YAFTERSCHOOL

We build strong kids, strong families, strong communities.

# 2017-2018
# After School Care
# CHILD CARE PROGRAM

**Professional staff offers educational activities and fun in a caring, safe environment.**

This program will be held at North Dearborn Elementary School start and at the end of the school day until 6:30 pm. Children may be schedule for a full or part time week. Weekly fees are as follows

**AFTER SCHOOL CARE**

| | | |
|---|---|---|
| **FULL TIME** | $50.00 | 4 or 5 evenings per week |
| **PART TIME** | $35.00 | 3 or fewer afternoons per week |

****** 10 % Discount on each additional child.**

To enroll your child for next year, complete this registration form below and return with **25.00 / 50.00** per family NON REFUNDABLE fee to either: Site Administrator at the North Dearborn Y Kids Site or Drop off during "book days" at the YMCA table

**Enrollment is not considered complete until the Site Administrator receives first week payment and entirely completed enrollment packet. A complete enrollment Packets are available at the site. First week payment and packet are due no later than one week prior to first day of school if you wish your child to begin at the start of the school year.**

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## Y'S KIDS REGISTRATION 2017-2018

SCHOOL_____ GRADE_____

CHILD'S NAME_____ BIRTHDATE_____

MOTHER'S NAME_____ WORK PHONE_____

FATHER'S NAME_____ WORK PHONE_____

MAILING ADDRESS_____ HOME PHONE_____

ZIP CODE_____ SCHEDULE _____F/T _____P/T

**PLEASE RETURN WITH $25 PER CHILD/$50 MAXIMUM PER FAMILY**
**NON-REFUNDABLE FEE**
**MAKE CHECK PAYABLE TO: NDE Y Kids**

**Scholarships are available through the YMCA of Greater Cincinnati Scholarship Program. For more information please contact the Site Administrator at rosestevens316@gmil.com**

# Y's Kids Tuition Agreement

As a Y's Kids parent/guardian, I agree to make my tuition payment on each Friday for the following week's schedule. I understand that if I fall behind on my payment, My child(ren) will be temporarily withdrawn from the program, until my account is paid in full. Registration fee is non-refundable.

I understand that tuition is based on a part-time (3 days or less/week) or a full time rate (4 days or more?week). A tuition chart for the program is enclosed in the enrollment packet. A $20 service charge is assessed for all checks returned for insufficient funds.

I understand that tuition payments will all be made by Mandatory Automatic Payment using a credit or debit card.

_____ _____

Parent/Guardian Date

# Y's Kids Permission Form

I hereby grant permission for my child to use all the equipment and participate in all of the activities of the center.

I hereby grant permission for my child to be included in evaluations and pictures connected with the childcare program.

I hereby grant permission for the director or acting director to take whatever steps may be necessary to obtain emergency medical care if warranted as stated on the Emergency Medical Authorization Form.

I understand that expenses incurred in obtaining medical treatment are my responsibility.

I understand that the Center is not responsible for anything that may happen as a result of false information given by the parent/guardian.

I understand that the YMCA of Greater Cincinnati and the Center will not assume responsibility for a child who is not signed in when he/she arrives for the day, if enrolled in the SACC program.

_____ _____

Parent/Guardian Date

Clippard Family YMCA
SACC Programs

## Mandatory Automatic Payment Enrollment

*Automatic payment enrollment is now required for all Clippard childcare participants. Please read the policies carefully.

**Payment Policies:**

- **A valid credit/debit card must be on file for all weekly payments.** Only the registration fee/deposits can be paid by other means.
- **My credit/debit card will be charged in full for any programs I have selected on the Friday *before* the selected week.**
- **I will be charged in full (whether or not my child attends) unless I withdraw my child from a selected program using the *Status Change Form* and return it no later than 2 weeks before the start of the selected week.** No verbal or over the phone withdrawals are accepted.
- If my card is rejected, I will be notified the no later than Monday of the week of service. **My child will not be able to attend the selected program until the fee is paid and a valid card is on file.**

***The information on this form will be kept in a locked safe in a secure location.**

Parent's Name: _____

Phone #: _____ Membership #: _____

Child(ren)'s Name(s): 1. _____ 2. _____

3. _____ 4. _____

☐ I understand my card will be charged on the Thursday before each week of the program.

Select Card Type: ☐ Visa ☐ Mastercard ☐ American Express

Card Holder Name _____ Card # _____ Exp.

Date _____

Billing Address _____ Zip _____

I understand and agree to the above payment policies. I authorize Clippard Family YMCA to charge the full fee for all programs selected on the registration form to the credit/debit card listed above.

Authorized Signature _____ Date _____

Y's Kids
Clippard Family YMCA SACC
Enrollment Form

Enrollment Date: _____ School Name: _____

**SCHEDULE INFORMATION**

My child will be in attendance in the Y's Kids program:

M T W TH F AM AND/OR M T W TH F PM

**CHILD'S INFORMATION**

Child's Name: _____

Birthdate: _____ Age: _____

Grade: _____ Phone: _____

Teacher's Name & Room #: _____

Parent's Birthdate: _____

Child lives with: Both Parents ___ Mother___ Father ___ Other ___
Marital Status of Parents: Married ___ Div. ___ Single ___ Other ___

****Note: In the case of divorce, adoption, foster parenting or other court-ordered activity, attach a copy of the court order granting custody.**

IN ADDITION TO PARENT/GUARDIAN, MY CHILD MAY BE RELEASED ONLY TO THE FOLLOWING PERSON (S):

NAME: ADDRESS PHONE RELATIONSHIP

_____
_____
_____
_____
_____

Date: __/__/__
Parent/Guardian signature_____

the YMCA™
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Ohio Department of Job and Family Services

# CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE CENTERS AND TYPE A HOMES

**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 Center |
|---|---|---|
| Home Address | | City |
| State / Zip Code | Home Telephone Number | |
| Parent/Guardian Name | Relationship to Child | |
| Home Address | Home Telephone Number | |
| City | State / Zip | |
| Email Address *(if applicable)* | Cell Phone | |
| Parent's Work/School Telephone Number | Parent's Work/School Name | |
| Parent's Work/School Address | City | |

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

**Where can you be reached while your child is in this program?**

| Parent/Guardian Name | Relationship to Child |
|---|---|
| Home Address | Home Telephone Number |
| City | State / Zip |
| Email Address (if applicable) | Cell Phone |
| Parent's Work/School Telephone Number | Parent's Work/School Name |
| Parent's Work/School Address | City |

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

**Where can you be reached while your child is in this program?**

**Emergency Contacts:** Parents <u>cannot be listed</u> as emergency contacts. List the name <u>of 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 within one hour of the center/home, 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 Food Supplements

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 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A 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 child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a 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 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

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 the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

| 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. |
| List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page. |

**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 center/type A home'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** | | | **Do Not Give *Permission* to Transport** | |
|---|---|---|---|---|
| Center or Type A Home Name | | | Center or Type A 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. | | **OR** Do not sign both | **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 center's or type A 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. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.

| 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 centers and type A homes to meet the requirements of rules 5101:2-12-37 and 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 and thereafter while the child is enrolled.

Reset Form

Ohio Department of Job and Family Services

# CHILD CARE PLAN FOR HEALTH CONDITIONS OR MEDICAL PROCEDURES FOR CHILD CARE CENTERS AND TYPE A HOMES

If care is provided for a child who has an ongoing health condition that requires child specific care or may require a medical procedure, the parent/guardian shall complete this form. The center staff shall implement the plan. This requirement does not include short term illnesses, unless the child care staff member needs to perform a medical procedure for the child. A separate plan must be written for each condition that requires different actions to be taken.

| Child's Name | Date of Birth |
|---|---|
| | |

Describe the health condition.

Describe the medical procedure to be completed and expected benefits of treatment, or ☐ N/A, no medical procedure required.

List activities/foods/environmental conditions to avoid or ☐ N/A, nothing to avoid.

Symptoms to watch for and actions to be taken if the symptoms are observed.

Is any medication required? ☐ Yes ☐ No
(If yes, complete JFS 01217 "Request for Administration of Medication", in addition to this form.)

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? ☐ Yes ☐ No If yes, please describe:

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? ☐ Yes ☐ No If yes, please describe:

| Signature of Trainer (Trainer must be a parent/guardian or certified professional) | Date |
|---|---|
| | |

Signature of child care staff members who have been informed about the child's condition so they can care for the child according to this care plan or trained to perform the medical procedure.

**There must always be a trained staff member present when the child is present.**

| Signature | Date | I have been ☐ Informed | I have been ☐ Trained |
|---|---|---|---|
| | | | |
| Signature | Date | ☐ | ☐ |
| Signature | Date | ☐ | ☐ |
| Signature | Date | ☐ | ☐ |

I give my permission for the staff listed above to perform the procedures in my child's care plan as described above.

| Parent's Signature | Date |
|---|---|
| | |

| Administrator's Signature | Date |
|---|---|
| | |

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

Ohio Department of Job and Family Services

# REQUEST FOR ADMINISTRATION OF MEDICATION

## Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

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

**Check all that apply:**

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☐ Topical product or lotion
- ☐ Food supplement
- ☐ Modified diet

**Complete all of the following information:**

Name of child:_____ Date of birth: _____ Weight: _____

Name of medication:_____ Exact dosage: _____

To be administered at the following times_____

For the following period of time:_____

Parent/Guardian signature:_____ Date: _____

**Box 2** -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be applied longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated) or food supplement; or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____
(name of child) (name of medication, vitamin, diet)

as follows: _____
(include dosage and instructions)

Possible side effects to watch for are: _____

Expiration date: _____ (May not exceed 12 months from the date of this request for medications or food supplements)

_____ _____ _____
Signature of physician, dentist or advance practice nurse Date of signature Phone number

This form must be used by child care centers and type A homes to meet the requirement of OAC rules 5101:2-12-31 and 5101:2-13-31

**Box 3** - The section below must be completed by the **center or type A home staff** and each administration of medication must be documented. **All** dosages must be recorded on page 2 of this form.

| | | |
|---|---|---|
| _____ was given _____ in the amount of _____ | | |
| (Name of Child) | (Name of Medication, Vitamin or Diet) | (Dosage) |

| Date and Time of Dosage | Dosage Amount | Signature of Designated Person Administering Medication |
|---|---|---|
| | | |
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This form must be used by child care centers and type A homes to meet the requirement of OAC rules 5101:2-12-31 and 5101:2-13-31