

# Bright Horizons Back-up Child Care Registration Materials

Dear Parent

Enclosed please find registration materials for Bright Horizons' back-up child care centers. The information requested in these forms is required by Bright Horizons Back-up Solutions and municipal and state child care licensing authorities to ensure that each child has a safe and successful day at the center. All shaded information is required for full registration and must be provided before your child visits the center. If you have any questions about the enclosed registration forms please call the Bright Horizons Back-up Child Care Toll-Free Registration Line at 866-273-2773.

There are three ways to register:

- Online at [www.brighthorizons.com/backup](http://www.brighthorizons.com/backup) (Select Register My Child)
- By phone at 866-273-2773 or by calling your center directly
- By fax/mail – complete the enclosed forms and fax or mail to your center

We look forward to serving your family!

You may submit your completed registration materials via fax mail or email. See below for your center's contact information.

## **Bright Horizons of Brecksville**

4949 West Snowville Road  
Brecksville, OH 44141

(440)740-0340 (phone)

(440)740-0343 (fax)

[nationalcity@brighthorizons.com](mailto:nationalcity@brighthorizons.com)

# Bright Horizons Back-up Child Care Registration Checklist



**Child Name:**

**Child Information Form**   
(one for each child to be registered)

**Participating Parent/Guardian Information Form**   
(one for each participating guardian in the family)

**Non-Participating Parent/Guardian Information Form**   
(one for each non-participating guardian in the family (if applicable))

**Authorization for Release and Emergency Medical Treatment**   
(one for each child to be registered)

**Authorized Non-Parent/Guardian Information Form**   
(one for each child to be registered)

**Medical and Insurance Information Form**   
(one for each child to be registered)

**Photograph of Child\***   
(see below for photograph requirements)

**Photograph of Parent(s)/Guardian(s)\***   
(see below for photograph requirements)

**Photograph(s) of Non-Parent/Guardian Authorized for Release\***   
(see below for photograph requirements)

**Ohio Child Medical Statement**   
(one for each child to be registered)

**Registration Agreement**   
(one for each child to be registered)

**Ohio Child Enrollment and Health Information Form**   
(one for each child to be registered)

**Ohio Health Care Plan**   
(one for each child to be registered)

\*Any photograph is acceptable (copy of drivers license or passport, family photo etc.) as long as the required parties are identified and the photograph is clear.

# Bright Horizons Back-up Child Care Child Registration Information



**Child Name:**  
\_\_\_\_\_

(last, first, middle initial)

**Child Date of Birth:**  
(     /     /     )

(mm/dd/yyyy)

**Child Nickname:**  
\_\_\_\_\_

**Child Gender:**  
Male                  Female

(please circle)

**Does your child have any allergies or food restrictions?**      yes    no    (please circle)

If yes, please describe: \_\_\_\_\_

**Does your child have any diagnosed special needs or medical conditions?**      yes    no    (please circle)

If yes, please describe: \_\_\_\_\_

**Are your child's activities restricted by any special needs, medical or other conditions?**      yes    no    (please circle)

If yes, please describe: \_\_\_\_\_

**Child Lives With:** \_\_\_\_\_

**Are there any custody arrangements for your child?**      yes    no    (please circle)

If yes, please describe: \_\_\_\_\_

(A court order with supporting documentation describing custody arrangements and restrictions must be provided.)

**Regular Care Arrangements:** \_\_\_\_\_

**Child's Primary Language:** \_\_\_\_\_

**School Attending:** \_\_\_\_\_

(for pre-school and school age children only)

**Sleeping Schedule:** \_\_\_\_\_

(for children under 36 months only)

**Toilet Schedule:** \_\_\_\_\_

(for children under 36 months only)

**Siblings:** \_\_\_\_\_

(Please list names and ages)

**Other Helpful Information:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

➔ shaded information is required for full registration and use of a Bright Horizons back-up child care center

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Bright Horizons Back-up Child Care Participating Parent/Guardian Information Form



A participating parent/guardian is a parent/guardian who has access to Bright Horizons back-up child care through his or her employer. If both parents are participating guardians please complete two Participating Parent/Guardian Information Forms.

## Parent/Guardian General Information

<b>Parent/Guardian Name:</b>

(last, first, middle initial)

<b>Employer (Company Name):</b>

<b>Work Email Address</b>

<b>Job Category:</b>
Administrative/Support      Mid-Level      Professional (please circle)

<b>Business Unit, Department or Subsidiary:</b>

<b>Relation to Child:</b>

<b>Gender</b>
<input type="checkbox"/> Male <input type="checkbox"/> Female

<b>Employee ID #:</b>

<b>Would you like an account to access your family's registration and reservation information online?</b>
<input type="checkbox"/> yes <input type="checkbox"/> no (please circle)

<b>Job Type:</b>
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time (please circle)

<b>Job Title:</b>

## Work Contact Information

<b>Work Address Line 1</b>

<b>Work Address Line 2</b>

<b>Work Address Line 3</b>

<b>Work Phone</b>
(    )      -

<b>Work Extension</b>

<b>Work Fax</b>
(    )      -

<b>Work City, State, Zip</b>

## Home Contact Information

<b>Home Address Line 1</b>

<b>Home Address Line 2</b>

<b>Home Address Line 3</b>

<b>Home Phone</b>
(    )      -

<b>Cell Phone</b>
(    )      -

<b>Home Email</b>

<b>Home City, State, Zip</b>

➔ shaded information is required for full registration and use of a Bright Horizons back-up child care program

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Bright Horizons Back-up Child Care Non-Participating Parent/Guardian Information Form



A non-participating parent or guardian is a parent or guardian who does not have access to Bright Horizons back-up child care through his or her employer.

## General Parent/Guardian Information

**Parent/Guardian Name:**

(last, first, middle initial)

**Relation to Child:**

**Employer (Company Name):**

**Work Email Address**

## Work Contact Information (Required if applicable)

**Work Address Line 1**

**Work Address Line 2**

**Work Address Line 3**

**Work Phone**  
( ) -

**Work Fax**  
( ) -

**Work Extension**

**Work City, State, Zip**

## Home Contact Information

**Home Address Line 1**

**Home Address Line 2**

**Home Address Line 3**

**Home Phone**  
( ) -

**Cell Phone**  
( ) -

**Home Email**

**Home City, State, Zip**

◆ shaded information is required for full registration and use of a Bright Horizons back-up child care program

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Bright Horizons Back-up Child Care  
Parent/Guardian Authorization for  
Release of Child and Emergency Medical**



Child Name: \_\_\_\_\_

Ohio requires that each child have at least 1 person other than the child's parent(s) or guardian(s) authorized for release and at least 1 person authorized to make medical decisions in the event of an emergency.

**Parent/Guardian Authorization for Release of Child:**

I authorize Bright Horizons to contact and/or release my child to the following representative(s) designated by me for this purpose:

Authorized Non-Parent/Guardian Name: \_\_\_\_\_

Authorized Non-Parent/Guardian Name: \_\_\_\_\_

Authorized Non-Parent/Guardian Name: \_\_\_\_\_

Authorized Non-Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please provide contact information for authorized non-parent/guardians on the Authorized Non-Parent/Guardian Information Form*

**Parent/Guardian Authorization for Emergency Medical Treatment:**

I understand that Bright Horizons staff is trained in basic first aid and CPR. I authorize Bright Horizons staff to administer first aid to my child for minor injuries or illnesses as appropriate and to notify me of any actions taken. For all other conditions requiring emergency medical treatment, Bright Horizons staff will attempt to contact me as the nature of the emergency permits. If I cannot be reached, I authorize Bright Horizons to contact the following representative(s) designated by me to act on my behalf for this purpose. If my representative cannot be reached, I authorize Bright Horizons staff to transport my child to a local hospital or other medical facility and obtain any necessary medical treatment at my expense.

Authorized Non-Parent/Guardian Name: \_\_\_\_\_

Authorized Non-Parent/Guardian Name: \_\_\_\_\_

Authorized Non-Parent/Guardian Name: \_\_\_\_\_

Authorized Non-Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please provide contact information for authorized non-parent/guardians on the Authorized Non-Parent/Guardian Information Form*

# Bright Horizons Back-up Child Care Authorized Non-Parent/Guardian Information Form



An authorized non-parent/guardian is someone other than the parent(s) or guardian(s) who is authorized to pick the child up and/or make medical decisions for the child in the event of an emergency when the parent(s) or guardian(s) cannot be reached.

**Child Name:** \_\_\_\_\_

Ohio requires that each child have at least 1 persons other than the child's parent(s) or guardian(s) authorized for release and at least 1 persons authorized to make medical decisions in the event of an emergency.

## Authorized Non-Parent/Guardian 1

<b>Authorized Non-Parent/Guardian Name:</b> _____ (last, first, middle initial)		<b>Relationship to child:</b> _____	
<b>Work Phone: (if applicable)</b> (    )    -	<b>Cell Phone: (if applicable)</b> (    )    -	<b>Home Phone:</b> (    )    -	
<b>Authorized for emergency medical decisions?:</b> yes          no          (please circle)		<b>Authorized for release of child?:</b> yes          no          (please circle)	

## Authorized Non-Parent/Guardian 2

<b>Authorized Non-Parent/Guardian Name:</b> _____ (last, first, middle initial)		<b>Relationship to child:</b> _____	
<b>Work Phone: (if applicable)</b> (    )    -	<b>Cell Phone: (if applicable)</b> (    )    -	<b>Home Phone:</b> (    )    -	
<b>Authorized for emergency medical decisions?:</b> yes          no          (please circle)		<b>Authorized for release of child?:</b> yes          no          (please circle)	

## Authorized Non-Parent/Guardian 3

<b>Authorized Non-Parent/Guardian Name:</b> _____ (last, first, middle initial)		<b>Relationship to child:</b> _____	
<b>Work Phone: (if applicable)</b> (    )    -	<b>Cell Phone: (if applicable)</b> (    )    -	<b>Home Phone:</b> (    )    -	
<b>Authorized for emergency medical decisions?:</b> yes          no          (please circle)		<b>Authorized for release of child?:</b> yes          no          (please circle)	

## Authorized Non-Parent/Guardian 4

<b>Authorized Non-Parent/Guardian Name:</b> _____ (last, first, middle initial)		<b>Relationship to child:</b> _____	
<b>Work Phone: (if applicable)</b> (    )    -	<b>Cell Phone: (if applicable)</b> (    )    -	<b>Home Phone:</b> (    )    -	
<b>Authorized for emergency medical decisions?:</b> yes          no          (please circle)		<b>Authorized for release of child?:</b> yes          no          (please circle)	

➔ All information on this page is required for full registration and use of a Bright Horizons back-up child care center.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Bright Horizons Back-up Child Care Medical and Insurance Information



Child Name: \_\_\_\_\_

## Doctor Information

Doctor/Clinic Name: _____		
Address Line 1 _____	Doctor/Clinic Phone ( ) -	Fax ( ) -
Address Line 2 _____	Address Line 3 _____	
City, State, Zip _____		

## Medical Insurance Information

Medical Insurance Carrier: _____	Membership ID #: _____
Name of Employer Providing Insurance: _____	Member Services Phone ( ) -

## Hospital Information

Affiliate/Preferred Hospital: _____	Hospital Phone ( ) -
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## Dentist Information (recommended for children over 18 months of age)

Dentist Name: _____		
Address Line 1 _____	Dentist Phone ( ) -	Dentist Fax ( ) -
Address Line 2 _____	Address Line 3 _____	
City, State, Zip _____		

➡ shaded information is required for full registration and use of a Bright Horizons backup child care center

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Bright Horizons Back-up Child Care Parent/Guardian Consents and Registration Agreement



Child Name: \_\_\_\_\_

## Parent/Guardian Consents

### Parent/Guardian Consent to Leave the Premises

I give permission for my child to leave the Center for exercise and educational purposes with Bright Horizons staff.

yes no (please circle)

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Parent/Guardian Consent for Photography/Video of Child or Parent/Guardian

I give permission for my child to be photographed and videotaped for use by or on behalf of Bright Horizons for educational, training, curriculum, marketing and similar purposes.

yes no (please circle)

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Registration Agreement

### I understand and agree to the following:

1. Completion of Registration: Information: Payments. Registration must be fully completed prior to my using the Center. I will notify Bright Horizons and update all medical, family and other information previously provided as part of the registration of my child. Medical, family and other information may be shared among Bright Horizons child care centers where necessary for registration. Additional registration information or materials may be needed to comply with local licensing requirements. Where applicable, all registration fees and/or per-use fees (co-payments) must be paid in connection with the registration of my child and use of the Center.

2. Parent Handbook: Policies and Procedures: Use of Center. I have received, reviewed and understand the Parent Handbook and related information concerning the Center and the backup child care services provided by Bright Horizons. I will use the Center in accordance with the terms of the Parent Handbook and Bright Horizons policies and procedures made available at the Center. Use of the Center and the backup child care services may be denied in the event I do not comply with the terms of this Agreement, or when determined by Bright Horizons to be in the best interests of my child or the children using the Center. The availability of the Center and the backup child care services are subject to change at any time.

3. No Employment. I will not solicit, employ or enter into any contract with any employee of Bright Horizons to perform child care or similar services under any circumstances without the express consent of Bright Horizons. If I employ or contract with any employee of Bright Horizons or person who within one year of the date of such employing or contracting was employed or under contract with Bright Horizons, I will pay Bright Horizons a placement fee of \$5,000.

4. Release of Bright Horizons. In consideration of the registration of my child, I release Bright Horizons Family Solutions, Inc., Bright Horizons Children's Centers, Inc., and their related companies, directors, officers, employees and agents, from any claims, losses, damages or costs (including attorneys' fees) caused by or arising from my child's registration, use of the Center, or participation in the programs and activities conducted by Bright Horizons other than to the extent caused by the negligent or willful misconduct of Bright Horizons Family Solutions, Inc., Bright Horizons Children's Centers, Inc., and their related companies, directors, officers, employees and agents.

5. Release of Employer. My employer has engaged Bright Horizons to provide backup child care services as a convenience for my employer's employees and other participants. My employer is not responsible for the Center or the backup child care services provided by Bright Horizons. In consideration of the registration of my child, I release my employer, and its directors, officers, employees and agents, from any claims, losses, damages or costs (including attorneys' fees) caused by or arising from my child's registration, use of the Center, or participation in the programs and activities conducted by Bright Horizons.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Ohio Department of Job and Family Services  
**CHILD ENROLLMENT AND HEALTH INFORMATION  
 FOR CHILD CARE CENTERS AND TYPE A HOMES**

Child's Name		Date form completed/updated		First Day at Center		
Date of Birth	Home Address			City		
State	Zip Code	Home Telephone Number				
Parent/Guardian Name			Relationship to child			
Home Address						
City		State		Zip		
Home Telephone Number			Cell Phone			
Work/School			Work/School Telephone Number			
Address				City		
Pager and directions for use						
<b>Where can you be reached while your child is in this program?</b>						
Parent/Guardian Name			Relationship to child			
Home Address						
City		State		Zip		
Home Telephone Number			Cell Phone			
Work/School			Work/School Telephone Number			
Address				City		
Pager and directions for use						
<b>Where can you be reached while your child is in this program?</b>						
<b>Emergency Contacts:</b> Parents cannot be listed as emergency contacts. List the name of <u>at least one person</u> who you want to be contacted in the event of an emergency or illness <b>if the parent/ guardian cannot be reached</b> . Persons listed should be able to assist in locating the parent/ guardian and at least one person listed must be local and able to take responsibility for the child in cases where the parent/ guardian can not be located.						
Name			Name			
City		State	City		State	
Telephone Number		Relationship to Child	Telephone Number		Relationship to Child	
Other numbers where emergency contact can be reached (optional)			Other numbers where emergency contact can be reached (optional)			
Name of Physician or Clinic/Hospital			Name of Dentist (Recommended for children over 18 months of age.)			
Street Address			Street Address			
City	State	Telephone Number		City	State	Telephone Number

Note: This is a prescribed form provided by JFS which must be used by centers and type A homes to meet the requirements of Rules 5101:2-12-37 and 5101:2-13-37. This form must be completed and on file at the center or type A home on or before the child's first day of attendance.

<b>Child's Name</b>		<b>Form Last Updated</b>		
<b>1. Give Permission to Transport</b>		<b>OR</b> Do <u>not</u> sign both	<b>2. Do Not Give Permission to Transport</b>	
I give (Center/Type A Home name) _____ _____ permission to have my child (name) _____ transported to ( Hospital/Clinic) _____ _____ for emergency medical care or to (Dentist) _____ _____ for emergency dental care, or to the nearest available source of assistance.			I do not give (Center/Type A Home name ) _____ my permission to have my child _____ transported for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish for the following action to be taken _____	
Parent's Signature	Date		Parent's Signature	Date
Allergies (food, medication or environmental) and precautions, reactions and treatment			<b>Check here if not applicable</b>	
			<input type="checkbox"/>	
Medications, food supplements, modified diet currently being administered			<input type="checkbox"/>	
Chronic Physical Problems			<input type="checkbox"/>	
History of Hospitalization			<input type="checkbox"/>	
History of diseases the child has had			<input type="checkbox"/>	
Any additional health or enrollment information you feel we should know about your child			<input type="checkbox"/>	

<b>Immunizations (enter month, day, and year) (Not required for children enrolled in school)</b>					
Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria, Tetanus, Pertussis (DTaP)					
Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
Measles, Mumps, Rubella (MMR)					
Inactivated Polio					
Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
The immunizations above are recommended immunizations. Please consult your child's physician for more information.					

**Parent Roster**

I agree to have my name and telephone number included on the center or Type A Home's parent roster which will be made available upon request to any parent whose child is enrolled in the center or Type A Home.		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Signature	Date
<input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Signature (If different information than parent listed above.)	Date

Note: This is a prescribed form provided by JFS which must be used by centers and type A homes to meet the requirements of Rules 5101:2-12-37 and Rules 5101: 2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance.

Ohio Department of Job and Family Services  
**CHILD MEDICAL/PHYSICAL CARE PLAN**  
**FOR CHILD CARE CENTERS & TYPE A HOMES**

This form may be used for children with health conditions as defined in Rules 5101: 2-12-38 and 5101: 2-13-38.

<b>Child's Name</b>	<b>Date of Birth</b>
<b>Special Health Conditions</b>	
<b>Symptoms to watch for and Emergency Action to be taken if the following symptoms occur</b>	
<b>Activities/Foods/Environmental Conditions to Avoid</b>	
<b>Medical Procedures to be followed and Expected Benefit of Treatment</b>	

**Are any medications required?**    No    Yes   (If yes, complete JFS 01217 Request for Administration of Medication)  
**If yes, what medications?**

<b>Training Instructions (Trainer must be a parent/guardian or certified professional)</b>
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<b>Signature of Trainer:</b>	<b>Date:</b>
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<b>Signature of trained staff members and staff who have been made aware of the condition.</b>	(There must always be a trained staff member present when the child is present.)
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Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained
Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained
Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained
Signature: _____	Date: _____	<input type="checkbox"/> Staff Informed	<input type="checkbox"/> Staff Trained

**(Only trained staff members shall be permitted to perform medical procedures listed above.)** Additional staff, may sign on the backside of this form, but need to indicate "trained" and/or "informed".

<b>Additional services (educational/therapeutic) child is receiving</b>
Who provides the above services?
Name: _____ Phone number: _____ May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes
Name: _____ Phone number: _____ May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes

<b>I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.</b>			
<b>Parent Signature</b>	<b>Date</b>		
<b>Administrator Signature</b>	<b>Date</b>		