



A Program of Sylvania Community Services
A trusted Child Care provider for over 25 years

Woodrow Preschool Childcare Policy 2011/2012

Woodrow Child Care Center • 5900 Woodrow • Sylvania, OH 43560
Woodrow 419-517-1367 Office 419-885-2451 Fax 419-882-1639 sylvaniachildcare.org

Registration Fee:

On or before 8/12/11: \$25 Beginning 8/15/11: \$35 For child returning from 2010-11: \$0

Deposit:

In addition, a **deposit** is required at the time of registration. **This deposit is not to be used as credit throughout the school year**, but will stay on file at SCS as long as your child(ren) is in the program. The deposit fees are as follows:

\$120 for a single child in the program – all grades and all ages
\$110 per child for multiple children in the program – all grades and all ages

Because our program is post-paid, we require that the deposit and registration fee be received before your child can attend. The deposit and registration fees must accompany the registration forms. Please fill out all registration information completely as it is necessary to start the program.

Payment Policy

If a family has more than one child in our program they will pay the family fee for each child, regardless of the program they are in. There is a one full-day per week minimum charge for Woodrow. If the program is not used in a 3-week period, SCS reserves the option to fill your child's slot.

Woodrow Preschool (Rates effective 8/29/11)	Single Rates	Family Rates
Weekly Rate	\$144.20	\$137.00
Daily Rate (5 hrs or more):	\$36.05	\$34.25
Half Day Rate (less than 5 hours):	\$26.05	\$24.25

Woodrow Preschool charges include care from 6:30am-6:30pm, and a morning and afternoon snack.

Inclement Weather Days In the winter, **we are open** during a Lucas County level 1. During a level 2 or 3, please call our recording to determine closure: 419-885-2451

Enrollment and Health Information

The State of Ohio requires that each child in our program have an enrollment and health information form (EHI) on file and that it be filled out **completely**. EHI's must be **updated annually**. *Please notify us immediately when telephone numbers or addresses change.* Also required is an **annual health form (immunization records)** which **must be returned prior to start date**.

Early Drop Off, Late Pick-Up Charge

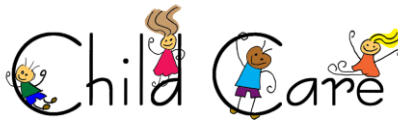
There is a \$1.00 per minute early/late charge per child, before 6:30 a.m. and after 6:30 p.m. The late fee will be billed to the child's invoice.

Showing Photo ID

Any person picking up a child from any SCS child care center must show a photo ID to the caregiver in charge of the child. Children will not be released from the center to anyone who does not have the proper authorization.

Closure Dates

Woodrow Child Care Center is closed the following days:
New Year's Day, Martin Luther King Day, Presidents Day, Good Friday, Memorial Day, July 4, Labor Day, Thanksgiving Day and the Day after, Christmas Eve, Christmas Day, New Year's Eve.



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Woodrow Child Care Registration

Please fill out a separate form for each child being registered.

Child's Name _____ Date: _____

Current Age _____

Date of Birth ____/____/____ Gender _____

E-mail Address: _____

Days you will be using Woodrow Child Care: (please circle) M T W Th F
Hours Child Care is needed (ex. 7am-4pm): _____

G Movie: My child has permission to watch a suitable G rated movie. _____ yes _____ no

Walking: I give SCS my permission for _____ to walk to suitable locations within one mile
(Child's name)
of Woodrow Child Care Center. All walks are supervised by SCS child care providers.

Photograph/Videotape:

I give consent for my child to be photographed or videotaped. _____

I do **not** give my consent to have my child photographed or videotaped. _____

This is for Sylvania Community Services purposes (ie website, facebook page) or any local newspaper/television station coverage.

Parent's Advisory Board: A group of parents who may meet once or twice a year.

_____ Yes, I will participate _____ No, I cannot participate

Parent's Signature _____

Date _____

Office Use Only

Check Number _____

Process Date _____

Invoice Number _____

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE CENTERS AND TYPE A HOMES**

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 Center	
Home Address				City	
State		Zip Code		Home Telephone Number	
Parent/Guardian Name			Relationship to Child		
Home Address					
City			State		Zip
Home Telephone Number			Cell Phone		
Work/School Telephone Number			Work/School Name		
Work/School Address				City	
Please indicate if this name should be included on a parent roster <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which number above to list on the roster <input type="checkbox"/> Work number <input type="checkbox"/> Cell number <input type="checkbox"/> Home number					
Where can you be reached while your child is in this program?					
Parent/Guardian Name			Relationship to Child		
Home Address					
City			State		Zip
Home Telephone Number			Cell Phone		
Work/School Telephone Number			Work/School Name		
Work/School Address				City	
Please indicate if this name should be included on a parent roster <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which number above to list on the roster <input type="checkbox"/> work number <input type="checkbox"/> cell number <input type="checkbox"/> home number					
Where can you be reached while your child is in this program?					
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 and at least one person listed must be within one hour of the center/home and able to take responsibility for the child in case you cannot be contacted.					
Name			Name		
City		State		City	
State		City		State	
Telephone Number		Relationship to Child		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 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 type A 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 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, 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.
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Diapering Statement

Is your child toilet trained? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> No
The program's policy is to check diapers every ____ hours. Please indicate if you want your child's diaper checked according to the center/type A home's policy or another:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> 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	Do Not Give <u>Permission</u> to Transport	
Center or Type A Home Name			Center or Type A 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 center's or type A home's policies and procedures/handbook.

Parent/Guardian Signature	Date
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Signatures

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. The administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form to indicate the date reviewed.

Parent/Guardian Signature(s)		Date	
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

Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.



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Woodrow Child Care 2010/2011

How did you learn about our program?

I have used SCS child care program previously with another one of my children who attends: (circle one): Central Highland Hill View
Maplewood Sylvan Stranahan Whiteford

A friend/neighbor

Woodrow Open House

Flyer brought home from school by my older child attending _____
Name of school

Postcard mailed to my home

Phone Book

AT&T Toledo Phone Book

Verizon Sylvania Phone Book

Ad in newspaper

Sylvania Advantage

Sylvania Herald

Toledo Blade

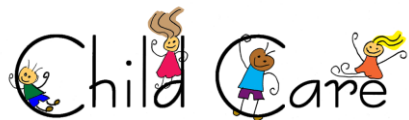
Toledo Area Parent

Internet

Our web site: www.sylvaniachildcare.org or www.scsonline.org

Our Facebook Page

Other _____



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PICK UP LIST

In order to protect your child, Sylvania Community Services Childcare Department would like your cooperation with the pick-up procedure.

Please fill out the following information and return it with your registration forms. This sheet will be kept at the site with your child's information so that any employee may have access to it.

Please remember anyone picking up your child will need to bring photo ID. Also remember to include yourself on the list.

Thank you for helping make our centers safe for the children.

Page Rostetter
Childcare Director

Desiree Thompson
Asst. Childcare Director

Child's name _____ Age _____

The following people may pick up my child(ren): **Please include yourself.**

<u>Name</u>	<u>Description</u>
1.	
2.	
3.	
4.	
5.	

Parent Signature _____ Date _____

Pick-up person needs to show photo I.D.



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Woodrow Child Care

Account Information

Billing/Invoice

It is the parent's responsibility to use their attendance code to clock the child in when dropping off and out when picking up. **If the parent does not clock in or out, the maximum time will be billed.** Your account will be billed weekly usually on Mondays. Parents are billed for care already given and are expected to pay upon receipt. All statements are mailed on the billing date and payment is due 5 days from the statement date. If you use tuition express all payments will be processed on the day the bill is generated. If an account is 5 days past due the child will be withdrawn from the program until the account is paid in full. When this occurs, all payments must be made by credit card, cash, or money order.

A \$10.00 finance charge is assessed to all past due accounts.

If, for any reason, we need to research your child's account past one current year, there will be a fee of \$40.00.

If you would like to set up two separate accounts for your child's billing purposes, there will be a \$75.00 non-refundable fee, per account, to initiate this process.

Returned Check or Credit Card fees are as follows:

Returned check: \$25.00

Declined electronic funds transfer or credit card: \$15.00

It is the policy of SCS that any three returned or declined payments in one year period, will forfeit any payment method other than cash or money order for a period of six months. If there is a 2nd offense, only cash or money order payments will be accepted while your child is in the program. Payment for a non-sufficient-funds check must be made by credit card, cash, or money order.

Required Fields:

Parent Responsible for Payment: _____

Social Security Number: _____

Date: _____

We now have tuition express to make payment easier for you!! Please see the next page.



ProCare Software

Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition has been paid on time! It's easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, automatic payment notifications or reviewing your payment history, please visit www.tuitionexpress.com.

For Bank Account Authorization, complete and return to center management

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I (we) authorize _____, (called "CENTER" in this Authorization) to initiate debit entries to my (our) Checking or Savings Account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize CENTER to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize CENTER to use the third party sender, Tuition Express* to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

_____ Your Name	_____ Phone #	_____ DEPOSITORY - Bank or Credit Union Name
_____ Address		_____ Bank or Credit Union Address
_____ City	_____ State	_____ Zip
		_____ City
		_____ State
		_____ Zip
		Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings

_____ Routing Transit Number (see sample below)	_____ Account Number (see sample below)
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This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

_____ Signature	_____ Date
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Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

*Tuition Express is an assumed business name of Blum Investment Group, Inc.



Routing Transit Number	Account Number	Check Number
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Please attach a copy of a voided check here. Deposit slips not accepted.

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT
 For Child Care Centers and Type A Family Child Care Homes

Child's Name (<i>print or type</i>)	Date of Birth
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This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in group care.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

List any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions) _____

Recommended Immunizations (<i>enter month, day, and year</i>)					
Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

Recommended Assessments/Screenings:

Vision: Yes No Date: _____ Hearing: Yes No Date: _____
 Dental: Yes No Date: _____ Lead: Yes No Date: _____
 BMI: Yes No Date: _____ Other: _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination
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Ohio Administrative Code rules 5101:2-12-37 and 5101:2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care center or type A home.

Name of Physician /Physician's Assistant/Advanced Practice Nurse	Telephone Number
Street Address	
City, State and Zip Code	

This is a sample form used to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37 of the Administrative Code.