



VALLEY CHRISTIAN EARLY LEARNING CENTER

2024-2025 Enrollment Form

Center Hours are 6am-5:30pm Monday through Friday

Child's Name _____
Preferred Name _____
Parent/Guardian _____
Phone Number _____
Email _____

Birth Date _____
Address _____
City _____ State _____
Zip Code _____
School District _____

Authorized Pick-Up (Names and Numbers) _____

Any Physical/Emotional/Medical Accommodations _____

PROGRAM FEES/SCHEDULES

Transitional Kindergarten

This is for students 5 years old not attending Kindergarten and is a required 5 half day program.

Monday-Friday 9am-1:30pm

Students must arrive no later than 9am

\$39 Full Day/\$29 Half Day

PLEASE NOTE:

Unless previous arrangements have been made with your child's teacher or the administrator, all students must arrive by 9:30 as to not disrupt the classroom daily schedules.

Thank you for your understanding!

Childcare Program

Infants (6 weeks-18 months): \$52 Full Day/\$38 Half Day

Toddlers (18 months-3 years): \$42 Full Day/\$30 Half Day

Preschool (3-5 years): \$39 Full Day/\$29 Half Day

School Age (5-12 years): \$36 Full Day/\$26 Half Day

School Age (Before/After Care): \$7.00 per hour

Half Day = up to 4 hours 59 min/Full Day = 5+ hours

**A NON-REFUNDABLE REGISTRATION/ACTIVITY FEE IS DUE AT TIME OF REGISTRATION
\$75 for Infant- Transitional Kindergarten/\$15 for School Age**

Please note if you are ODJFS or Private Pay _____

Valley Christian Early Learning Center Locations:

Austintown Campus (Highway Tabernacle) 3000 S. Raccoon Rd. Austintown 44505 (330) 727-1120

Canfield Campus (Old North) 7105 Herbert Rd, Canfield 44406 (330) 727-4742



VALLEY CHRISTIAN
SCHOOLS

VALLEY CHRISTIAN EARLY LEARNING CENTER

CHILD CARE SCHEDULE

Please note the hours that you will need care below.

Monday	Tuesday	Wednesday	Thursday	Friday

Does your schedule change frequently? Yes No

If Yes please explain:



VALLEY CHRISTIAN
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VALLEY CHRISTIAN EARLY LEARNING CENTER MEDIA CONSENT

Please read through this form
and fill out accordingly.

NAME OF GUARDIAN:

- ☐ Yes, I give Valley Christian Early Learning Center permission to publish in print, electronic, or video format the likeness or image of myself and/ or my child for VCS promotional materials, news media and the VCS/ VCELC website (including our facebook page and instagram. I release all claims against VCS and any project's sponsor with respect to copyright ownership and publication including any claim for compensation related to use of the materials.

NAME OF CHILD:

- ☐ Please do not publish my child's photograph on any online platform VCS or otherwise.
- ☐ I do not give permission for my child's photograph to be used in ANY school publication (print or electronic), news media usage or internet websites. I do not give permission for the news media to photograph and/or interview my child.

CONTACT DETAILS

PARENT/GUARDIAN

MOBILE

E-MAIL

ADDRESS

Signature of parent/guardian

Date

Ohio Department of Job and Family Services
ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information	
Routine Trip Destination(s) Walking through the church, to the Highway House, gym and outside.	
Date of Permission <i>(valid for one year)</i> 8/28/2024	
Mode of Transportation <i>(walking, school bus, public transportation, parent vehicles, provider vehicle and driver)</i> Walking or riding in a buggy/stroller	
During this trip children will have access to water that is 18 inches or more in depth. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? (if yes, a swimming permission slip is required) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Child's Information	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 8 years and/or over 4' 9"	
Signature	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date 8/28/2024



VALLEY CHRISTIAN
SCHOOLS

VALLEY CHRISTIAN EARLY LEARNING CENTER FINANCIAL POLICY

NAME OF GUARDIAN:

NAME OF CHILD:

- Parents must turn in the schedule portion of the enrollment packet. If you are a varied schedule, the weeks schedule must be turned in by Friday of the preceding week.
- We staff based on enrollment and student schedule therefore, students must adhere to their schedule each week. Arrival or departure after your scheduled time will incur a \$10.00 fee. (example: Schedule is 6:30 am-3:30 pm but arrives as 8:30 am or departs at 4:00 am. This would incur a fee. **If there is an emergency change necessary we need 24 hours notice to make sure we have accommodations and staff present.**
- Child care tuition is due the by the Friday before the week of attendance. Remember tuition is based upon enrollment rather than attendance. Tuition is due regardless of attendance unless absence is excused.
- **Payment methods accepted are:** Credit/Debit card on-line or check. Please be advised that check payments may take longer to process.
- **ODJFS subsidized students:** Any failure to TAP your child's attendance which results in a lapse in ODJFS childcare payments, will result in a charge to the parents account for the unpaid days. This would need to paid in order for the student to return.
- A discount of 10% will be offered for two of more children enrolled in the program. The discount will be applied to the oldest child enrolled.
- **Registration/Activity Fee:** An annual non-refundable registration fee for each child will be due and payable upon enrollment. Registration fees are as follows:

6 weeks of age - Transitional Kindergarten: \$75.00
School Age \$15

Late Pick-Up Fee: A late pickup penalty of \$15 will be assessed for any student picked up after closing. The initial penalty fee is charged after the first minute past closing and every subsequent 15 minute increment thereafter. Therefore a student picked up 15 minutes after closing will be assessed a \$30 charge(\$15 for the initial late fee penalty and \$15 per 15 minute increment).

A \$30.00 fee will be charged to all accounts for a returned NSF check

Signature of parent/guardian

Date



VALLEY CHRISTIAN
SCHOOLS

**VALLEY CHRISTIAN EARLY
LEARNING CENTER
HANDBOOK STATEMENT**

Please read through this form
and fill out accordingly.

NAME OF GUARDIAN:

NAME OF CHILD:

I have received and read a copy of the 2024/2025 Valley Christian School Parent Handbook. I understand and agree to abide by the procedures the center has established. We also have received the financial policy and procedures.

Signature of parent/guardian

Date

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 #1			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City			State	Zip	
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information 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 #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information 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 <u>of at least one person</u> 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 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 Medical Foods

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 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/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 to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or 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 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

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 file.

☐ N/A - program does not provide meals or snacks to the child.

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.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

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 2 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 Valley Christian Early Learning Center			Program or Home Name Valley Christian Early Learning Center	
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, 5101:2-13-15, and 5101:2-14-04. 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.

Valley Christian Early Learning Center

MESSENGING APP

Valley Message System

Through the Kaymbu for Families app, you can receive information from the center, and share drop-off notes and documentation with your child's teachers. The Kaymbu for Families app is connected to our assessment and progress report as well. With Kaymbu, teachers record photos, videos, and anecdotes of classroom activities to document your child's progress and growth, and give you deeper insight into their learning experiences.

This messaging system is our primary means of communicating events, urgent messages and inclement closures to families.

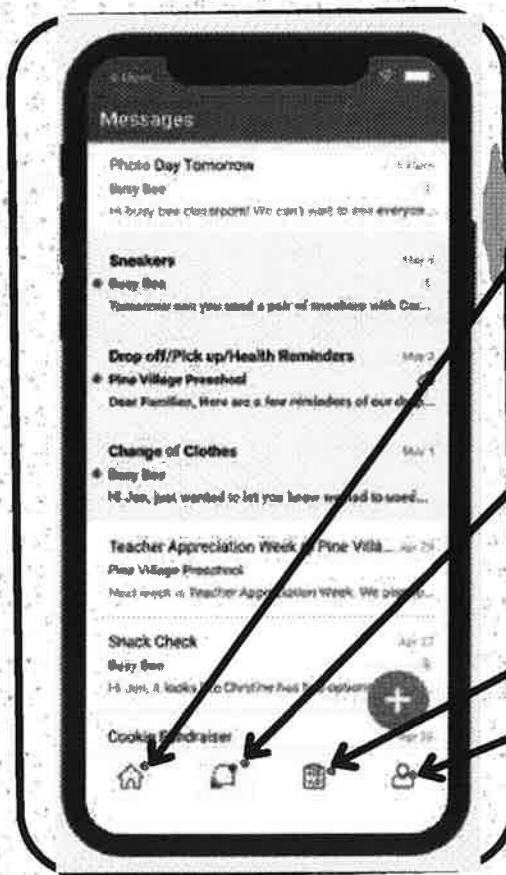
Registration



Download on the
App Store

GET IT ON
Google Play

- Download the Kaymbu for Families app from Google Play or App Store.
- Log in with phone number you provide at the bottom of this registration form.



How It Works

- **Home:** A feed of documentation your child's teachers have shared with you. It might be photos, videos, or anecdotes of classroom activities, newsletters, or learning portfolios. Click the green plus button to share a photo or video of your child's learning with your child's teachers.
- **Messaging:** An inbox of the Conversations and Announcements teachers and the Administrator have sent you. Please note that Announcements are read-only, but you can respond to an existing Conversation or start a new one by clicking the green plus button in the lower right.
- **Drop Off:** A log of your drop off notes. Click the green plus button to add a new note.
- **Profile:** A page to manage your contact information and notification preferences. This is where you can enable push notifications or text notifications. It is advised to have notifications enabled in the event there is a schoolwide notification.

Valley Christian Early Learning Center

MESSENGING APP

Registration Information

Please provide information for any individuals that should have access to your child's notifications and school announcements. Each person's app log in will be the number provided in this registration form.

First Name : _____

Last Name : _____

Relationship to Child: _____

Phone number: _____

SMS Notification: Yes No (circle one)

Is this person an emergency contact: Yes No (circle one)

First Name : _____

Last Name : _____

Relationship to Child: _____

Phone number: _____

SMS Notification: Yes No (circle one)

Is this person an emergency contact: Yes No (circle one)

First Name : _____

Last Name : _____

Relationship to Child: _____

Phone number: _____

SMS Notification: Yes No (circle one)

Is this person an emergency contact: Yes No (circle one)

First Name : _____

Last Name : _____

Relationship to Child: _____

Phone number: _____

SMS Notification: Yes No (circle one)

Is this person an emergency contact: Yes No (circle one)



VALLEY CHRISTIAN
SCHOOLS

Safe Foods Policy

Infants to Toddlers

- Cut food into ¼ inch cubes (about the size of a pea) for 1 Examples of food that need this preparation: hot dogs/sausage, apples/pears, celery, beans, cherry/grape tomatoes, grapes, cherries, strawberries and meat/chicken.
- No hard candy
- Spread peanut butter thinly
- No sticky or hard foods
 - Examples include: skittles/M&Ms, nuts, popcorn, seeds, dried fruit, gum/gum drops, gummy candy, chips, pretzels
- No marshmallows
- No bagels or crusty bread as it can become gummy when chewed

Preschool to Transitional Kindergarten

- Cut food into ½ inch pieces
- Cheese should be thinly sliced or ½ inch pieces
- Round foods should be cut in half lengthwise, i.e. hot dogs, grapes, tomatoes, strawberries
- Spread peanut butter thinly
- No hard candy or gum



711 Belmont Ave., Youngstown, OH 44502 * Phone (330) 793-2487 * Fax (330) 743-5748

Dear Parent/Guardian,

Alta Behavioral Healthcare offers a preventative service to your child in the classroom at **no cost**. We are excited to introduce our Early Childhood Mental Health services that encompass both individual and classroom consultations aimed at enhancing your child's well-being while fostering a positive learning environment. Our services are intended to increase the social and emotional skills for birth to six years of age. Helping children learn these essential skills prepares them for school readiness. The Early Childhood Consultants will support teachers and parents in developing and implementing strategies to improve children's resiliency and reduce challenging behaviors. Please review the information below and indicate your preferences by signing the appropriate section.

Early Childhood Consultation Services Parent/Legal Guardian Permission Form

If you are interested in having Early Childhood Consultation services provided to your child by the Alta Behavioral Healthcare staff, please sign this permission form in Section 1 below.

If you do not give permission for Early Childhood Consultation services to your child by the Alta Behavioral Healthcare staff, please sign the "Refusal" in Section 2 below.

Section 1. _____ **Yes**, I grant my permission for my child to participate in the Alta Behavioral Healthcare Early Childhood classroom and individual consultation service. I understand that these services include observation, assessments, and consultation with the teacher.

_____ Child's Name	_____ Date of Birth	_____ Name of Preschool
_____ Signature of Parent/Legal Guardian	_____ Printed name of Parent/Legal Guardian	_____ Date
_____ Phone number	_____ Email	

Section 2. (Refusal) _____ **No, I do not** give permission for my child to have Early Childhood Consultation services provided for my child by Alta Behavioral Healthcare staff.

_____ Child's Name	_____ Name of Preschool
_____ Signature of Parent/Legal Guardian	_____ Printed name of Parent/Legal Guardian

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)	Date of Birth
Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):	
Section A- EXAMINATION	
√ The above named child has been examined.	
√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).	
√ The above named child does not have allergies OR is allergic to the following (<i>please list in space below</i>):	
<i>Check below, if applicable:</i>	
<input type="checkbox"/> Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.	
Optional: Measurements and Recommended Assessments/Screenings Height _____ Vision _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Weight _____ Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No BMI _____ Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Notes: _____	
Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (Complete ONLY ONE SECTION below)	
Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases: Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.	
Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER: <input type="checkbox"/> The above named child has been immunized against the diseases listed above. <i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i>	Initials of Examining Health Care Practitioner Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): <input type="checkbox"/> I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	Signature of Parent Date