FAIRFIELD CHRISTIAN ACADEMY CHILD'S NAME _____

Fairfield Christian Academy Childcare & Preschool To Do Checklist

Thank you for your interest in Fairfield Christian Academy's childcare and preschool services. To complete the enrollment process, please finish each item on the checklist below.

- ☐ $65 Application Fee (Check made payable to FCA)
- ☐ Complete & Sign Family & Additional Information
- ☐ Complete Emergency Medical Release (Form A)
- ☐ Complete Transportation Permission Sheet (Form B)
- ☐ Complete FACTS Agreement (Form C)
- ☐ Enroll in FACTS Online at https://online.factsmgt.com/signin/3CNP5
- ☐ Sign Liability Release/Acknowledgment of Policies (Form D)
- ☐ Child Medical Statement (Must be Signed & Dated by Your Child's Physician)
- ☐ Acquire a Copy of Immunization Records from Your Child's Physician

FAIRFIELD CHRISTIAN ACADEMY

CHILD'S NAME _____

Family Information

Father/Guardian Name: _____ **Spouse's Name:** _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( )_____-_____ Cell Phone: ( ) _____-_____ Work Phone: ( )_____-_____

E-mail: _____ Best phone number you can be reached at during this program? Cell or Work

Job Title: _____ Employer: _____

Mother/Guardian Name: _____ **Spouse's Name:** _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( )_____-_____ Cell Phone: ( ) _____-_____ Work Phone: ( )_____-_____

E-mail: _____ Best phone number you can be reached at during this program? Cell or Work

Job Title: _____ Employer: _____

Student(s) resides with:

☐ Father/Mother (*same residence*) ☐ Father (*separate residence*) ☐ Mother (*separate residence*)

☐ Other: _____ _____
(Name – *Please Print*) (Relationship to Student)

Is either parent (or other) forbidden by court order from having equal access to the child or the school records? ☐ Yes ☐ No ***(If "Yes," copies of custody papers must be submitted with this application.)***

Additional Information

Please indicate if this is a new application or a renewal application for your child.

◯ New Application ◯ Renewal Application

Please explain your child's previous schooling or child care experiences.

_____

_____

Does your child have any siblings that are currently enrolled at FCA?

◯ Yes ◯ No

If yes, please provide their names.

_____

Has your child ever been diagnosed with a speech or hearing disability?

◯ Yes ◯ No

Is your child potty trained? (All students are required to be fully potty trained to attend preschool.)

◯ Yes ◯ No ◯ N/A for age of my child

FAIRFIELD CHRISTIAN ACADEMY

CHILD'S NAME _____

List any chronic physical problems and history of hospitalization.

_____

List any diseases that your child has had.

_____

Does your child wear glasses?

◯ Yes ◯ No

Do you attend church?

◯ Yes ◯ No

If yes, where?

_____

Has your child ever been dismissed or asked to leave a school or child care facility?

◯ Yes ◯ No

If yes, please explain.

_____

Has your child ever been tested for behavioral, emotional or psychological conditions or any other conditions that require specialized care?

◯ Yes ◯ No

If yes, please explain.

_____

Do you feel there are any characteristics relating to the health or personality of your child that may be helpful to your child's teacher?

◯ Yes ◯ No

If yes, please explain.

_____

Race/Ethnic Class

Please select the appropriate Race/Ethnic class for your child (The IRS and Ohio Reporting requirements request this information)

- ◯ Do not wish to provide this information
- ◯ Black
- ◯ Hispanic
- ◯ American Indian
- ◯ Multi-racial
- ◯ White
- ◯ Asian

Parent/Guardian Signature_____ **Date**_____

FAIRFIELD CHRISTIAN ACADEMY

CHILD'S NAME _____ **A**

Childcare

Student Name	***Gender M or F***	***Date of Birth***	***Main Phone*** *(Is this Mother or Father)*
Address	***City***	***State***	***Zip***

Section 3313.712 of the Ohio Revised Code requires the following: Purpose – To **ENABLE** parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when the parents or guardians cannot be reached.
Part 1 or Part 2 MUST BE COMPLETED.

Part 1 (To Grant Consent)

In the event reasonable attempts to contact me or the other parent/guardian listed below at the numbers provided have been unsuccessful, ***I HEREBY GIVE MY CONSENT*** for **(1)** the administration of any treatment deemed necessary by the preferred physician or preferred dentist listed below, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and, **(2)** the transfer of the child: Outside of Fairfield County to the nearest emergency facility, or in Fairfield County, to Fairfield Medical Center. If the situation necessitates transport to another facility, those arrangements would be made through Fairfield Medical Center or the facility outside of Fairfield County to which the child has been transported. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. ***Please complete answers below to which the physician should be alerted:***

ALLERGIES	**Yes**	**No**	**Please explain "yes" answers**
Environmental			
Food			
Insects (bees)			
Medication			

IS HE/SHE ON MEDICATION (prescription and over-the-counter medication the child takes on a regular basis)?

Medications (Name and Strength)	Dose/Frequency	Days Taken	Home	School

MEDICAL CONDITIONS:
☐ Yes ☐ No If yes, please explain: _____

	1st Parent/Guardian to be Contacted	**2nd Contact** ***(If no 2nd Parent/Guardian, List Alternative Contact)***	**Preferred Physician**	**Preferred Dentist (Required info, even for infants)**
Name				
Relationship			Physician	Dentist
Home Phone				
Cell Phone				
Work Phone				

A Parent/Guardian PRINTED Name ***A Parent/Guardian SIGNATURE*** ***Date***

Part 2 (Refusal To Consent) *DO NOT COMPLETE Part 2 IF YOU HAVE COMPLETED Part 1*

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to ***TAKE NO ACTION OR TO***:

_____

_____

A Parent/Guardian PRINTED Name ***A Parent/Guardian SIGNATURE*** ***Date***

FAIRFIELD CHRISTIAN ACADEMY

CHILD'S NAME _____ **B**

TRANSPORTATION PERMISSION

Student Name _____

I give **ONLY** the following people permission to pick up my child from child care. Please list all possible persons at this time. Please be sure to **include yourself, spouse, and those whom you have listed as emergency contacts**. The office must receive additional requests in writing prior to the day that a new person will be picking up your child.

Name	Phone Number	Relationship to Child

Please check the anticipated days needed and times of Drop off and Pick up throughout the week.

	Drop off Time	Pick up Time
Mon	_____	_____
Tue	_____	_____
Wed	_____	_____
Thurs	_____	_____
Fri	_____	_____

PHOTO RELEASE

☐ I give permission for my child _____to be included in videotaping and photos to be used by Fairfield Christian Academy.

☐ I ***do not*** give my permission for my child _____ to be included in videotaping and photos to be used by Fairfield Christian Academy for the following reasons:

PERMISSION TO PARTICIPATE IN WATER PLAY

☐ I give permission for my child to participate in water play at Fairfield Christian Academy. Water depth will not exceed two feet.

☐ I ***do not*** give my permission for my child to participate in water play.

ANNUAL CLASS ROSTER

☐ I authorize my child's name, my name, and phone number to be listed on the parent roster.

☐ I **do not** wish for our names or phone number to be included on the parent roster.

Parent/Guardian Signature_____ **Date**_____

FAIRFIELD CHRISTIAN ACADEMY

CHILD'S NAME _____ **C**

CHILDCARE FACTS AGREEMENT

In signing the Statement of Agreement, I/We agree to the following:

1. **Tuition and Fees Financial Policy:** Tuition and fees will be charged according to the Schedule of Tuition and Fees adopted by the school for the applicable year. By signing this contract, I agree to abide by the policies relating to the payment of such tuition and fees.
2. **The person(s) responsible for payment of tuition and fees**:

   Name: _____ Phone: _____

   Email Address: _____

   Billing Address: _____

3. **For the next year I will pay my child's tuition through FACTS:**

   ❑ Monthly Payments: **TWELVE** monthly payments through FACTS only (NO cash or check payment options).Parents who use the automated process of tuition payments may elect to pay tuition on the 5th or 20th of each month through the FACTS Payment plan. The FACTS annual enrollment fee is $45.

I/we understand that for any student withdrawals, two weeks' notice is required with two-week tuition payments. Any subsequent changes in my payment option after enrollment will result in a $20 administrative charge. I/we further understand that checks returned from the bank for insufficient funds, will necessitate a $25 returned check fee along with being put on the FACTS payment plan or paid with cash through the office. I/We realize that failure to meet this financial agreement will result in student withdrawal.

For any additional financial questions please send Emails to pmccarty@fcaknights.us.

In signing this Statement of Agreement, I/we agree that I am/we are responsible for payment of all tuition and fees for the child covered by this agreement.

_____ _____ _____

Parent/Guardian PRINTED Name **Signature** **Date**

_____ _____ _____

Parent/Guardian PRINTED Name **Signature** **Date**

FAIRFIELD CHRISTIAN ACADEMY

CHILD'S NAME _____ **D**

Liability Release

BOTH PARENTS/GUARDIANS MUST SIGN UNLESS ONLY ONE HAS ALL CUSTODY RIGHTS

This Release of Liability is executed in consideration for allowing the above-named child to enroll in Fairfield Christian Academy and to participate in activities related to the school. **This Release of Liability must be signed by BOTH parents/guardians** unless only one parent/guardian has all custody rights**.**

We/I, on behalf of our/my child do hereby release and forever discharge and agree to hold harmless Fairfield Christian Academy, Fairfield Christian Church, and the School Administration, Staff and Volunteers, from any and all loss, liability, claims, or demands of any nature, including but not limited to negligence, which may be incurred by the undersigned, and the child while he/she is enrolled at Fairfield Christian Academy.

Furthermore, we/I and on behalf of our/my child assume all risks of personal injury, sickness, death, damage, and expenses as a result or participation in recreation, study, and school-related activities in which the designated child is involved.

We/I, the undersigned, further hereby agree to hold harmless and indemnify Fairfield Christian Academy, Fairfield Christian Church, and its School Administration, Staff and Volunteers, for any liability sustained by Fairfield Christian Academy, Fairfield Christian Church as a result of the negligent, willful, or intentional acts of the named child, including any related expenses

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Acknowledgement of Policies

I reviewed a copy of the Fairfield Christian Academy Child Care parent handbook on Fairfield Christian Academy's website and I was provided with clear and accurate information regarding all policies and guidelines of Fairfield Christian Academy Child Care. I understand the policies and guideline by which the center operates.

I agree to abide by all policies stated in the parent handbook. I understand that I will be notified of any changes made to these policies.

I also understand that any breach of the center's policies may be grounds for termination from the program. A two-week notice will be provided in such a circumstance unless the infraction is severe enough to warrant termination without notice.
I further understand that failure to be prompt and accurate with payment will be grounds for termination.

Parent/Guardian Signature _____ Date _____

Email Address _____

FAIRFIELD CHRISTIAN ACADEMY

Early Education

Child Medical Statement

*This form, including your **child's current immunization record**, must be completed and signed by your child's physician and returned to:*

Fairfield Christian Academy, Attention: Childcare Preschool Department
1965 North Columbus Street, Lancaster, Ohio 43130
Fax Number (740) 654-7689 Telephone (740) 740-652-9023

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT
Child Care Centers and Type A Homes

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

This is to certify that I have examined this child and their health records and found that:

1) This child has had the immunizations required by section 3313.671 of the Revised Code for admission to school, or has had the immunizations recommended by the state department of health according to the child's age, or is to be exempted from these requirements for medical reasons. Please note exemptions: _____.

Immunizations(*) (enter month, day, and year)

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)					

*The immunizations above are recommended immunizations. Please consult your child's physician for more information.

2) Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care.

3) List any limitations or health conditions (including allergies, daily medications, dietary restrictions) _____
_____.

Recommended Assessments/Screenings:

Vision: Yes ☐ No ☐ Date: _____ Hearing: Yes ☐ No ☐ Date: _____
Dental: Yes ☐ No ☐ Date: _____ Lead: Yes ☐ No ☐ Date: _____
BMI: Yes ☐ No ☐ Date: _____ Other: _____

Signature of examining Physician/Certified Nurse Practitioner/Physician's Assistant	Date of Examination / /

Ohio Administrative Code rules 5101:2-12-37 and 5101-2-13-37 require that this examination be given no more than twelve months prior to the date of admission to the child care facility.

Name of Physician/Certified Nurse Practitioner/Physician's Assistant	Telephone Number ( )
Street Address	
City, State, and Zip Code	Fax Number ( )

Updated 9/1/2017