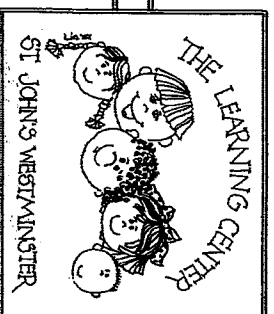


The Learning Center
513.922.2703



St. John's Westminister
f: 513.620.5660
Tax ID: #30-0035904

thelearningcenter@sjwlc.net

Dear new families,

Welcome! We are so glad you chose St. Johns Westminister Learning Center as your preferred childcare! We take pride in developing young minds and bodies every day, please let us know if you or your children have any special needs we can meet for you.

On your first day please bring the following items with you:

- Your paperwork (if not already turned in)
- Diapers and wipes if applicable
- A change of seasonally appropriate clothing
- Nap items such as a blanket, pillow or stuffed animal. We prefer sleep sacks for infants.
- Food for the day, labeled and dated

Please know we have an open door policy and welcome parents in our center at any time during the day. Please feel free to contact us by phone, 513-922-2703 or by the following emails:

Candace Lemke, Director Candace@sjwlc.net

Jessica Hunt, Assistant Director Jessica@sjwlc.net

Thank you for your business and we look forward to serving your childcare needs while also providing the best learning environment for your child.

Sincerely

SJWLC Administration Team

The Learning Center • St. John's Westminister • 1085 Neeb Rd. Cincinnati 45233 • 513.922.2703
thelearningcenter@sjwlc.net



St. John's Westminster Learning Center

Start-Up and Tuition Fee Break Down

Start Up Cost/Fees (due at time of Registration)

1. \$50.00 Registration Fee (non-refundable)
2. Tuition Deposit of 1 week of tuition (non-refundable, may be used as 1st weeks payment)

Weekly Tuition Rates: (due on 1st week at center)

-Payments are expected in advance on the Friday before the week you are paying for.

Current Center Rates* (as of 3/2017)

0-18 months.....	\$223 per week
18 months – 3.5 years	\$206 per week
3.5 years – 5 years (pre-K)	\$184 per week
Multiple discount	\$15 per week

- Please note that the tuition rates are subject to change at any time. Advanced notice will always be given if rates are due to change. Please contact the Director to get the most up to date rates for the center.

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		Relationship to Child			
Home Address		Home Telephone Number			
City		State	Zip		
Email Address (if applicable)		Cell Phone			
Parent's Work/School Telephone Number		Parent's Work/School Name			
Parent's Work/School Address		City			
<p>Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email</p> <p>Where can you be reached while your child is in this program/home?</p>					
Parent/Guardian Name		Relationship to Child			
Home Address		Home Telephone Number			
City		State	Zip		
Email Address (if applicable)		Cell Phone			
Parent's Work/School Telephone Number		Parent's Work/School Name			
Parent's Work/School Address		City			
<p>Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email</p> <p>Where can you be reached while your child is in this program/home?</p>					
Parent's Work/School Telephone Number		Parent's Work/School Name			
Parent's Work/School Address		City			
<p>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 within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.</p>					
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 Food Supplements

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 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care 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, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

- No
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a 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 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

- No
 Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

- No
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.
 N/A - program does not administer any medications.

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 the JFS 01217 "Request for Administration of Medication."
 N/A - child does not attend a full time program.

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.

List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

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		Do <u>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 and 5101:2-13-15. 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
CENTER PARENT INFORMATION
REQUIRED BY OHIO ADMINISTRATIVE CODE

The facility is licensed to operate legally by the Ohio Department of Job and Family Services. This license is posted in a conspicuous place for review.

A toll-free telephone number is listed on the facility's license and may be used to report a suspected violation of the licensing law or administrative rules. The licensing law and rules governing child care are available for review at the facility upon request.

The administrator and each employee of the facility is required, under Section 2151.421 of the Ohio Revised Code, to report their suspicions of child abuse or child neglect to the local public children's services agency.

Any parent, custodian, or guardian of a child enrolled in the facility shall be permitted unlimited access to the facility during all hours of operation for the purpose of contacting their children, evaluating the care provided by the facility or evaluating the premises. Upon entering the premises, the parent, or guardian shall notify the Administrator of his/her presence.

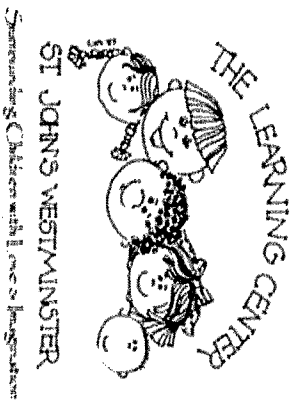
Contact information for parents/guardians of the children attending the facility is available upon request. This information will not include the name, telephone number or email of any parent/guardian who requests that his/her name, telephone number or email not be included.

Recent licensing inspection reports and any substantiated complaint investigation reports for the past two years are posted in a conspicuous place in the facility for review.

The licensing record, including licensing inspection reports, complaint investigation reports, and evaluation forms from the building and fire departments, is available for review upon written request from the Ohio Department of Job and Family Services. The center's licensing inspection reports for the past two years are also available for review on the Child Care in Ohio website. The website is: <http://jfs.ohio.gov/cdc/childcare.stm>.

It is unlawful for the facility to discriminate in the enrollment of children upon the basis of race, color, religion, sex or national origin or disability in violation of the Americans with Disabilities Act of 1990, 104 Stat. 32, 42 U.S.C. 12101 et seq.

This information must be given in writing to all parents, guardians and employees as required in 5101: 2-12-30 of the Ohio Administrative Code.



St. Johns Westminster Learning Center Full Day Program Registration

Child's name _____

Male Female Childs Date of Birth: _____ Start date at Center _____

Mother's Name: _____

Father's Name: _____

Home Address: _____

Mother's Cell Phone & Email: _____

Father's Cell Phone & Email: _____

Registration fee of \$75 Due: _____ Paid: _____

Parents Signature: _____

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)	Date of Birth
<input checked="" type="checkbox"/> This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care. <input checked="" type="checkbox"/> This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).	
Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination
Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number
Street Address	
City, State and Zip Code	

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the Immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

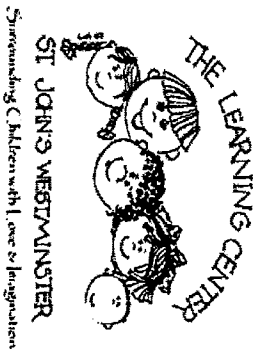
Signature of Parent	Date of Signature
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Optional Recommended Assessments/Screenings			
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lead	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
Measurements		Notes	
Height			
Weight			
BMI			

Ohio Department of Job and Family Services
CHILD MEDICAL/PHYSICAL CARE PLAN
FOR CHILD CARE

Child's Name	Date of Birth		
Special Health Conditions			
Symptoms to watch for and emergency action to be taken if the following symptoms occur			
Activities/foods/environmental conditions to avoid, if applicable			
Medical procedures to be followed and expected benefit of treatment, if applicable			
Are any medications required? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete JFS 01217 "Request for Administration of Medication")</i> If yes, what medications?			
In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Training Instructions <i>(Trainer must be a parent or certified professional)</i>			
Signature of Trainer	Date		
Signature of trained providers, substitutes or child care staff members who have been made aware of the condition. <i>(There must always be a trained caregiver present when the child is present)</i>			
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
<i>(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)</i>			
Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.			
Parent Signature	Date		
Administrator/Provider Signature	Date		

Note: A separate plan must be written for each condition that requires different actions to be taken



Parent Designated Child Pick-Up List

Child's Name: _____ Date: _____

I, _____ give my permission to the persons named to this list to pick up my child from St. John's Westminster Learning Center.

Parent/ Guardian Signature Date

Parent/ Guardian Signature Date

1. Name: _____
Relation: _____
Phone Number: _____
Alternate Phone Number: _____

2. Name: _____
Relation: _____
Phone Number: _____
Alternate Phone Number: _____

3. Name: _____
Relation: _____
Phone Number: _____
Alternate Phone Number: _____

4. Name: _____
Relation: _____
Phone Number: _____
Alternate Phone Number: _____

Ohio Department of Job and Family Services
BASIC INFANT INFORMATION FOR CHILD CARE

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.

Child's Name	Nickname
Child's Date of Birth	Siblings
What are you feeding your infant? (Check all that apply) <input type="checkbox"/> Formula (include brand) <input type="checkbox"/> Breast milk	
Formula preparation (if center/provider is to prepare.)	
Amount for each feeding	Frequency of feedings
My infant likes a bottle warmed: (Check one) <input type="checkbox"/> Room temp <input type="checkbox"/> Warm <input type="checkbox"/> Very warm/NOT HOT	
Juice (type, amount, when?)	
Does child use a cup yet? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Solid foods (baby food, brand, types, amounts, frequency) <i>*you must have written permission from your child's physician if your child is under 4 months and given solid foods.</i>	
Are foods served room temperature or warmed?	
Table food (types, amounts, frequency, special instructions)	
Security items (pacifier, blankets, etc.)	
Nap schedule	
Hints for getting baby to sleep	
Sleeping Position <input type="checkbox"/> Back <input type="checkbox"/> Side* <input type="checkbox"/> Tummy* <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 JFS 01235.</i>	
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	

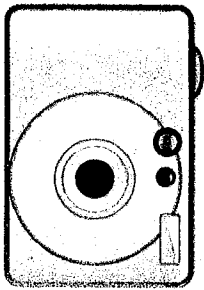


Photo Release

St. John's Learning Center



St. John's Westminster Learning Center uses photographs to document classroom activities, children interacting with teachers, field trips, play on indoor and outdoor equipment, special events, and general everyday happenings within the Center. Photos and digital images are used as part of promotional materials in various forms of print, on websites, and social media. Facebook and Instagram are social media outlets that we utilize to share your child's adventures with you. Please sign the form below to allow us to post and share their activities. Names are never included in images use outside of the classroom.

By signing the form below you grant permission for The Learning Center to take and use photos, digital images, and/or video of your child to be used on social media.

Child's Name: _____

_____ Date

I, _____, give my permission for St. John's Westminster Learning Center to take and use photographs, digital images, and/or videos of my child in the classroom and promotional materials, including, but not limited to printed materials, websites, and social media.

Parent/Guardian Signature _____

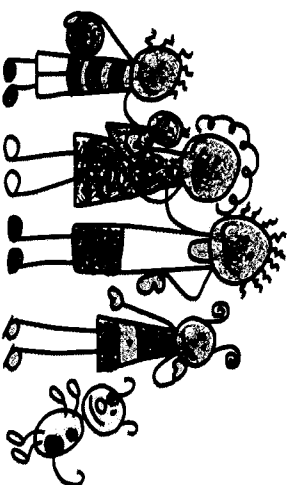
_____ Date

I, _____, *do not* give my permission for St. John's Westminster Learning Center to take and use photographs, digital images, and/or videos of my child for any purpose.

Parent/Guardian Signature _____

_____ Date

All about our family



Childs Name	Nickname is any	Childs D.O.B

By providing complete information about your child, you will be assisting staff in creating a positive experience for your child while in our care. List any information about your child's habits, abilities or personalities that will be helpful to the staff that cares for your child.

Family members in the home? Including pets.

Other family member whom are frequently involved.

Are there any special parenting arrangements we need to be made aware of?

Are there any changes or transitions that have recently taken place that could be currently affecting your child? (Moved, death, divorce, new sibling etc....)

Are there any cultural or religious practices that we should be aware of?

<p>Does your child have any medical/physical conditions that will need to be treated while attending the center?</p>
<p>If YES you will need to fill out a CHILDCARE PLAN FOR HEALTH AND MEDICAL PROCEDURES. Please fill out this form and explain your child's health/medical procedure(s) that need to be followed while in our care at the center.</p>
<p>Is your child currently taking any medication that will need to be administered while they are at the center?</p>
<p>If YES you will need to fill out a REQUEST FOR ADMINISTRATION OF MEDICATION FORM you will need one form per medication</p>
<p>Has your child had previous care arrangements?</p>
<p>How often does your child drink each day? (bottles, cups of milk, juice, water)</p>
<p>How often does your child eat solid foods? (snacks, meals)</p>
<p>Due to allergies or sensitivities are there any foods your child may NOT have?</p>
<p>(If YES you will need to fill out a CHILD CARE HEALTH PLAN FOR HEALTH AND MEDICAL PROCEDURES)</p>
<p>Please tell us a little about your child, personality traits, quirks, is there anything that may frighten them? How do you calm them if they are upset?</p>

<p>What routines/actions or items do you use to comfort your child?</p>
<p>What is something that causes your child to feel angry or frustrated?</p>
<p>How do you handle misbehaviors with your child?</p>
<p>Is your child potty trained, or working toward potty training? If your child is potty training please explain your process.</p>
<p>Does your child need assistance with going to the bathroom? If so, What ways do we need to help them?</p>
<p>What might you or your child be anxious about as they start at St. Johns?</p>
<p>What do you expect to get out of your time here at St. Johns program?</p>
<p>Does your child have a problem with any of the following? Constipation Gas Diarrhea Diaper rash Reflux</p>
<p>If yes how do you help with symptoms?</p>
<p>What other information would be helpful for the staff member caring for your child?</p>

Signature _____ Date _____

I have received and read a copy of St. John's
Westminster Learning Center's Handbook and I
understand and will abide by all of the policies and
procedures contained in it.

Parent/Guardian Signature

Date

-----Please return to the School Office-----