

Parents,

Here is your 2025-2026 LOLCP enrollment packet. Please fill out and return by August 1, 2025. **It is much easier to fill it out and return it NOW before the end of school, than have to make an extra trip during the summer.**

The medical form must be filled out by a doctor; you can hold onto it if your child has an appointment over the summer. These forms are good for 1 year (from their last exam) so if we have a current one on file, we can use it until it expires.

Start of School Dates 25-26

Asynchronous Parent Info Night-Thurs 8/21 (information will be sent via email)

End of Summer Playdate - Fri 8/22, 10am, (location TBD)

Meet the Teacher 4s - Mon 8/25, Lions 10-11am, Tigers 1-2pm

Meet the Teacher 3s & 5s - Tues 8/26, Bears, Penguins & Cheetahs 10-11am,
Zebras 1-2pm

First Day 4's Weds 8/27

First day 3's & 5's Thurs 8/28

Meet the Teacher - 2 1/2s Busy Bees Weds 9/3, 10-11am

First Day 2 1/2's - Weds 9/10

Note: Pay in full payments are due by August 1, 2025. Monthly payments will be taken out at the first of the month.

Let me know **if** you have further questions.

Thanks

Paula



Lord of Life Christian Preschool

6329 Tylersville Rd, West Chester OH 45069*513-779-3499*director@lolcp.com

LOLCP Families,

Here is your 2025/2026 Enrollment Paperwork. All forms must be printed, filled in, signed and returned by 8/1/25, including this checklist page. You may print these at home or hard copies are available at school. Forms may be mailed in or dropped off - our last day of school is May 15. There is also a lock box outside the front (church) doors.

Enrollment Checklist

_____ **Child Enrollment Form**

- Note: you will receive an updated handbook at Parent Information Night so please sign in the appropriate box that you have received a parent handbook
- If you checked yes in any of the boxes (health issues) there is an additional form (JFS forms #1236) that need to be filled out, please see the director.

_____ **Child Medical Statement**

- If you have a current, up to date medical form on file, we can continue to use it for the 2025-2026 school year. Forms are good for 12 months so if you schedule your child's physical around their birthday, you can submit an updated form at that time. This form MUST be signed by the doctor.

_____ **Child Release Form**

_____ **Photo Release/ Information Release Form**

_____ **Financial Form**

Student's name _____

Email: _____

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 cannot be listed 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 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 _____ 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			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, 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.

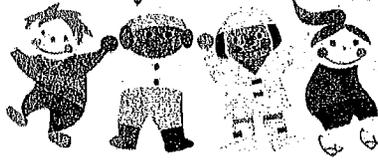
Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

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
Weight _____	Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
BMI _____	Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____
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:	Initials of Examining Health Care Practitioner
<input type="checkbox"/> The above named child has been immunized against the diseases listed above.	Date
<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>	
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):	Signature of Parent
<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):	Date

LORD OF LIFE CHRISTIAN PRESCHOOL



Child's Name: _____

Photo Release

By registering your student, you acknowledge that Lord of Life Christian Preschool may take pictures and/or video of your child which may be used within the building or in publicity materials - including but not limited to the website and Facebook page. **Your child will not be identified by name.**

I AGREE to give consent for my child's photograph to be published. ()

I REFUSE to give consent for my child's photograph to be published. ()

Information Release

By registering your student, you give consent for your child's name, parents' name and email address to be given to his/her classmates.

I AGREE to give permission for my information to published. ()

I REFUSE to give permission for my information to be published. ()

Parent's signature _____ Date _____

2025-2026 LOLCP Financial Agreement Form

Your May tuition is paid at the time of enrollment. There are two options for payment of the remaining eight months (September-April). Please choose **ONE** payment option and **ONE** payment method below. If this agreement pertains to the younger sibling of an enrolled child, please check here to have the 10% Sibling Discount rates applied. _____

Step 1: Select payment option

Option #1: Pay-in-Full

(5% discount if payment is received by August 1, 2024)

I understand that:

- My payment must be received by August 1st to be eligible for the 5% discounted price.
- Payment by check made payable to "LOLCP" is recommended to avoid processing fees.

Oldest Child Rates:

Class Age	Paid by Aug. 1	After Aug. 1
2 1/2 year old	\$684	\$720
3 year old	\$1,254	\$1,320
3 + Enrichment	\$1,900	\$2,000
4 year old	\$1,558	\$1,640
5 year old	\$1,900	\$2,000

Sibling Discount Rates:

Class Age	Paid by Aug. 1	After Aug. 1
2 1/2 year old	\$615.60	\$648.00
3 year old	\$1,128.60	\$1,188
3 + Enrichment	\$1,710.00	\$1,800.00
4 year old	\$1,402.20	\$1,476.00
5 year old	\$1,710.00	\$1,800.00

Option #2: Monthly Pay

(September – April)

I understand that:

- Payments must be received by the 1st of the month. Payments received after the 5th of the month will incur a \$20 late fee.
- My child will be withdrawn from school if payment is not made by the end of the month.

Oldest Child Rates:

Class Age	Monthly
2 1/2 year old	\$90
3 year old	\$165
3 + Enrichment	\$250
4 year old	\$205
5 year old	\$250

Sibling Discount Rates:

Class Age	Monthly
2 1/2 year old	\$81.00
3 year old	\$148.50
3 + Enrichment	\$225.00
4 year old	\$184.50
5 year old	\$225.00

Step 2: Select payment method

Payment Method (choose one): Check (Payable to "LOLCP") Credit Card (3.5% fee) ACH (1%fee)

By signing below, I acknowledge that I have read and understand the conditions detailed above. I acknowledge that there will be no refunds for the days my child is absent, and that tuition for May is non-refundable should I withdraw my child before the end of the year.

If I choose to pay by Credit Card or ACH, I understand that I will receive an emailed invoice and can choose to save my payment information to be used for remaining/future invoices.

Student's Name: _____ Parent's Name: _____

Parent Signature: _____ Date: _____

Email address to be used for invoicing: _____

