

Ohio Department of Job and Family Services
CHILD ENROLLMENT AND HEALTH INFORMATION
FOR TYPE B FAMILY CHILD CARE AND IN-HOME AIDES

Child's Name			Date of Birth		Date form completed/updated		First Day in Care	
Home Address				City		Names of additional children in the family in care		
State	Zip Code	Home Telephone Number						
Parent/Guardian Name					Relationship to child			
Home Address								
City				State		Zip		
Home Telephone Number				Cell Phone				
Employer/School/Training				Work/School/Training Telephone Number				
Address						City		
Pager and directions for use								
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				
Employer/School/Training				Work/School/Training Telephone Number				
Address						City		
Pager and directions for use								
Where can you be reached while your child is in this program?								
Emergency Contacts: List the names of <u>two local persons</u> who you want to be contacted in the event of an emergency or illness if the parent/guardian cannot be reached. Persons listed should be able to assist in locating the parent/ guardian and at least one person listed must be able to take responsibility for the child in cases where the parent/ guardian can not be located. Parents cannot be listed as emergency contacts.								
Name				Name				
City		State		City		State		
Telephone Number		Relationship to Child		Telephone Number		Relationship to Child		
Other numbers where emergency contact can be reached (optional)				Other numbers where emergency contact can be reached (optional)				
Name of Child's Physician or Clinic/Hospital				Name of Child's Dentist or Clinic				
Street Address				Street Address				
City		State	Telephone Number		City		State	Telephone Number

Note: This is a prescribed form provided by JFS which must be used by Type B homes and in-home aides to meet the requirements of chapter 5101:2-14. This form must be completed and on file at the Type B home or with the in-home aide on or before the child's first day of attendance.

Child's Name

Complete Box 1 OR Box 2. Do NOT complete both

Box 1. Give Permission to Transport	OR	Box 2. Do Not Give Permission to Transport
I give (Type B Home name, in home aide or their emergency caregiver) _____ permission to have my child (name) _____ _____ transported to (hospital/clinic) _____ _____ for emergency medical care or to (dentist) _____ _____ for emergency dental care, or to the nearest available source of assistance.	Do <u>not</u> sign both	I do not give (Type B Home name, in home aide or their emergency caregiver) _____ my permission to have my child _____ _____ transported for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish for the following action to be taken _____ _____ _____

Caretaker/Parent Signature	Date
----------------------------	------

Allergies (food, medication or environmental) and precautions, reactions and treatment *	Check here if not applicable
	<input type="checkbox"/>
Medications, food supplements, modified diet currently being administered	<input type="checkbox"/>
Chronic Physical Problems	<input type="checkbox"/>
History of Hospitalization	<input type="checkbox"/>
History of diseases the child has had	<input type="checkbox"/>
Any additional health or enrollment information you feel I should know about your child	<input type="checkbox"/>

* Any health condition that may require the provider to take action or medical procedure that may need to be completed while the child is in care, must be documented on a JFS 01928 "Medical/Health Care Plan".

Immunizations (enter month, day, and year)	(Not required for children enrolled in school)				
Vaccine	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)					
Other					

Note: This is a prescribed form provided by JFS which must be used by Type B homes and in-home aides to meet the requirements of chapter 5101:2-14. This form must be completed and on file at the Type B home or with the in-home aide on or before the child's first day of attendance.

Distribution for in-home aides: Original to county agency; copy to in-home aide, copy to parent/caretaker.
Distribution for Type B Homes: Original to provider, copy to county, copy to parent/caretaker.