Church of the Lakes
Child Care Center
FAMILY REGISTRATION PACKET

We appreciate and feel privileged that your family has chosen Church Of The Lakes Child Care Center for your child's care. Registration can be confusing, so we have put together a packet to help you through the process. Please complete all the forms attached and return them as soon as you can to secure your child's spot for the coming year. I cannot stress enough that registration is a busy time and class space fills quickly so do not delay. Please ask any questions that you have, we are here to help.

All children registering are subject to a $50.00 registration fee for one child or $100.00 registration fee for a family registration (2 or more children) which must accompany all completed forms contained within this packet at the time of you registering your child.

The following paperwork must be completed for this registration. Your registration cannot be completed or your spot secured until all forms are completed and returned to the center.

Please return the following to reserve your spot(s):

- **Student Registration Form**
- **Child Medical Statement for Child Care JFS01305* (Before 1st Day of School)**
- **Child Enrollment and Health Information for Child Care JFS 01234 (4 pages)**
- **Student Pick-Up Authorization Form**
- **Financial Agreement**
- **Custody Orders (We cannot refuse access to a parent without legal documentation)**
- **Registration fee (Cash or Check written to COTL)**

***The JFS 01305 form must be completed by your child's examining physician. The form must be signed and dated by them along with a copy of your child's immunization record attached to it before the first day of school.** If your child has been diagnosed with asthma, a food or environmental allergy, food sensitivity or a medical condition that would require our staff to monitor them for symptoms/reactions and to take action if they display symptoms/reactions? If so, you will need to complete a separate **Child Medical/Physical Care Plan JFS01236 form** for each diagnosis. If your child requires a modified diet that eliminates fluids (milk of any kind) or an entire food group (ie. Nuts, etc) it is also required. Please see the Child Care office and we will be happy to supply you with the correct form.

Thank you for choosing our family to care for your children, we are looking forward to a great year.

Sincerely,

Lisa Wright, Director

Church of the Lakes
Child Care Center

Tuition Rates
2025-2026

Child Care	**Ages** 2.5 - 4yrs	**Times** 6:30 AM - 5:30 PM	**Weekly Charges** 2 Day $130 3 Days $165 5 Days $230
Pre-School	**Ages** 2.5 - 4yrs	**Times** 9:00 AM - 12:00 PM	**Monthly Charges** 2 Days $225 3 Days $240 5 Days $320
Play Group	**Ages** 2.5 - 4yrs	**Times** 12:00 PM - 3:00 PM	**Daily Charge** $25
Transitional Kindergarten	**Ages** 5 yrs	**Times** 9:00 AM - 12:00 PM (by Aug.1)	**Monthly Charges** $320
Registration Fee (Child Care/Preschool)	1 Child Family	$50 Nonrefundable $100 Nonrefundable	
School Age	**Grades K-5** Before School After School	**Times** 6:30 AM -Bus Pick Up Bus Drop Off - 5:30 PM	**Daily Charges** $10 $15
Registration Fee (School Ager)	1 Child Family	$25 Nonrefundable $50 Nonrefundable	
Late Pick Up:	$10 per 15 minutes		

Chuch of the Lakes Child Care Center

Student Registration

2025-2026

5944 Fulton Drive, NW
Canton, OH 44718
330.499.0500
www.cotlchildcare.com
info@cotlchildcare.com

Preschool: 9:00AM-12:00PM
Childcare: 6:30AM-5:30PM
Before Care 6:30AM - Bus
After Care: Bus - 5:30PM

Student's Information

Name: (Last) _____ (First) _____

Nickname: _____ Date of Birth: ___/___/___ ☐ M ☐ F

Address: _____ City & Zip: _____

Known Food Allergies: _____

Dietary Restrictions: _____

Medical/Health Conditions: _____

Does your child have an IEP or does your child receive services:? YES NO
Please explain: _____

Has your child attended preschool before: YES NO

If so, When/Where: _____

Siblings ages and names: _____

_____

Parent's Information

Parent Name: _____ Cell: _____

Email: _____

Employer/Position: _____

Parent Name: _____ Cell: _____

Email: _____

Employer/Position: _____

Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

Child lives with: ☐ Mother ☐ Father ☐ Other: _____

Emergency Name/Contact: Who to call if your child is ill?

_____ Cell: _____

_____ Cell: _____

PROGRAMS

Please select program and circle days

2.5 - 3 Year Childcare - Weekly $230
2 Days $130 / 3 Days $165
Mon / Tue / Wed / Thur / Fri

2.5 - 3 Year Preschool - Monthly $320
2 Days $225 / 3 Days $240
Mon / Tue / Wed / Thur / Fri

3 Year Childcare - Weekly $230
2 Days $130 / 3 Days $165
Mon. / Tue / Wed / Thur / Fri

3 Year Preschool - Monthly $320
2 Days $225 / 3 Days $240
Mon / Tue / Wed / Thur / Fri

4 Year Childcare - Weekly $230
2 Days $130 / 3 Days $165
Mon / Tue / Wed / Thur / Fri

4 Year Preschool - Monthly $320
2 Days $225 / 3 Days $240
Mon / Tue / Wed / Thur / Fri

PreK (5yo) Childcare - Weekly $230
Must be 5 by Aug 1, 2025
One year of preschool expereience
5 Days $230

PreK (5yo) Preschool - Monthly $320
Must be 5 by Aug 1, 2025
One year of preschool experience
5 Days $320

Before Care - Daily $10
Mon / Tue / Wed. / Thur / Fri
School: _____
Grade: _____

After Care - Daily $15
Mon / Tue / Wed / Thur / Fri
School: _____
Grade: _____

I hereby accept all responsibility for, and assume the risk of any injury or damage to my person or dependent children, which might arise directly or indirectly as a result, and or participation in Church of the Lakes Child Care program. I hereby expressly release, discharge, and hold harmless from any liability whatsoever Church of the Lakes Child Care Center, expressly including, but not limited to, its owner and employees, except for injuries caused intentionally, or by willful misconduct. I certify that I am familiar with the contents of this release, that I have read and understand the same, and that it is my intention by signing this release that the same be binding not only on me, but my heirs, administrators, executors, successors, and assigns. Church of the Lakes Child Care center is not responsible for misplaced, lost or stolen items.

_____
Parent/Guardian Signature Date

Office Use Only:
Date Rec'd: _____ Check No. _____

Church of the Lakes
Child Care Center

2025-2026 Financial Policies
Tuition Agreement

1. **Forms of Payment:** Cash, Personal Check, Credit Cards, Auto are acceptable forms of payment.
2. **Due Dates:** Childcare Fees are a weekly payment due the first day of the current week, each week. Preschool and Transitional Kindergarten fees are a monthly payment due by the 10th of the current month. Playgroup fees are due at the time of the service or can be included in your Autopay transactions.
3. **Overdue Payment Charges:** All payments not made within the above mentioned due dates are subject to a late fee charge of $10 per week until the outstanding balance is paid in full.
4. **NSF Check Charges:** A **recovery fee of $35.00** will be assessed for any check that is returned due to Non Sufficient Funds.
5. **Registration Fee** each child/family will be assessed a $50 fee for 1 child or a $100 fee for 2 or more children. The registration fee is due at the time of registration and is nonrefundable.
6. **Credits:** Fees will not be waived or refunded for any reason. Credits for center closure will be extended to Child Care students only. No adjustments of fees will be extended to monthly tuition. No credits will be extended for illness or vacation.
7. **Center Closures:** The list that follows are the only dates the **Center** is **closed** unless otherwise noted. **Labor Day** (Monday), **Columbus Day** (Monday), **Thanksgiving** (Wednesday, Thursday & Friday), **Christmas Break** (same as Jackson Local Schools), **MLK Day** (Monday), **President's Day** (Monday), **Good Friday, Spring Break** (Follow Jackson Local Schools).
8. **Late Pickup/Early Drop-Off Fees:** A fee of $10.00 per hour will be charged for preschool children dropped off more than 15 minutes prior to their scheduled class start time and to children picked up later than their classes scheduled ending time. A fee of $10.00 per 15 minutes will be charged for each child picked-up after 5:30PM.

Your Monthly Preschool tuition rate of $ _____ due prior to the 10th of the current month.
(Payments not made prior to the 10th of the current month will be charged a $10 fee each week until paid in full)
(1 month of unpaid tuition may result in the expulsion of your child until the balance is paid in full.)

Your Weekly Child Care tuition rate of $_____ due the beginning of every week.
(Payments not made by the last day each week will be charged a $10 fee each week until paid in full)
(2 weeks of unpaid tuition may result in the expulsion of your child until the balance is paid in full.)

Preschool/Child Care registration fee of $ _____ must be paid prior to acceptance of enrollment paperwork. $50.00 (1 CHILD) $100.00 (FAMILY) (All registration fees are non-refundable)

Your Weekly Before/After Care tuition rate of $_____ due the beginning of every week.
(Payments not made by the last day each week will be charged a $10 fee each week until paid in full)
(2 weeks of unpaid tuition may result in the expulsion of your child until the balance is paid in full.)

Before/After Care registration fee of $ _____ must be paid prior to acceptance of enrollment paperwork. $25.00 (1 CHILD) $50.00 (FAMILY) (All registration fees are non-refundable)

The parent/guardian agrees to be responsible for the tuition payment of the agreed upon, scheduled days for the school year. Fees will not be waived or refunded for school days missed due to family vacations, illness, or for any other reason.By signing this enrollment/tuition agreement I understand and I will abide by the above mentioned conditions.

Parent / Guardian Signature _____ Date_____

Parent / Guardian Name (Print) _____

Church of the Lakes
Child Care Center

STUDENT PICK-UP AUTHORIZATION

The people listed below are 18 years of age or older and are authorized to pick up my child(ren) from Church of the Lakes Child Care Center.

Child's Name: _____

Time of pick-up: _____ (Approx)

Mother's Name_____ Cell #_____

Father's Name_____ Cell #_____

Adult's Name_____ Relationship_____ Cell #_____

Adult's Name_____ Relationship_____ Cell #_____

Adult's Name_____ Relationship_____ Cell #_____

PLEASE NOTE:

Anyone coming to pick up your child(ren) who is not on this list will <u>not</u> be allowed to leave with your child(ren). At the time of pick-up, the designated pick up person will be asked to present a state issued picture identification or driver's license. This is to ensure the safety of your child(ren). Parent signature below acknowledges acceptance of this policy.

Parent/Guardian Signature_____ Date:_____

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	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 (*please list in space below*):

Check below, if applicable:

☐ 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 _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ 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: ☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	**Initials of Examining Health Care Practitioner**
	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ 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

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 ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information 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 #2	Relationship to Child	
Home Address ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information 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 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

over

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

over →

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 *Permission* to Transport		**OR**	~~***Do Not Give Permission* to Transport~~	
Program or Home Name Chruch of the Lakes Childcare Center		**Do not sign both**	~~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)*
on website

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

NO

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.