



Jewish Community Center of Youngstown
Early Learning Center

Dear Parents,

In these unusual times all of us at the JCC of Youngstown and its Early Learning Center are happy to be able to assist you by taking care of your children, so that you may continue to do your extremely important jobs. As a community center, it is central to our mission to support our medical community, particularly in a time of crises.

Our early childhood and school age educators will be working alongside our JCC professionals to provide high quality care to your children. We have implemented health monitoring protocols for everyone entering our building, and intend to keep interaction between classroom groups to a minimum. We also employ police officers, who will be on duty to provide security and support to our learning center.

Despite these strange times, your children will have opportunities for learning through various materials and the programs designed by our educators. The JCC facilities also have a multitude of opportunities for physical activity through our playground, gymnasium, and various other large spaces ideal for gross motor and physical activities, including our swimming pool (more information on this to come as we design the aquatics program). We will also have wifi and a small computer lab available for those students that need to complete assignments online.

And on a personal note, I come from a family of doctors (a surgeon, my Grandfather - Dr. Bertram Katz of Northside Hospital, as well as two gastroenterologists, and a urologist) and I would like to acknowledge and thank you for the calm courage shown and the dedication provided to your patients during this pandemic. I have some appreciation for the challenging work you do and thank you for the opportunity to help you in your hour of need. We look forward to meeting you and your children and welcome to the JCC of Youngstown!

Sincerely,

Ben Katz

Director of Early Learning

Bkatz@jewishyoungstown.org

330.746.3251 ext 119



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Early Learning Center
330-746-3250 ext 119 or 125

Document Requirements for Enrollment:

- Child Care hours needed
- Pandemic Child Care Center Enrollment Addendum JFS01259
- Health Information Sheet JFS 01234
- ELC Agreement/Policies and Procedures
- Authorized Pick up List
- Medication form for all medications, and diaper creams (if applicable) JFS 01217
- Care plan for all serious health conditions (if applicable) JFS 01236
- Basic Infant Information (For all children under 18 mos.) JFS 01218

Should Care last longer than 30 days we will also require:

These documents and additional information will be provided to you closer to the 30 day mark of child care with the Early Learning Center.

- Child Medical Statement for Child care and an updated shot record. JFS 01305
- Family Information Sheet JFS 01511



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Child Care Hours

Please note the hours that you will need care below. Please be sure to note if it is AM or PM. If your schedule changes frequently please let us know.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Does your schedule change frequently?
If Yes please explain:

Yes

No

Ohio Department of Job and Family Services
PANDEMIC CHILD CARE CENTER CHILD ENROLLMENT ADDENDUM

Child's Name	Child's Date of Birth	Parent's Name
Name and Address of Pandemic Child Care Center		
Is Your Child Receiving Publicly Funded Child Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: List the Provider's Name and Address	
Description of Parent's Employment Providing Health and Safety Services as defined by the Ohio Department of Job and Family Services (ODJFS). Please attach verification.		
Find Your Family Size in the Chart. Is Your Income Below These Annual or Monthly Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Family Size	Annual Income	Monthly Income
1	\$24,980	\$2,082
2	\$33,820	\$2,819
3	\$42,660	\$3,555
4	\$51,500	\$4,292
5	\$60,340	\$5,029
6	\$69,180	\$5,765
7	\$78,020	\$6,502
8	\$86,860	\$7,239
9	\$95,700	\$7,975
10	\$104,540	\$8,712
11	\$113,380	\$9,449
12	\$122,220	\$10,185

Signature of Parent	Date
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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	
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				
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				
Where can you be reached while your child is in this program/home?				
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	
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				
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				
Where can you be reached while your child is in this program/home?				
Emergency Contacts: Parents <u>cannot be listed</u> 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 <u>you cannot be reached</u> . 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.				
Name		Name		
City		State	City	
State		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		OR Do not sign both	Do Not Give <u>Permission</u> to Transport	
Program or Home Name Jewish Community Center			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.



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ELC Agreement/Policies and Procedures

Parents/Guardians must sign and agree to their child care center’s policies, as well as provide permission for the center's activities. If you would like more detailed information on our center’s formal policies please reach out to an administrator.

Child’s Name: _____ Child’s Birthday: ____/____/____

Parent/Guardian Name: _____

Walking Field Trips

I give permission for my child to participate in walking field trips on the campus of the JCC. Trips include the following places: Any room in the Jewish Community Center including the JCC pool, JCC Fitness Center, Akiva Academy, JCC walking trail, and JCC playgrounds.

I Agree Parent Signature _____

Communication/Photo Media Permission

I give permission for my child to be photographed or videotaped for purposes of media coverage, postings within the JCC, use in JCC marketing materials, on the JCC website or JCC Facebook page, This permission includes any programs or special events my child participates in while attending the JCC.

Yes, I give permission

No, I do not give Permission Parent Signature _____

Water Play & Swimming

In the event that we are able to provide swimming programs in the JCC pool, written permission is required for all water activities. For children under 3 years of age water activities include sensory play and sprinklers. Permission for swimming at the JCC pool is only valid for children over 3 years of age. For children to be considered a swimmer they must be able to swim in the deep end of the pool (11 feet in depth) without the help of a flotation device. I hereby grant permission for my child to participate in the aforementioned water activities and swimming activities as described.

Swimmer (can swim in 11 feet of water without flotation device)

Non-Swimmer (can NOT swim in 11 feet of water without flotation device)

I Agree Parent Signature _____



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Authorized Pick up List:

* Please note anyone listed in the health information sheet is automatically authorized to pick up. These are any additional people that may need to pick up your child.

First Name	Last Name	Phone Number	Relationship to Child



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Supplies to bring once enrolled:

Infants:

- Diapers
- Wipes
- Extra Clothes
- Formula
- Breast Milk (must be marked with date pumped)
- Any Diaper creams (with form #01217)

Toddlers:

- Diapers/Pull ups
- Wipes
- Extra Clothes
- LUNCH
- Any Diaper creams (with form #01217)

Preschool:

- Lunch
- Extra Clothes
- Cot Sheet, and blanket for nap

School Age:

- Lunch
- Cot Sheet, and blanket (for overnight)
- Electronics are permitted at your own discretion



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Additional Paperwork

- If you have a child under 18 months please complete the additional form #01218
- If your child takes any medication, or if you plan to bring in diaper cream for your infant/toddler please continue to complete the additional form #0127
- If your child has a medical condition such as asthma or an allergy requiring an epi pen please complete form contact an ELC administrator and we will complete form #01236 with you

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? <i>(Check all that apply)</i>			
<input type="checkbox"/> Formula (include brand)		<input type="checkbox"/> Breast milk	
Formula preparation <i>(if center/provider is to prepare.)</i>			
Amount for each feeding		Frequency of feedings	
My infant likes a bottle warmed: <i>(Check one)</i> <input type="checkbox"/> Room temp <input type="checkbox"/> Warm <input type="checkbox"/> Very warm/NOT HOT			
Juice <i>(type, amount, when?)</i>			
Does child use a cup yet? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Solid foods <i>(baby food, brand, types, amounts, frequency)</i> <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 <i>(types, amounts, frequency, special instructions)</i>			
Security items <i>(pacifier, blankets, etc.)</i>			
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			

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

Box 1	The following section must always be completed by the parent/guardian.	
Check all that apply and complete all of the information.		
<input type="checkbox"/> Prescription Medication <input type="checkbox"/> Nonprescription Medication <input type="checkbox"/> Food Supplement <input type="checkbox"/> Topical Product or Lotion <input type="checkbox"/> Refrigeration Required <input type="checkbox"/> Modified Diet		
Name of Child		Date of Birth Weight
Name of Medication		Exact Dosage
To be administered at the following times		For the following period of time
<input type="checkbox"/> I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).		
Signature of Parent/Guardian		Date
Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.	
1. The medication contains codeine or aspirin. 2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions). 3. It is a sample medication without a prescription label. 4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period. 5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.		
Name of child		Name of medication, vitamin, diet, supplement
Dosage		Possible side effects to watch for are
Expiration date (May not exceed twelve months from the date of this request for medications of food supplements).		
Instructions		
This child is under my care and should receive the above medication as written.		
Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant		
Date of signature		Phone number
Name of child		Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

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
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