Welcome

To

Great Day Child Care/Learning Center

14810 Madison Road
Middlefield, Ohio 44062
Phone: 440-632-1832
Greatday1@netlink.net

2471 Hubbard Road
Madison, Ohio 44057
Phone # 440-428-5993
Greatday3@netlink.net

4325 Manchester Road
Perry, Ohio 44081
Phone: 440-259-8125
Greatday4@netlink.net

Days and Hours of Operation:
Monday – Friday
6:00 am to 6:00 pm
5:30 am to 6:00 pm (Middlefield Only)

Registration: _____

Quote on Daycare Prices:

_____

_____

Center Parent Information

The center is licensed to operate legally by the Ohio Department of Job and Family Services (ODJFS). This license is posted in a noticeable place for review.

A toll-free telephone number is listed on the center's license and may be used to report a suspected violation of the licensing law or administrative rules. The licensing rules governing child care are available for review at the center.

The administrator and each employee of the center is required, under Section 2151.421 of the Ohio Revised Code, to report their suspicions of child abuse or child neglect to the local public children's services agency.

Any parent of a child enrolled in the center shall be permitted unlimited access to the center during all hours of operation for the purpose of contacting their children, evaluating the care provided by the center or evaluating the premises. Upon entering the premises, the parent, or guardian shall notify the Administrator of his/her presence.

The administrator's hours of availability to meet with parents and child/staff ratios are posted in a noticeable place in the center for review.

The licensing record, including licensing inspection reports, complaint investigation reports, and evaluation forms from the building and fire departments, is available for review upon written request from the ODJFS. Inspections are also online at http://childcaresearch.ohio.gov/. Parents may search for a specific program and sign up to be notified when the program's latest inspection is posted online.

It is unlawful for the center to discriminate in the enrollment of children upon the basis of race, color, religion, sex, national origin or disability in violation of the Americans with Disabilities Act of 1990, 104 Stat. 32, 42 U.S.C. 12101 et seq. To file a discrimination complaint, write or call Health and Human Services (HHS) or ODJFS. HHS and ODJFS are equal opportunity providers and employers.

Write or Call:
HHS
Region V, Office of Civil Rights
233 N. Michigan Ave, Ste. 240
Chicago, IL 60601
(312) 886-2359 (voice)
(312) 353-5693 (TDD)
(312) 886-1807 (fax)

Write or Call:
ODJFS
Bureau of Civil Rights
30 E. Broad St., 37th Floor
Columbus, OH 43215-3414
(614) 644-2703 (voice)
1-866-277-6353 (toll free)
(614) 752-6381 (fax)
1-866-221-6700 (TTY) or (614) 995-9961

For more information about child care licensing requirements as well as how to apply for child care assistance, Medicaid health screenings and early intervention services for your child, please visit http://jfs.ohio.gov/cdc/families.stm.

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

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 2 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 sign both	***Do Not Give Permission* to Transport**	
Program or Home Name Great Day Child Care			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.

Great Day Child Care Learning Center
2471 Hubbard Rd
Madison, Ohio 44057
440-428-5993
Greatday3@netlink.net

Permission of Photographs for Center use on Company Website, Local Newspapers and/or Social Media

Great Day Child Care has permission to take pictures of my child(ren) and use these pictures on the Company Website, Local Newspapers and/or Social Media. My child(ren)'s name will not be listed with any of the photographs.

Date- _____

Parent's Signature- _____

Child's Name-_____

Great Day Child Care Learning Center

Registration Form
Age: _____
Birth Date: _____

Classroom: _____
Registration Fee: _____
Date of Enrollment: _____

Child's Name: _____
(Last) (First) (Middle)

Home Address: _____
(Number) (Street) (City) (State) (Zip Code)

Father's Name: _____ Home Phone: _____
Home Address: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

Mother's Name: _____ Home Phone: _____
Home Address: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

List two people who may be contacted in an emergency, if the parent cannot be reached:

Name: _____ Relationship: _____
City/State: _____ Phone: _____
Authorized to pick-up and drop-off children: _____

Name: _____ Relationship: _____
City/State: _____ Phone: _____
Authorized to pick-up and drop-off children: _____

List people (other than parent) authorized to pick-up and drop-off child(ren) at the center:

Name: _____ Relationship: _____
Address: _____ Phone: _____

Name: _____ Relationship: _____
Address: _____ Phone: _____

Weekly Schedule (approximate Drop-off / Pick-up times)

	Monday	Tuesday	Wednesday	Thursday	Friday
Drop-Off Time					
Pick-Up Time					

Other Children in Family: (Name and Age)

_____
_____

Child's Interests: _____
Child's Dislikes or Fears:
_____

I received and reviewed the policies and procedures discussed in the parent handbook of Great Day Management Inc.
Parent/Guardian: _____ **Date:** _____

Great Day Child Care Learning Center- Tuition Agreement

1. **Tuition is based on the days children are scheduled to attend.** Tuition is based on the number of days your child is scheduled to attend. The center has to do a weekly schedule. This allows us to be able to serve as many families as we can. If your child is on the schedule and does not attend on a day they are scheduled to attend, **you will still be charged and expected to pay the balance in full once vacation/sick days have been used.** We ask that you give as much notice as possible if you know your child/children will not be attending on a scheduled day. (Middlefield: 440-632-1832; Email: greatday1@netlink.net; Madison: 440-428-5993; Email: greatday3@netlink.net; Perry: 440-259-8125; Email: greatday4@netlink.net

2. Tuition will be due either on or before the Friday prior to the care week/month or the Monday of the week of care. I understand tuition payments not paid in full by the Monday of care means I will lose my spot at the center & it will be given to someone else. Any accounts with an outstanding balance will be billed a late fee of $10.00 on Mondays.

3. Vacation days are allotted as follows 5 days a week = 10 days vacation, 4 days a week is 8 days vacation, 3 days is 6 days vacation, 2 days is 4 days vacation, 1 day scheduled is 2 days vacation. This is effective from January 2023 to December 2023. Any extra days will not carry over to the following year. You must let the office know ahead of time by turning in a vacation slip so we can plan accordingly. If a vacation slip is not turned in they will be charged to the account.

4. Center closes at 6:00 pm. If my child/children are not picked up by the center's closing time, a late pick-up fee of $1.00 per minute, per child will be added to your account.

5. Drop-In child care payments are due the day your child attends or you can pay a larger amount to have a credit on your account.

6. **The center requires a 1 week written notice for withdrawal. If notice is not given, you will be billed for 1 week.**

7. Failure to meet the center's payment policy will result in immediate termination of child care services.

8. The reinstatement will be the same as enrollment and requires a $50.00 **enrollment fee**.

9. Please be sure to check your account on the computer, ProCare app or in the office when checking in or out.

10. I understand that a NSF charge of $35.00 will be charged to may account if a check is returned to the center due to insufficient funds. A cash payment will then be required in full to cover the NSF check.

11. You are responsible for providing your child/children with a lunch that meets the Nutritional Guidelines by the State. If the center has to supplement any foods in your child/children's lunch you will be charged a fee of $10.00.

12. I have received a handbook and have read the above policies and payment regulations of Great Day Child Care Learning Center and agree to these policies.

I agree to pay $_____ per week/per day/per month on or before the Friday prior to the care week or the Monday of care week.

Parent or Guardian signature _____ Date: _____

Administrators Signature-_____ Date: _____

Madison – 440-428-5993
greatday3@netlink.net

I give my permission for Great Day Child Care to apply the below named topical product on my child.

Please circle the sunscreen that can be applied to your child. Once you bring the sunscreen in, we will write their name on it.

Equate
Banana Boat
Aveeno
Think baby
Blue Lizard
Kids Block Out
Coppertone
Studio Selections
Babyganics
Hello Bello
Neutrogena
All Good
Butter Me Up Organics
Young Living
Walgreens

_____

Child's Name: _____
Child's Date of Birth: _____
Parent's Signature: _____

Madison – 440-428-5993
greatday3@netlink.net

I give my permission for Great Day Child Care to apply the below named topical product on my child.

Please circle the diaper cream that can be applied to your child. Once you bring the diaper cream in, we will write their name on it.

A& D Ointment
Equate
Pinxav
Bordeaux Butt Paste
Neutragena
Aquaphor
Burt's Bees
Babyganics
Desitin
Cetaphil
Baby Mantra
Earth Mama
Triple Paste
Weleda
Baby Bum
Hello Bello
Vaseline
Baby Healing Ointment
Walgreens
Parent's Choice
Gentle Steps
Petroleum Jelly

_____

Child's Name: _____
Child's Date of Birth: _____
Parent's Signature: _____

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This form is to be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

Child's Name	Date of Birth *(if needed to determine the correct dosage)*	Weight *(if needed to determine the correct dosage)*

Box 1 The following section must always be completed by the parent/guardian.

Name of medication	Dosage	
Iodide Tablet	1 pill ☐ See attached	
To be administered at the following times As directed by the Lake County EMA	For the following period of time 12 Months	Medication expiration date 10/31/29

I understand:

1. *This form expires twelve months from the date of my signature, if box 2 has not been completed.*
2. *That my child must receive at least one dose of medication at home prior to the program administering the medication (unless the medication is used for emergencies).*

Signature of Parent/Guardian	Date

Box 2 The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant when any of the following apply:

1. The nonprescription medication contains codeine or aspirin;
2. A physician's instruction is needed for a nonprescription medication;
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication;
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen-day period;
5. The intended use differs from the manufacturer's instructions or use

Instructions

Open blister pack. Dispense pill into either child's hand or mouth. Offer a cup of water if needed. Instruct the child to swallow the pill.

☐ See Attached

Possible side effects to watch for are

None at this time.

☐ See Attached

The child is under my care and should receive the above medication as written. I understand this form expires twelve months from the date of my signature.

Signature of licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant	Date of Signature
Phone Number	

This form shall be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name	Name of Medication
	Iodide Tablet

Date	Time	Dosage	Signature of designated person administering medication

Great Day Child Care Learning Center

Permission to provide transportation in the event of a disaster

In consideration of **Great Day Child Care Learning Center** arranging transportation and administering Iodide tablets in the event of a directive from the Lake County Emergency Planning Commission and the Lake County Department of Health, I hereby for myself, my heirs, administrators and assigns, waive and release any and all rights and claims of any nature I may have against **Great Day Child Care Learning Center**, their representatives, successors and assigns for any and all injures or damages of any nature which my child may incur while taking part in an ordered evacuation. I further agree that I need to go directly to **Norte Dame-Cathedral Latin School, 1300 Auburn Road Munson Twp.**. Further, I understand that the Center is registered with the Lake County Emergency Management Agency.

_____
Name of child

_____
Name of parent or guardian

Signature of parent or guardian Date

It is extremely important that you keep your contact information up-to-date. Please notify the center of any changes in phone numbers. Families will be contacted as soon as is reasonably possible.

PLEASE COMPLETE THIS FORM AND RETURN TO THE CENTER

Great Day Child Care Learning Center

Permission to provide transportation in the event of a disaster

In consideration of **Great Day Child Care Learning Center** arranging transportation and administering Iodide tablets in the event of a directive from the Lake County Emergency Planning Commission and the Lake County Department of Health, I hereby for myself, my heirs, administrators and assigns, waive and release any and all rights and claims of any nature I may have against **Great Day Child Care Learning Center**, their representatives, successors and assigns for any and all injures or damages of any nature which my child may incur while taking part in an ordered evacuation. I further agree that I need to go directly to Edgewood High School, Ashtabula, Ohio. Further, I understand that the Center is registered with the Lake County Emergency Management Agency.

_____
Name of child

_____
Name of parent or guardian

Signature of parent or guardian Date

It is extremely important that you keep your contact information up-to-date. Please notify the center of any changes in phone numbers. Families will be contacted as soon as is reasonably possible.

PLEASE COMPLETE THIS FORM AND RETURN TO THE CENTER

Great Day Child Care & Learning Center
Pick-Up Authorization

As part of our ongoing effort to give your child the best care possible, we need to understand who is allowed to pick up your child from the Center.

Any individual that you have listed on the Emergency Authorization Form is automatically allowed to pick up/visit your child at any given point in time. The Center will need written permission for anyone else that you would like to pick up/visit your child.

In addition, please list below anyone who is **NEVER** allowed to pick up your child:

1.) Name_____

Relationship with Child _____

Parent Signature _____ Date_____

Child Name _____

Please remember that any individual that IS NOT listed on your Emergency Authorization Form will need a note to pick up your child.

Thank you for your help in our efforts to keep Great Day Child Care a safe place for your child and our Staff.

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

BASIC INFANT INFORMATION FOR CHILD CARE

This information should be completed by the parents prior to the child's first day. This information should be updated periodically as the infant's needs change.

Child's Name	Nickname
Child's Date of Birth	Siblings

What are you feeding your infant? *(Check all that apply)*

☐ Formula (include brand) ☐ Breast milk

Formula preparation *(if center/provider is to prepare.)*

Amount for each feeding	Frequency of feedings

My infant likes a bottle warmed: *(Check one)* ☐ Room temp ☐ Warm ☐ Very warm/NOT HOT

Juice *(type, amount, when?)*

Does child use a cup yet? ☐ No ☐ Yes

Solid foods *(baby food, brand, types, amounts, frequency)*
**you must have written permission from your child's physician if your child is under 4 months and given solid foods.*

Are foods served room temperature or warmed?

Table food *(types, amounts, frequency, special instructions)*

Security items *(pacifier, blankies, etc.)*

Nap schedule

Hints for getting baby to sleep

Sleeping Position ☐ Back ☐ Side* ☐ Tummy*
**You must secure a sleep position waiver from your child's physician if your baby is to sleep on their tummy or side. Please contact the center/provider for a JFS 01235.*

Special Precautions

Any additional information about your child that would be helpful or you would like staff to know.

Parent Signature	Date
Primary Caregiver Signature	Date

Date form last updated					

Automated Payment Processing

Procare SOLUTIONS

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

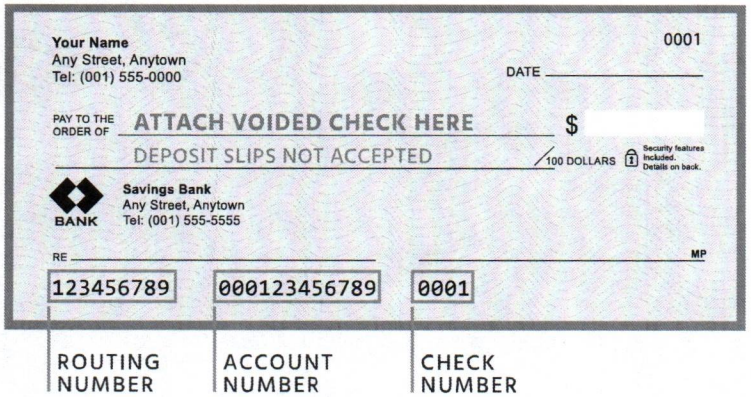
Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____



FOR OFFICIAL USE ONLY

Date Received

Employee Signature

800.338.3884 • procaresoftware.com

Great Day Childcare Learning Center
440-428-5993
greatday3@netlink.net

VACATION SLIP

Today's Date-_____

Child's Name-_____

Vacation Date(s)-

_____

_____

Parent's Signature-_____ Date-_____

Great Day Childcare Learning Center
440-428-5993
greatday3@netlink.net

VACATION SLIP

Today's Date-_____

Child's Name-_____

Vacation Date(s)-

_____

_____

Parent's Signature-_____ Date-_____