTIFIED PROFESSIONAL TRAINER

(A signature from a Certified Professional Trainer is not required if the parent/guardian has provided instructions for care, training, or administering medication)

If a Certified Professional Trainer provided instructions, my signature indicates that:

☐ I have provided instructions for care and/or training for the medical procedure.

☐ I have provided instructions for administering medication.

Certified Professionals Name (please print)	Phone Number
Certified Professionals Signature	Date of Signature

PROGRAM STAFF

Signatures of all individuals who have received instructions for care, have been trained in performing the procedure for this child and/or administering medication. Additional names and signatures can be attached on a separate sheet.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

DOCUMENTATION OF ADMINISTRATION OF MEDICATION OR MEDICAL FOOD

Child's Name	Name of Medication/Medical Food

Date	Time	Dosage	Signature of person administering medication/medical food

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 Contact1 #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: _____