MOM'S DAY OUT 2021-2022 REGISTRATION
For Alumni and New Families

Welcome to the Mom's Day Out Program, a ministry of Dublin Baptist Church.

We are looking forward to another great year as we begin registration for the 2021-2022 school year. Attached is your registration form and below is a list of helpful information.

The Mom's Day Out program accommodates children 18 months through Kindergarten age. To qualify for the 2021-2022 school year, your child's birthdate must be before March 1, 2020. We can enroll children who are eligible for Kindergarten but are not attending or who will be attending Kindergarten in the afternoon.

Your child does not need to be potty trained to attend our program.

Please keep in mind that **we are not licensed to administer any medication** (such as, but not limited to, Epi-Pens, Benadryl, inhalers) to any child, including those with allergies.

We offer a **one, two,** or **three-day** program. For our one-day program you may register for Tuesdays, Thursdays, or Fridays. For our two-day program you may choose any two of these days. Or you may choose all three days.

We will have guaranteed openings for all returning children and eligible siblings if their 2021-2022 registration forms are turned in by Friday, April 23rd. Registration forms will be collected from alumni, and those families new to the program, beginning Monday, March 1st. All alumni and new family registrations will be added in the order received, as space allows.

You will need a **separate** registration form for **each** child you plan to enroll. All completed forms must be accompanied by **one** check covering the one-time supply fee. The supply fee is $50 (1 day), $75 (2 days), and $100 (3 days) for each child. Your **non-refundable** check, made payable to DBC (Dublin Baptist Church), should be stapled to the registration form(s) and turned in where indicated.

Below is a chart indicating monthly tuition. Monthly tuition is due the first day each month your child attends MDO, beginning September 2020. We take cash or check, but not credit cards.

	One child	Two children
One day	$130	$260
Two days	$230	$360
Three days	$330	$460

A physician clearance form is also attached. This does **not** need to be turned in at the time of registration but will need to be filled out **before** the beginning of school in September. Additional copies of this medical form are available at www.dublinbaptist.com under "Ministries", then "Children", then scroll down to find "Mom's Day Out".

Please double check your child's **birth year** and the **day(s) of the week you have chosen** to make sure both are accurate on the registration form.

All alumni and new families will be notified by mail of their standing no later than May 31st. If you register and are notified that we no longer have spots available, you will be placed on a waiting list and your check will be returned.

The Mom's Day Out e-mail address is: mdo@dublinbaptist.com if you have any questions.

Thank you,

Patty Giammarco
MDO Administrator
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www.dublinbaptist.com
mdo@dublinbaptist.com

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DAY CHOICE

Please circle day(s) your child will attend:

TUESDAY THURSDAY FRIDAY

Enrollment for the 2021-2022 Program is for children born before MARCH 1, 2020.

SPECIAL REQUESTS:

CHILD'S NAME:

NICKNAME:

BIRTHDATE:

FAMILY E-MAIL ADDRESS:
(this will be used for weekly emails)

_____

CHURCH ATTENDING:

_____

ENROLLMENT FEES ARE DUE WITH REGISTRATION FORMS, PLEASE MAKE CHECKS PAYABLE TO **DBC**

	1 Child	2 Children
1 DAY	$50	$100
2 DAYS	$75	$150
3 DAYS	$100	$200

REMEMBER

ALL MONIES PAID ARE NON-REFUNDABLE
See attached letter regarding monthly tuition rates

For us to process your registration application we will need COMPLETED REGISTRATION FORMS and your ENROLLMENT FEE.

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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

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.

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.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ 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

Optional

Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		