Camp Fee, Refund and Cancelation Policy

There will be an initial non-refundable $20 registration fee for each child. This fee will assist in any miscellaneous cost involved with administrative program development.

Cost of the camp is $75 per week for the first child and an additional $65 per week for each additional sibling beyond one; however, a one-time discounted rate of $500 for the first child and $450 for each additional sibling can be paid prior June 1st and increases to $525 per child up to one week prior to camp start

Parent/Guardian Initial _____

If a parent/guardian will be late picking up a student, program must be notified. A late fee of $1 per minute per child is assessed (after the first five minutes) for late pick-ups. The charge will be payable upon pick-up of the student. Continual tardiness may result in the child's dismissal from the program.

Parent/Guardian Initial _____

Cancelations must be received in writing by email via the centralohioplay.org website to include the complete address of requestor. In the event of camp cancelation due to situations beyond the control of PROBE other than COVID-19 related circumstances there will be no refunds.

Parent/Guardian Initial _____

No refunds will be made for requests received by any other form and incomplete requests will be considered at non-existent.

Parent/Guardian Initial _____

Refunds will be issued by check and mailed to the appropriate address of requestor. Please allow seven to ten business days for processing.

Parent/Guardian Initial _____

Photo and Video Release

I give permission for my child's picture and video's to be used in advertisements for PROBE.

Parent/Guardian Initial _____

I have read and fully understand the Important Information, Camp Program Acceptance, Release of Liability and Permission to Secure Treatment, Photography Release, along with Fee, Refund and Cancelation Policy.

_____

SIGNATURE OF OR PARENT / GUARDIAN PRINTED NAME

_____

DATE

Important Information

PROBE is committed to conducting its programs and activities in the safest manner possible and holds the safety of participants in the highest possible regard. Participants and parents registering their children in programs and activities must recognize, however, that there is an inherent risk of injury when choosing to participate in the PROBE Athletic, Academic & Adventure Camp to reduce such risks and insists that all participants follow safety rules and instructions which have been designed to protect the participant's safety.

Please recognize that PROBE does not carry medical accident insurance for injuries sustained in its programs and activities. The cost of such medical expense would make program fees prohibitive. Therefore, each person registering themselves or a family member for a program or activity should review their own health insurance policy for coverage. It must be noted that the absence of health insurance coverage does not make PROBE automatically responsible for the payment of medical expenses. Your cooperation is greatly appreciated.

Camp Program Acceptance

The PROBE Athletic, Academic & Adventure Camp is a program that requires the acceptance and approval of its Executive Director for youth to attend, therefore, an interview of potential camper and parent must be conducted prior to acceptance into the program.

PROBE does reserve the right to reject or refuse any potential camper based on values that could serve detrimental to the overall standards and goals of this program. Immediate removal of participants displaying such factors can also occur and shall be agreed not to bring any legal action by any outside entity as may be reported by a parent, guardian or any direct individual representing the camper and no refund of any previously paid fees will be granted.

Parent/Guardian Initial _____

Release of Liability & Permission to Secure Treatment

I recognize and acknowledge that there are certain risks of physical injury to participants in the above program(s) and I agree to assume the full risk of any injuries, damages or loss regardless of severity which I or my minor child/ward may sustain as a result of participating in any and all activities connected with or associated with such program(s).

I agree to waive and relinquish all claims I or my minor child/ward may have against PROBE and its officers, agents, volunteers, employees and any companies associated as a result of participation in the program.

I do hereby fully release and discharge PROBE and its officers, agents, volunteers and employees from any and all claims from injury, damage or loss with the activities of the program(s).

I further agree to indemnify and hold harmless and defend PROBE and its officers, agents, servants and employees from any and all claims resulting from injuries, damages, and losses sustained by me or my minor child arising out of, connected with, or in any way associated with the activities of the program(s).
In the event of any emergency, I authorize PROBE to secure from any licensed hospital, physician and/or medical personnel any treatment deemed necessary for me or my minor child/ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered.

Parent/Guardian Initial _____

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 _____ 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			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.

FCDJFS #1401-CC (9/11)

Child Care Center Change Request

Type of Change: □ Initial □ Redetermination □ Case Termination Change

Provider E-mail Address: centohiocif@yahoo.com

Case Name First Middle Last	Case Number	Requested Start Date of Care
Street Address	City	State	Zip Code
Provider Name PROBE	Provider Address 873 Walcutt Ave., Columbus, OH 43219	Provider Vendor Number/ State Id 2210024528

Household Composition	First Name	Last Name	Gender	Social Security Number	Date of Birth Month	Day	Year	Primary (P) or Multiple (M)	Full time(FT)/ Part time (Pt)
Male Adult									
Female Adult									
1st Child									
2nd Child									
3rd Child									
4th Child									
5th Child									
6th Child									
7th Child									
8th Child									

Instructions for change:

PLEASE READ BEFORE SIGNING: The undersigned child care provider hereby certifies that the information contained herein is true and accurate, and understands that it *(child care provider)* will be held responsible for any overpayment that occurs as a result of having provided inaccurate and/or misleading information. ***(To be signed by provider using ink)***

The undersigned parent/customer hereby acknowledges that a Child Care Center Change Request form must be signed in order to initiate services, to add children, and/or to change a schedule, and that the failure to sign may delay or prevent the processing of the change. By signing this form, I certify that the information contained herein is true and accurate, and understand that I will be held responsible for any overpayment that occurs as a result of having provided inaccurate and/or misleading information.

My signature below also serves as authorization for (***Provider Name***) PROBE to provide FCDJFS with information necessary to determine eligibility for publicly funded child care, and/or to monitor or evaluate the delivery of said care. Any information shared pursuant to this document shall remain confidential according to state and federal law. This authorization shall remain in effect, as needed, unless revoked by me in writing. ***(To be signed by parent/customer using ink***

Provider Signature X — Date

Provider Name **PRINTED** Bobby J. Walker — Telephone Number 614-322-9388

Parent/Customer Signature X — Date

Parent/Customer Name **PRINTED** — Telephone Number

***** Documentation of Change MUST be submitted with this form *****

Franklin County
Department of Job & Family Services