

STUDENT INFORMATION

Please answer the following questions. If you are registering more than one child, please indicate which child the answer pertains to.

1. What school will your child be attending in the Fall of 2026? _____

2. Does your child have an IEP? _____

3. Does your child have behavioral issues or concerns? _____

4. Is there any other information you feel we should know about your child(ren)?

STUDENT RELEASE AUTHORIZATION

Only the following adults are authorized to pick up _____ from the Easterseals Summer Camp program.

1. _____
2. _____
3. _____
4. _____

Do **NOT** allow the following individuals to pick up this child:

1. _____
2. _____
3. _____
4. _____

Parent/Guardian Signature: _____

Date: _____

GENERAL PUBLICITY RELEASE

I understand and agree that any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of myself made by Easterseals or its respective employees and agents may be used by Easterseals, and those acting with its permission, for illustration, broadcast, or testimonial shared with the general public in connection with the work of Easterseals, I assign to Easterseals all of my rights to these materials.

I understand that these materials made by Easterseals, its employees and agents are owned by Easterseals and that they may copyright them. I further consent to allow Easterseals, their respective employees and agents, and those acting with Easterseals' permission, to use my child's protected health information, as defined under 45 C.F.R. 164.501, for the purpose of illustration, broadcast, or testimonial in connection with any work of Easterseals and to release this information to the general public.

I understand that these materials maybe published on Easterseals' social network of Web sites and this may disclose mine or my child's personal and protected health information online. Easterseals does not need to submit these materials to me for further approval. I understand that these materials may be modified and that Easterseals may decide not to use them.

I acknowledge that the rights described above are granted to Easterseals on an unlimited basis without any compensation or payment being made for any current or future use. I understand that this authorization is voluntary and that Easterseals will not condition any treatment or funding to myself on the completion of this authorization. I also understand that I may revoke my consent to allow Easterseals to release my child's protected health information if the information has not already been disclosed. To revoke my consent, I must notify Easterseals Central and Southeast Ohio in writing.

I understand and agree that once Easterseals, its respective employees and agents, and those acting with its permission, disclose my child's protected health information, the Health Insurance Portability and Accountability Act of 1996 may no longer protect this information. This release and authorization expires 10 years from the date of my signature below.

___ I certify that I am over the age of 18 years old. If not, how old are you_____.

___ AGREE I have read this release and authorization before signing below, and I fully understand and agree to its contents.

___ DO NOT AGREE I have read this release and authorization before signing below, and I fully understand and do not agree to its contents.

I am the parent or legal guardian of _____, a child under the age of 18 years old.

General Publicity Release must be completed for each individual whose photo will be used.

General Publicity Release for: _____

(name of individual)

Signature Date

Printed Name (parent/guardian)

Address City, State, Zip Code Home Phone Number

E-Mail Address

BEHAVIORCONTRACT

2026 Summer Camp

The Easterseals Youth Out-of-School Time Programming is an amazing **free** resource for families and participants to increase and encourage Physical Wellness (Physical Fitness and Nutrition), SEL (Social-Emotional Learning), and STEM (Science, Technology, Engineering, and Math) development. As such, participants are required to participate in activities within these subject areas. Upon enrollment, it is assumed that your child will want to actively participate in activities and will follow directions as requested by staff.

Acts of physical and verbal aggression will not be tolerated by participants or parents/guardians, including but not limited to, hitting, kicking, pushing, throwing things, spitting, yelling, cursing, name calling, bullying, threatening, etc. A participant or parent/guardian displaying any of these acts towards staff or other participants can result in immediate dismissal from programming.

Please note that it is also at the discretion of the School Age Programs Manager to withdraw a participant if it is determined that we cannot ensure the safety of the participant and those around them.

_____ I have read and understood the expectations above.

_____ I have discussed the expectations and rules as described above with my child(ren).

Name(s) of Participant(s): _____

Parent/Guardian Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

EastersealsCentral and Southeast Ohio, Inc.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You may be assured that Easter Seals has always had policies in place to protect the confidentiality of you and your medical information. This notice is a requirement of the government for your information and protection.

OUR DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

Individually identifiable information about your past, present or future health or conditions, the provision of health care to you, or payment for health care is considered "Protected Health Information" (PHI). We are required to extend certain protections to your PHI, and to give you this notice about our privacy practices that explains how, when and why we may disclose your PHI. Except in specific circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

We are required to follow the privacy practices described in the Notice, though we reserve the right to change our privacy practices and the terms of this notice at any time.

YOUR RIGHTS WITH RESPECT TO YOUR PHI

1. You have the right to see and obtain copies of your PHI.
2. You have the right to a listing of those organizations, agencies or individuals to whom disclosures have been made (unless it is a disclosure that does not require your written consent.)
3. You have the right to request (in writing) an amendment to your file using our amendment process.
4. You have the right to request that we contact you at an alternate site (other than home) or by alternate means (other than phone, mail or fax).
5. You have the right to request a restriction on our uses and disclosures of PHI (but we are not required to agree to your request).
6. You have the right to receive a copy of this notice.
7. Use of your PHI for marketing and publicity purposes can only be done with your authorization.
8. You have the right to communicate electronically with Easter Seals personnel. Doing so, however, may put your transmitted information at risk of unauthorized disclosure. We advise that you avoid or minimize the amount of protected health information that you transmit electronically.

HOW WE MAY USE AND DISCLOSE YOUR PHI

1. We may disclose information for treatment, payment and health care operations.
2. We may disclose to the consumer or personal representative.
3. We may disclose to others with proper authorization from consumer or personal representative.
4. We may disclose to Business Associates if a signed written contract exists that protects the PHI.
5. We may refuse to share information if we believe there is danger to the patient if the information is released.

***Other Uses: For more detailed information about other uses and disclosures allowed by law, please contact our privacy officer.**

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think we have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file as follows:

First contact our Privacy Officer:

Easter Seals Central and Southeast Ohio, Inc.

ATTN: Privacy Officer

3830 Trueman Court

Hilliard, Ohio 43026

PH: 614-228-5523

Then you may contact the U.S. Office of Civil Rights

U.S. Office of Civil Rights

Regional Manager

Department of Health and Human Services

233 N. Michigan Avenue, Suite 240

Chicago, Ill 60601

PH: 312-866-1807

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Easterseals CentralandSoutheastOhio,Inc.

Consumer Name: _____

I received the notice of privacy practices, which explains how Easterseals may use or disclose my protected health information, and what my rights are regarding my medical records.

Communication with Easterseals personnel via email is unsecured, and by choosing to communicate in this manner, any transmitted information may be at risk of unauthorized disclosure. I understand that I may choose to communicate electronically with Easterseals personnel, and doing so is at my own risk.

Easterseals values my comments and concerns. If I have any questions, I will call 614-228-5523 to speak with the privacy officer.

Signature: _____ Date: _____

(Consumer/Personal Representative)

(Relationship to Consumer)

Ohio Department of Job and Family Services
**CHILDENROLLMENT AND HEALTHINFORMATION
 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	<u>Do Not Give 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.

2023-2024 OST/Youth Enrichment – TANF Registration Form

Subrecipient: Easterseals Central & Southeast Ohio, Inc. 3830 Trueman Ct. Hilliard, OH 43026	Site Location: Finland Elementary School 1835 Finland Ave. Columbus, OH 43223
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A. IDENTIFYING INFORMATION

	List/Identifying Information for Each Youth Participating in the Program (list the information listed on the left for each program participant)			
	Participant 1	Participant 2	Participant 3	
Participant Information				
Legal Name (first & last)				
Gender (male or female)				
Social Security Number (all nine digits)				
Date of Birth (month/date/year)				
Relationship to Parent/ Legal Guardian (i.e. son, niece, foster child &, etc.)				
Grade				
School Attending				
Race				
Ethnicity - check one	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Country of Origin				
Resident Status -check one	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Lawful Resident Alien	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Lawful Resident Alien	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Lawful Resident Alien	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Lawful Resident Alien

List Identifying/Demographic Information for Parent/Legal Guardian (list below)

<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian	Last Name		First Name	Middle Initial
Social Security Number		Street Address			
City	Zip Code	State	County		
Phone Numbers (Area code & Number)		Race:		Resident Status- check one	
Home:				<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Lawful Resident Alien (attach verification)	
Cell:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		<input type="checkbox"/> Other- Parent/Legal Guardian Applying for a Minor Citizen	
Work:		Country of Origin:			

B. BENEFIT INFORMATION

Check the FCDJFS (qualifying TANF) Benefits the Family Receives- check all that apply
 (check the box(d) for any listed TANF qualifying benefits the family has received in the last 30 days.
 If the family does not receive one of the listed benefits select the N/A box)

Ohio Works-First-Cash Assistance Supplemental Nutrition Assistance Program- Food Assistance
 N/A (the family does not receive a TANF qualifying FCDJFS Benefit)

C. INCOME INFORMATION

Check the Appropriate Income Boxes for the Family- check all that apply
 (list the amount of household income for each section: gross earned, unearned & total for the last 30 days)

Income Category	Type of Earned/Unearned Income		Amount of Household Income for the Last 30 Days (gross earned income, unearned income & total household income)
<input type="checkbox"/> Earned Household Income	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	Earned Income (gross amount) \$
	<input type="checkbox"/> Wages/Tips	<input type="checkbox"/> Self-Employed	
<input type="checkbox"/> Unearned Household Income	<input type="checkbox"/> SSI	<input type="checkbox"/> Child Support	Unearned Income \$
	<input type="checkbox"/> SSDI	<input type="checkbox"/> Retirement	
	<input type="checkbox"/> Unemployment Compensation		
	<input type="checkbox"/> Zero Income Statement		
<input type="checkbox"/> Other (explain):			
Total Amount of Household Income (Gross Earned & Unearned) for the Last 30 Days:			Total Income (earned & unearned) \$

D. HOUSEHOLD MEMBERS

List the Household Member's Name and Relationship to the Applicant

-Complete the chart below for the members of your household; you must include immediate family members (self, spouse/father of minor child, and minor children)

-You may also include others living in the household

-If you are the non-custodial parent to a child residing in Ohio who is younger than 18 years of age or 18 years of age if still in high school, include him/her in the table

Name	Relation to Applicant	Date of Birth MM/DD/YY	Name	Relation to Applicant	Date of Birth MM/DD/YY
1	Self		6		
2			7		
3			8		
4			9		
5			10		

E. INELIGIBLE HOUSEHOLD MEMBERS

Ineligible Household Members

Yes No

1. Is there a household member in debt to Franklin County Department of Job and Family Services for an OWF overpayment due to fraud?
2. Is there a household member who is not a resident of Franklin County?
3. Is there a household member who is not a citizen or lawful resident alien?
4. Is there a household member who is a fugitive felon or probation/parole violator?
5. Is there a household member who has failed to cooperate in establishing paternity or securing child support?
6. Is there a household member who has been found to have fraudulently misrepresented his/her residence to obtain benefits in more than one state in the past 10 years?
7. Is there a household member who is an unmarried parent under age 18, not living in a supervised living arrangement?
8. Is there a household member who is an unmarried, non-high school graduate parent under the age of 19 who is not attending high school or the equivalent?

If you answered yes list the number of the question(s) and the name of the person below:

9.

F. APPLICANT SIGNATURE

1. I certify I am the parent or legal guardian of a minor child and the information provided on this application is complete and correct to the best of my knowledge.
2. I understand that the information on this form will be used to determine eligibility for a TANF Funded program.
3. I understand that receiving these services will not prevent me from receiving other PRC assistance offered by Franklin County.

Signature of Parent/Guardian

Date

G. TANF ELIGIBLE HOUSEHOLD SIZE

Household Size	
Number of Household Members (listed in the household member chart in section D)	
Number of Ineligible Household Members	
(number of people listed in Section E. question #9, these individuals will not be counted in total household size)	
TotalHouseholdSize	—
income must be included to qualify for TANF	

(number of household members, minus ineligible household members)

H. PARTICIPANT STATUS

Check the Box Representing How Eligibility was Determined - Check All that Apply (boxes 2 & 3 should not both be marked)
 If the person identified as ineligible is the applicant, he/she is not eligible for services

- * Household member(s) listed as ineligible and are not the applicant, cannot be counted in household size; however, their
- 1. **Eligibility Based on Qualifying FCDJFS Benefits**
 - This individual(s) receives or is a member of a family that receives FCDJFS benefits and has a minor child
 - Qualifying FCDJFS benefits include-- **Ohio Works First (cash payments) and SNAP(food assistance)**
 - Child care assistance or medical assistance cannot be used to determine TANF eligibility** because of income requirements

2. **Program Eligible Based on Income at or below 200% of the FPG (Federal Poverty Guidelines)**

- Eligibility determination is based upon household income and family has a minor child
- Household income includes gross earned (income from employment) & unearned income (i.e. child support, SSDI, SSI, retirement, zero income statement &, etc.)

2024 Income Guidelines Reference Table

200%	1	2	3	4	5	6	7	8	9	10
FPG	\$N/A	\$3407	\$4303	\$5200	\$6097	\$6993	\$7890	\$8787	\$9683	\$10580

3. **Program Eligible Based on Income at or below 300% of the FPG**

- Eligibility determination is based upon household income and family has a minor child
- Household income includes gross earned (income from employment) & unearned income (i.e. child support, SSDI, SSI, retirement, zero income statement &, etc.)

2024 Income Guidelines Reference Table

300%	1	2	3	4	5	6	7	8	9	10
FPG	\$N/A	\$5110	\$6455	\$7800	\$9145	\$10490	\$11835	\$13180	\$14525	\$15870

Signature of Agency Representative	Title
	Date