East Dayton Christian School
Preschool & Daycare

999 Spinning Road
937-253-7485
www.eastdaytonchristian.org

HOURS:
6:30 AM - 5:30 PM

Coordinator: Mrs. Ronalee Koverman

East Dayton Christian School
Preschool and Daycare
999 Spinning Road,
Dayton, Ohio 45431
(937)-253-7485

Application for Enrollment of Child

Child's Name _____

Date of Child's Birth ____/_____/_____ Age_____

Parent's Name _____

Place of Occupation _____

Home Address _____

City_____State_____Zip Code _____

Telephone Numbers: Home _____

Mom's Work_____

Dad's Work_____

Mom's Cell Phone _____

Dad's Cell Phone _____

Email Adress_____

Date of Insurance Coverage_____

Permission Given for Pictures to be taken Yes_____ No ____

Signature of Mother _____

Signature of Father _____

I agree to have my name and telephone number included on my child's class roster which will be made available upon request to any parent whose child is enrolled in my child's class.

Child's Name _____ Date of Admission_____/_____/_____

Address _____Date of Birth _____/_____/_____

Yes _____ No _____ Signature _____

Date _____/_____/_____

Recommended by Whom _____

Date of Withdrawal _____/_____/_____

Ohio Department of Children and Youth

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

Child's Name	Date of Birth	First Day at Program

Address			

City	State	Zip Code

Parent #1 Name	Parent #1 Phone Number		
Parent #1 Address ☐Same as Child's	City	State	Zip Code
Parent #1 Email Address (if applicable)	Parent #1 Cell Phone (if applicable)		
Parent #1 Work/School Name (if applicable)	Parent #1 Work/School Phone Number (if applicable)		

Check here if Not Applicable ☐	Parent #2 Name	Parent #2 Phone Number		
Parent #2 Address ☐Same as Child's		City	State	Zip Code
Parent #2 Email Address (if applicable)		Parent #2 Cell Phone (if applicable)		
Parent #2 Work/School Name (if applicable)		Parent #2 Work/School Phone Number (if applicable)		

Primary Emergency Contact #1 Name (cannot be parent/guardian)	Check here if Not Applicable ☐	Optional Emergency Contact #2 Name (cannot be parent/guardian)
Primary Emergency Contact #1 Phone Number	Optional Emergency Contact #2 Phone Number	
Primary Emergency Contact #1 Other number or email address for emergency contact *(if applicable)*	Optional Emergency Contact #2 Other number or email address for emergency contact *(if applicable)*	
My child may be released to this emergency contact ☐ Yes ☐ No	Optional My child may be released to this emergency contact ☐ Yes ☐ No	

Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication?

☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

Child's Name	Date of Birth

Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes
☐ No

Name of service provider(s) and frequency

☐ N/A

Emergency Transportation Authorization

☐ **The program 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.

☐ **The program 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:

SIGNATURE

This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.

Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures

By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures (parent handbook).

Parent Signature	Date

Program Acknowledgement of Completion

By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.

Program 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
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review