

MOM'S DAY OUT 2026-2027 REGISTRATION

For Alumni and New Families

Welcome to the Mom's Day Out Program, a ministry of Dublin Baptist Church.

We are looking forward to another great year as we begin registration for the 2026-2027 school year. Attached is your registration form and below is a list of helpful information.

The Mom's Day Out program accommodates children 18 months through kindergarten age. To qualify for the 2026-2027 school year, your child's birthday must be before March 1, 2025. We can enroll children who are eligible for kindergarten but are not attending and who will be attending Kindergarten in the afternoon.

Your child does not need to be potty trained to attend our program.

Please keep in mind that **we are not licensed to administer any medication** (such as, but not limited to, Epi-Pens, Benadryl, inhalers, diaper cream, sunscreen) to any child, including those with allergies.

We offer a **one, two, or three-day** program. For our one-day program you may register for Tuesdays, Thursdays, or Fridays. For our two-day program you may choose any two of these days. Or you may choose all three days.

We will have guaranteed openings for all returning children and eligible siblings if their 2026-2027 registration forms are turned in by Thursday, April 30th. Registration forms will be available for alumni, and those families new to the program, beginning Monday, March 2nd. All alumni and new family registrations will be added in the order received, as space allows.

You will need a **separate** registration form for **each** child you plan to enroll. Please fill in each blank on the registration form. Once completed forms are in, an invitation to join Procure will be sent, and an invoice for a one-time registration fee will be generated. The registration fee remains \$50 (1 day), \$75 (2 days), and \$100 (3 days) for each child. Payment can be made online through Procure, payable by check to DBC (Dublin Baptist Church), or cash in an envelope clearly marked with your child's name.

Below is a chart indicating monthly tuition. Monthly tuition is due the first day each month your child attends MDO, beginning September 2026.

	<u>One child</u>	<u>Two children</u>
One day	\$145	\$275
Two days	\$255	\$405
Three days	\$365	\$525

A physician clearance form is attached at the back of the registration packet. This form does **not** need to be turned in at the time of registration but will need to be filled out **before** the beginning of school in September. Additional copies of this medical form are available at momsdayoutdbc.com.

Please double check your child's **birth year** and the **day(s) of the week you have chosen** to make sure both are accurate on the registration form.

All alumni and new families will be notified by e-mail of their standing no later than May 31st. If you register and are notified that we no longer have spots available, you will be placed on a waiting list, and your registration fee will be returned.

The Mom's Day Out e-mail address is: mdo@dublinbaptist.com if you have any questions.

Thank you,

Patty Giammarco
MDO Administrator

Dublin Baptist Church 7195 Coffman Rd. Dublin, Ohio 43017 (614) 718-0895
momsdayoutdbc.com



Mom's Day Out

A Ministry of Dublin Baptist Church
7195 Coffman Road Dublin, OH 43017
(614) 718-0895

email: mdo@dublinbaptist.com

CHILD'S FULL NAME:

First name teachers will use in classroom:

CHILD IS: currently enrolled sibling new student

BIRTHDATE (Must be before March 1, 2025):

CIRCLE THE DAY(S) YOUR CHILD WILL ATTEND:

Tuesday

Thursday

Friday

BEST EMAIL FOR DAILY PICTURES AND WEEKLY NEWSLETTERS:

ANYTHING WE SHOULD CONSIDER WHEN DECIDING CLASS PLACEMENT:

We must have a completed registration packet to proceed with the registration of your child.

New student medical statements may be turned in just before school starts.

Ohio Department of Children and Youth
**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		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 DCY 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 DCY 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 DCY 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 DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 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 1.5 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)

Found on momsdayoutdbc.com

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 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.

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.

Reset Form

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>):	
Check below, if applicable: <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: <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