



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

WILD ABOUT CAMP



2025 SUMMER DAY CAMP

To Register: Complete the registration packet and turn it into the YMCA's front desk or director. Please allow 2 business days for processing before the child starts attending. If your child has a medical condition or requires medication at camp, additional paperwork will be required. A director will contact you to let you know what else is needed. All required paperwork must be completed correctly and required medication must be given to staff BEFORE the child starts attending the program.

A payment method must be provided at time of registration. If you receive Publicly Funded Child Care, authorization must be obtained before attending, or the private pay rate will be owed.

Our Dedicated Staff:

Christina Vegh, Youth Enrichment Director
Lindsay Socotch, Youth Enrichment Director
Maci Nestlerode, Assistant Child Care Director

Monday – Friday 7:00 am – 6:00 pm

**Serving children who have completed
Kindergarten through entering 6th Grade**



PARENT INFORMATION PAGE

Tear off and keep for your records!

FIELD TRIP PERMISSION FORM WILL BE RELEASED AT A LATER DATE



DAY CAMP FEES and PUBLICLY FUNDED CHILD CARE

Registration Fee: \$40 per child

Non YMCA Member Fee: \$210/week

YMCA Member Fee: \$190/week

Child must have completed at least one full year of Kindergarten in order to attend camp. The last year a child can attend camp is the summer before starting 6th grade

Voris CLC License #: 106755

FPY License #: 102939



CAMP TIMES

Before Care: 7:00AM - 8:30AM

Camp: 8:30AM - 4:00PM

After Care: 4:00PM - 6:00PM

- Before & After Care are provided at no extra charge.

- Children need to arrive no later than 8:30AM. If you miss the bus, you may transport your child to the field trip. **You cannot drop your child off to Voris CLC or FPY if their group is out of the building.**



DATES TO REMEMBER

Day Camp at Voris CLC:

Monday, June 9 - Friday, July 25

Thursday, June 19th- No Camp

Friday, July 4th- No Camp

Day Camp at Firestone Park YMCA:

Monday, July 28 - Friday, August 15



WHAT TO BRING

- Camp T-Shirt big trip days (Thur/Fri)
- Closed-Toe Shoes (tennis shoes)
- Water Bottle
- Backpack
- Swimsuit (one-piece or full coverage two piece)
- Towel

Label all items with names if possible



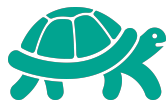
LUNCHES AND SNACKS

Snacks and lunches are provided following USDA SUN Meal (formerly Summer Food Service Program) guidelines. If you would like to pack your own lunch or supplement additional snacks for your child please do. Sharing of these extra snacks with others is not allowed, even between siblings.



WHAT NOT TO BRING

- Open-Toe Shoes (ex. Flip Flops, Crocs)
- Electronics or Cell Phones
- Toys from Home
- Two-Piece Swimsuits with bare midriff
- Money
- NO MICROWAVABLE LUNCHES OR DELIVERIES



FINANCIAL ASSISTANCE

The Y strives to make programs available to all. Financial assistance may be available to those who qualify. Please stop into the Firestone Park Y to pick up a Financial Assistance Scholarship Application from the front desk.



CABIN PHONE NUMBERS

- Directors: 330-620-7253
- Cabin 1: 330-414-3141
- Cabin 2: 330-607-5690
- Cabin 3: 330-414-6907
- Cabin 4: 330-603-4154



WHO TO CALL

LINDSAY SOCOTCH

Youth Enrichment Director
330-724-1255 ext. 1419
lindsays@akronymca.org

MACI NESTLERODE

Assistant Child Care Director
330-724-1255 ext. 1461
macin@akronymca.org

Child's Information

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

Child's Date of Birth ____/____/____ Age ____ T-Shirt Size ____

My child will be entering ____ grade in Fall 2025 at _____ School

****Child must have completed at least one full year of Kindergarten in order to attend****

Street Address _____

City _____ State _____ Zip _____

Weeks Child Will Be Attending Summer Day Camp

- | | | |
|--|--|---|
| <input type="checkbox"/> Week 1: June 9 - June 13 | <input type="checkbox"/> Week 5: July 7 - July 11 | <input type="checkbox"/> Week 8: July 28 - Aug. 1 |
| <input type="checkbox"/> Week 2: June 16 - June 20 | <input type="checkbox"/> Week 6: July 14 - July 18 | <input type="checkbox"/> Week 9: Aug. 4 - Aug. 8 |
| <input type="checkbox"/> Week 3: June 23 - June 27 | <input type="checkbox"/> Week 7: July 21 - July 25 | <input type="checkbox"/> Week 10: Aug. 11 - Aug. 15 |
| <input type="checkbox"/> Week 4: June 30 - July 4 | | |

Parent/Guardian Information

Parent Name _____ Parent Name _____

Primary Number () ☐C ☐H ☐W Primary Number () ☐C ☐H ☐W

Secondary Number () ☐C ☐H ☐W Secondary Number () ☐C ☐H ☐W

Email _____ Email _____

Date of Birth _____ Date of Birth _____

Payment Information

Please draft payment: ☐ Weekly on Fridays ☐ Other (contact Maci Nestlerode)

Account: ☐ Use account in file (ending with ____) ☐ Provide account info at registration

Person responsible for tuition: _____

Do you have Publicly Funded Child Care? ☐ Yes ☐ No

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 () ☐C ☐H ☐W Second Number () ☐C ☐H ☐W

Name _____ Relation _____

Primary Number () ☐C ☐H ☐W Second Number () ☐C ☐H ☐W

Name _____ Relation _____

Primary Number () ☐C ☐H ☐W Second Number () ☐C ☐H ☐W

Name _____ Relation _____

Primary Number () ☐C ☐H ☐W Second Number () ☐C ☐H ☐W

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 _____

2025 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.

☐

Weekly tuition is due on Fridays prior to the week of service via auto draft.

☐

I understand that if my childcare payments fall one week 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 week's tuition in-full, regardless of attendance.

☐

I understand that late pick up fees in the amount of \$1.00 per minute per family will be imposed if my child(ren) is picked up after the center's designated closing time (6:00 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.

FOR PUBLICLY FUNDED CHILD CARE RECIPIENTS ONLY

☐

I understand that my Publicly Funded Child Care co-pay is due every Friday via auto draft prior to care.

☐

I understand that if my Publicly Funded Child Care authorization is not current and/or for the correct location, I will be responsible for private pay rates.

☐

I understand that I must tap using the tablet daily. I understand there is a back date period if daily taps are missed. If I miss the back date period, I understand that I will be charged the difference between my co-pay and the weekly private-pay rates. I understand it is my responsibility to know for which dates and times I need to back date.

Parent/Guardian Signature _____ 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 <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> 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 <u>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 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? <input checked="" type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> 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:	
<input type="checkbox"/> I agree with the program's schedule	<input type="checkbox"/> I do not agree, please check my child's diaper every ____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport	OR	Do Not Give <u>Permission</u> to Transport
Program or Home Name Firestone Park 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.	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 program's or home's policies and procedures/handbook. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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 Children and Youth
FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)

<p><i>We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL</i></p> <p>Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.</p>			
Child's/Children's Name(s):		Caretaker's Name:	Date Completed:
TOPICS		Briefly List CONCERN	
Child Development and Education- Does anyone in your family have any need for resources or support in the areas listed below?			
Y	N	Information on child growth and development.	
Y	N	Guiding and supporting a child's behavior.	
Y	N	Medical or disabilities or possible conditions for any child or adult in the family.	
Y	N	Obtaining toys or activities to use to help any child in your home.	
Y	N	Preparing your child for kindergarten.	
Child and Family Health- Does anyone in your family have any need for resources or support in the areas listed below?			
Y	N	Health insurance and/or access to regular medical care, dental care, or medications.	
Y	N	Medical or health supplies or supports that anyone in your family needs.	
Y	N	Accessing immunizations.	
Y	N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.	
Y	N	Concerns with depression, anger, anxiety, or mental health needs.	
Y	N	Concerns with alcohol, drug, or addiction problems.	
Financial and Household Supports- Does anyone in your family have any need for resources or support in the areas listed below?			
Y	N	Help paying for child care.	
Y	N	Help finding housing or safe housing.	
Y	N	Help paying your mortgage or rent.	
Y	N	Help with food expenses.	
Y	N	Finding household items such as furniture, clothing, or school supplies.	
Y	N	Access to transportation or transportation expenses.	
Y	N	Attending school (such as a GED, Certifications, or college degrees)	
Y	N	Help finding work or job training	

Are there other needs you or your family have that are not listed above:

Parent Signature	Date:
Administrator or Designee Signature:	Date:

For Staff Use:

Bronze Rating Level	Silver Rating Level	Gold Rating Level
Resources provided to the family:	Resources provided to the family:	Resources provided to the family:
Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
	Referrals provided to the family:	Referrals provided to the family:
	Administrator or Designee Signature & Date:	Administrator or Designee Signature & Date:
		Follow-up provided to the family:
		Administrator or Designee Signature & Date:

2024 HOUSEHOLD APPLICATION FOR FREE AND REDUCED-PRICE SUMMER MEALS
(FOR USE BY CAMPS AND CLOSED ENROLLED SITES)

Part 1. ALL HOUSEHOLD MEMBERS

Names of <u>all</u> household members (First, Middle Initial, Last)	Name of school and grade level for each child/or indicate "NA" if child is not in school. School	Grade	Check if a foster child (legal responsibility of welfare agency or court). *If all children listed below are foster children, skip to Part 5 to sign this form.	Check if No Income
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Part 2. BENEFITS: If any member of your household receives SNAP or OWF benefits, provide the name and 7-digit case number for the person who receives benefits and **skip to Part 5**. If no one receives these benefits, **skip to Part 3**.

NAME: _____ 7-DIGIT CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call Shannah Carino, Homeless Education Liason at scarino@apslearns.org or Project Rise, projectrise@apslearns.org, 330-761-2969
 Homeless ☐ Migrant ☐ Runaway ☐

Part 4. TOTAL HOUSEHOLD GROSS INCOME (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once.

1. NAME (List all household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED														
	Earnings from work before deductions	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Public Assistance, Child Support, Alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, All other Income	Weekly	Every 2 Weeks	Twice Monthly	Monthly
(Example) Jane Smith	\$200	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$150	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part 5. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 4 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will receive federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that deliberate misrepresentation of the information may cause my children to lose meal benefits and I may be subject to prosecution under state and federal statutes.

Sign here: X _____ Print name: _____ Date: _____

Address: _____ Phone Number: _____

Last four digits of your Social Security Number: _____ ☐ I do not have a Social Security Number

Part 6. Children's ethnic and racial identities. We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced-price meals.

Choose one ethnicity:

- ☐ Hispanic/Latino
☐ Not Hispanic/Latino

Choose one or more (regardless of ethnicity):

- ☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American
☐ White ☐ Native Hawaiian or other Pacific Islander

Do not complete this section. Intended for school use only

Annual Income Conversion: Weekly x52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12.

Total Income: _____ Per ☐ Week ☐ Every 2 Weeks ☐ Twice per Month ☐ Monthly ☐ Yearly

Household Size _____ Categorical Eligibility: ☐ Free ☐ Reduced ☐ Denied Reason Denied: _____

Determining/Approval Official's Signature _____ Date _____

(BLANK FOR PRINTING PURPOSES)

Summer Program Parent/Guardian Consent Form – Release of Student Records

Akron Area YMCA- THRIVE is partnering with the Akron Public Schools and Summit Education Initiative to promote the success and academic achievement of students in Summit County. Summit Education Initiative (SEI) is a nonprofit organization located in Akron, Ohio, dedicated to increasing educational attainment in Summit County, Ohio.

The Family Education Rights and Privacy Act (FERPA) protects students and parents by prohibiting most third parties from accessing student records, information, or data without clear permission from a parent or guardian if the student is under 18.

This form requests your consent to allow Akron Area YMCA- THRIVE to share the **name, grade level, date of birth, student ID number** and **school** of your child with SEI. With this information, SEI will access your child's Akron Public Schools data, including test scores, grades, attendance records, and results of student surveys. In turn, SEI will provide a summary of aggregate results back to Akron Area YMCA- THRIVE to determine the impact and effectiveness of their program(s). Akron Area YMCA- THRIVE **will not see the individual academic records, information or data of your child.**

Accessing student information or data will be done *only* to promote Akron Area YMCA- THRIVE's efforts to support your student's academic success and achievement, and to evaluate services being offered. **No records, information, or data will be used for any other purpose, and will not be shared with any party other than those listed in this release.**

PARENT/GUARDIAN CONSENT

INITIAL HERE

I give consent for Summit Education Initiative to access my child's Akron Public Schools personally-identifiable information. I understand the following information will be accessed:

- Student Name, grade level and date of birth, student ID number
- School district name and school building name
- Course grades and Grade Point Average
- National and state test score results
- Attendance records (count of absences without details)
- Discipline events (count of events without details)
- Results of surveys administered at the building and/or district level

I understand that my child's information will only be accessed by Summit Education Initiative who will only provide aggregate results and reports to the Akron Area YMCA- THRIVE. I understand that this consent may be terminated at any time by my written request as the parent/guardian listed below. It is also my understanding that this consent will last until my child is 18 years old, unless it is revoked by me in writing, or unless my child is no longer affiliated with the Akron Area YMCA- THRIVE or registered as a student in Akron Public Schools. As a parent or guardian, I have the right to revoke consent at any time. I also have the right to obtain copies of any information about my child that is accessed because of this form.

Parent/Guardian Name (print)

Date of Consent

Parent/Guardian Signature

Child's Name

Child's School District

Date of Birth (MM/DD/YYYY)

Child's School Building

Child's School Student ID Number/Lunch Number