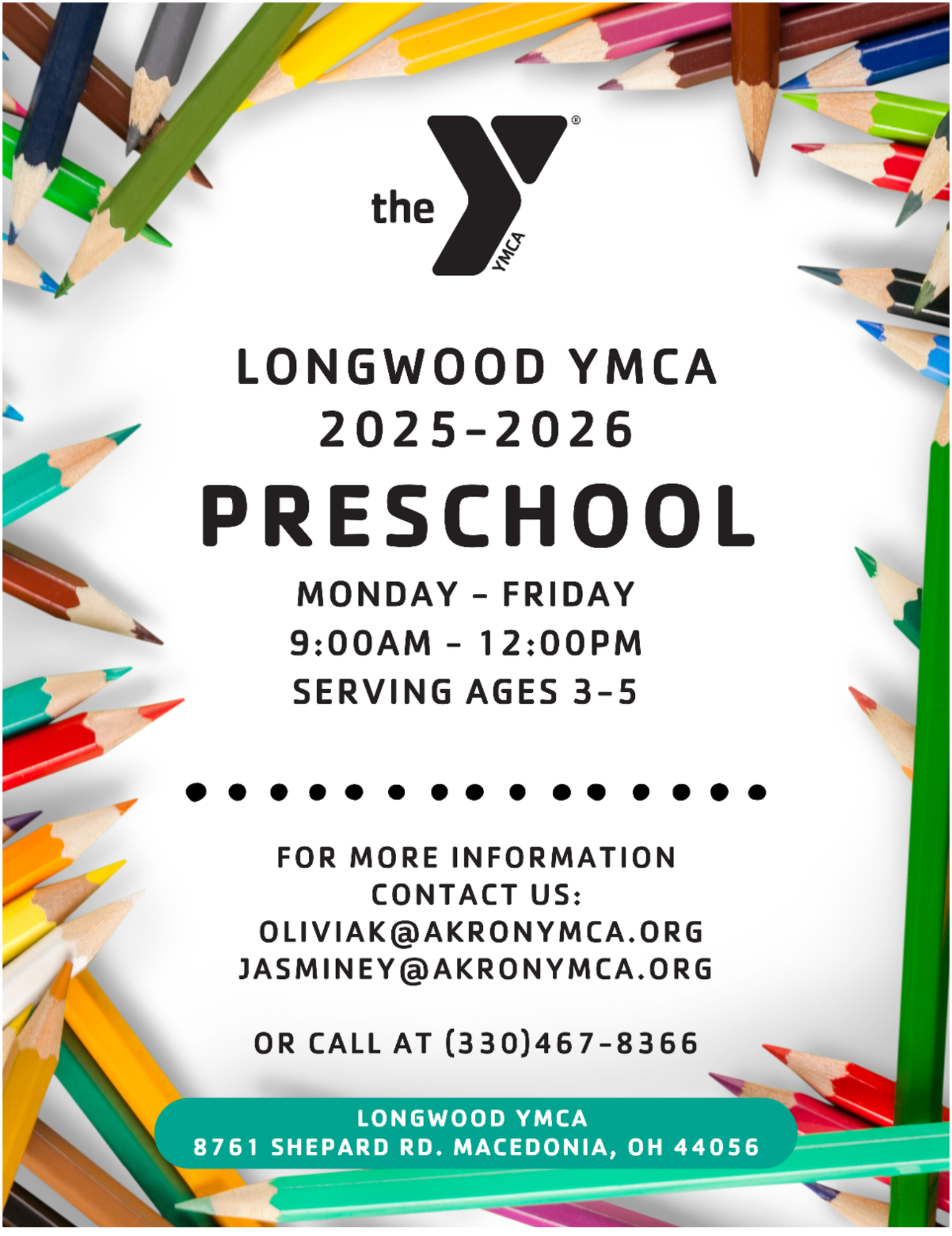

LONGWOOD YMCA
2025-2026
PRESCHOOL

MONDAY - FRIDAY
9:00AM - 12:00PM
SERVING AGES 3-5

FOR MORE INFORMATION
CONTACT US:
OLIVIAK@AKRONYMCA.ORG
JASMINEY@AKRONYMCA.ORG

OR CALL AT (330)467-8366

LONGWOOD YMCA
8761 SHEPARD RD. MACEDONIA, OH 44056

PARENT INFORMATION PAGE

PREK/PRESCHOOL FEES

Monday - Friday

9:00am-12:00pm

Ages 3-5

5-Day Rate (M-F): $270/month

3-Day Rate (MWF): $200/month

2-Day Rate (TTh): $160/month

Annual $40 registration fee is due at the time of registration for all programs

BRING TO THE Y

- Small Bag or Backpack
- Extra Clothes (Underpants, Pants/Shorts, Shirts, Socks)
- Water Bottle

Label all items with names!

DO NOT BRING TO THE Y

- **Nuts of Any Kind** (Nut-Free Facility)
- Open-Toed Shoes (ex. Flip Flops, Crocs)
- Electronics or Cell Phones
- Toys from Home (unless asked by the teachers)
- Money / Valuables

NOTES ON PAPERWORK

- The additional forms "Child Medical/Physical Care Plan" needs to be completed if your child has specific medical needs, such as asthma or allergies.

- The "Child Medical Statement for Child Care" and immunization forms must be completed by your child's physician and returned within **30 days** of their start date.

SPECIAL NEEDS

The Longwood YMCA PreK/Preschool is open to children of all abilities. If your child has special needs, please speak with the Youth Enrichment Director to arrange appropriate accommodations.

DATES TO REMEMBER

Preschool Begins: Tuesday, Sept. 2nd, 2025

Preschool Ends: Friday, May 26th, 2026

- We follow the Nordonia Hills School District calendar for all days off. Preschool will be closed on all scheduled school days off and snow days.

WHO TO CALL

OLIVIA KENT
Youth Enrichment Director
330-467-8366 ext 1802
oliviak@akronymca.org

JASMINE YOUNGBLOOD
Youth Enrichment Director
330-467-8366 ext 1803
jasminey@akronymca.org

FINANCIAL ASSISTANCE

PAITON HARDY
Executive Director
330-467-8366 ext 1801
paitonh@akronymca.org

PLEASE NOTE

- Our suggested ages for our classes would be...

- 2/Day Class:
  - Primarily for 3-year-olds
  - Also available for 4 and 5-year-olds as an alternative option
- 3/Day Class:
  - For 4-year-olds
- 5/Day Class:
  - For 5-year-olds
  - Children who are going into Kindergarten the following school year

PLEASE KEEP THIS PAGE FOR YOUR REFERENCE

Preschool Program 2025-2026

☐2-day ☐3-day ☐5-day

Child's Information

Child's Name and Nick Name _____ ☐male ☐ female ☐other

Child's Date of Birth_____/_____/_____ Age at start of School _____

Street Address _____

City _____State _____Zip _____

Does child live with both parents? ☐Yes ☐No If no, please indicate which parent has custody of child. (Custody papers must be provided if there is any issue.)

Parent/Guardian Information

Parent Name _____ Parent Name _____

Primary Number_____ Primary Number_____

Secondary Number_____ Secondary Number_____

Email _____ Email _____

Date of Birth _____ Date of Birth _____

Person responsible for tuition _____

Are you or another parent/guardian currently an employee of the YMCA? ☐Yes ☐No

Authorized Persons to Pick Up Child

Your child will only be released to a parent/guardian or persons listed in this section.
Staff will require a government issued identification before releasing your child.

Name _____ Relation _____

Primary Number Second Number

Name _____ Relation _____

Primary Number Second Number

Name _____ Relation _____

Primary Number Second Number

Name _____ Relation _____

Primary Number Second Number

Please note: if there are any custody issues involved with your child, you must provide the center directors with full court papers indicating who has permission to pick up the child. The program may not deny a parent access to his/her child without proper documentation.

*If you receive publicly funded child care, all authorized persons to pick up will be required to use the mobile TAP System.

Child's Name_____

Photograph Consent

I give my permission for my child _____ to be in photographs, slides, DVD's, and/or videos for the promotion of the Akron Area YMCA.

Parent/Guardian Signature _____Date _____

Permission for Routine Walks

Weather permitting, I give permission for my child _____ to accompany his/her class on routine walks on Akron Area YMCA grounds.

Parent/Guardian Signature _____Date _____

Child Drop-Off/Pick-Up Policy

When you enroll your child in any YMCA Child Care Program, it is to be understood that our policy is for you to bring your child into the center each morning, sign the attendance sheet, and let one of the staff members know your child has arrived. Please note: we are not legally responsible for your child when he/she is dropped off without completing the above procedure.

I understand that state law requires me to sign my child in and out each day, as well as notify staff that my child is leaving for the day.

Parent/Guardian Signature _____Date _____

Hand Sanitizer Permission

I give my child, _____, permission to use hand sanitizer that is being given by an adult staff member.

Parent/Guardian Signature _____ Date _____

==========

Please Note:

We are a **NUT FREE** facility. Please do not pack your child peanut butter or anything including nuts.

All snacks provided are allergy friendly. If your child has specific requirements, please contact the Youth Enrichment Director to make appropriate accommodations.

Child's Name_____

2025-2026 Center Policies Agreement

Please read the policies carefully and initial in each box

☐ I understand there is a $40 non-refundable registration fee per child (unless registering before June 1, 2025).

☐ Monthly tuition is due on the 1st of the month via auto draft (unless other arrangements are made per the Executive Director).

☐ I understand that if my childcare payments fall one month behind I will be asked to withdraw my child until payment is made.

☐ Outstanding balances of $100.00 or more that are past 30 days in arrears will be turned over to collections.

☐ I understand that if I have any outstanding balance at any facility within the Akron Area YMCA Association I am unable to register for any programs or memberships until balance is paid.

☐ I understand that there will be a $10.00 fee assessed for any and every returned payment.

☐ **CANCELLATION POLICY:** Written notification must be given no later than one week in advance. Otherwise, I understand that I will be responsible to pay that month's tuition in-full, regardless of attendance.

☐ I understand that late pick up fees in the amount of $1.00 for every 1 minute per family will be imposed if my child(ren) is picked up after the program's designated closing time (12:00 pm).

☐ I understand that staff will contact Summit County Children Services if my child remains at the center longer than one hour after closing and all attempts to reach me, the child's other parent, and authorized persons have been made, without success.

☐ I understand that state licensing requires that all forms in this registration packet must be **completely filled out** and turned in prior to the child's admission to the program.

☐ I understand that I am required to disclose all medical, physical, or behavioral issues that pertain to my child at the time of enrollment, and supplement that information on an ongoing basis as needed.

☐ I have read the YMCA Child Care Registration Packet in full and agree to all terms therein for my child(ren) to receive childcare. I also understand that I forfeit the privilege of childcare if all policies are not followed.

_____ _____

Parent/Guardian Signature **Date**

Child's Name_____

Child/Family Information Form

In an effort to understand your child and to meet his/her needs, we would like you to complete the following:

Who is in the child's immediate family? _____

Who lives at home with your child? (pets included) _____

What is the primary language spoken in your child's home? _____

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.?_____

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend, or pet) _____

_____

Are there any cultural or religious practices of your family we should be aware of? (dietary restrictions, clothing, head coverings, etc.) _____

Has your child had a previous care arrangement? If so, what kind? (Center based, in home, with family, with parents, etc.) _____

What causes your child to feel angry or frustrated? _____

_____

What methods do you use to respond to your child's negative behavior? _____

_____

Does your child need assistance when using the toilet? If so, how? _____

What time(s), and for how long, does your child usually nap? _____

What might you and/or your child be anxious about as he/she starts in this program? _____

_____

What are your expectations of this program? _____

Would you like information or referrals for any of the following?

YES	NO		YES	NO	
		Food Assistance			Help meeting the needs of your special needs child
		Housing			Family Counseling
		Nutrition			Parenting Education of Information
		Health/Immunizations			Dental
		Other:			

Staff Use:

Referrals Made (date) _____ (to where) _____

Follow up _____ (date)

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 **Longwood Branch YMCA**			~~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.

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

LEFT BLANK FOR PRINTING

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

AUTOMATIC DRAFT FORM

Child's Name: _____

Parent's Name: _____

Program: ☐ Before/After Care ☐ Fun/Snow Days ☐ Preschool ☐ Summer Camp

I elect to pay my weekly/monthly child care fees with:

Bank Account (please attach a voided check)

Name on Account: _____

Routing Number: _____

Account Number: _____

Choose One: ☐ Checking ☐ Savings

Debit/Credit Card (Choose: ☐ Visa ☐ MasterCard ☐ Discover)

Credit Card Number:_____

Expiration Date: _____ CVC CODE: _____

Name on Card: _____

Address: _____

·I authorize Akron Area YMCA to automatically draft from the above account for my weekly/monthly child care fees.

·I understand that this automatic draft will begin on Friday prior to the week of service. Preschool program fees will auto draft on the 1st of each month.

·I understand that this automatic draft will be terminated at the end of the current program enrollment, or upon giving the Akron Area YMCA 7-day written notice of my child's termination.

·I understand that the YMCA is not responsible for any NSF fees incurred for not maintaining the required funds in my account.

_____ _____

Signature Date