PARENT INFORMATION PAGE

Tear off and keep for your records!

SUMMER CHILD CARE FEES

Weekly Fee: $190/week
YMCA Member Fee: $170/week
Child must have completed at least one full year of Kindergarten in order to attend camp.

CAMP TIMES

Before Care: 7:00 am - 9:00
am Camp: 9:00 am - 4:00 pm
After Care: 4:00 pm - 6:00 pm
- Before and After Care are provided at no extra charge.

WHAT TO BRING

- Closed Toe Shoes (Tennis Shoes)
- Packed Lunch
- Water Bottle
- Backpack

****Label all items with names!****

WHAT NOT TO BRING

-Open Toe Shoes of Any Kind (ex. Flip Flops, Crocs)
-Electronics or Cell Phones
-Toys from Home
-Money (unless requested)
-Valuables

DATES TO REMEMBER

First Day of Care: Monday June 8
Last Day of Care: Friday August 28

PASSPORT PROGRAM

Register your child for 6 or more weeks of Day Camp at any Akron Area YMCA or YMCA of Central Stark location and receive 20% off one week of Overnight Adventure Camp at Camp Y-Noah! (Particular week of overnight camp is subject to availability.) To take advantage call Camp Y-Noah at 877-GOT-CAMP or visit http://www.akronymca.org/campynoah/Register/

The Y strives to make programs available to all. Financial assistance may be available to those who qualify. Please stop into the business office to pick up a Financial Assistance Scholarship Application. Contact Business Manager, Beth Noga, for processing at 330-467-8366 ext 1 or bethn@akronymca.org.

WHO TO CALL:

MELANIE MAYER
YOUTH ENRICHMENT DIRECTOR
330-467-8366 EXT 3
MELANIEM@AKRONYMCA.ORG

ANGELA TRAVARCA
ASSISTANT CHILD CARE DIRECTOR
330-467-8366 EXT 6
ANGELAT@AKRONYMCA.ORG

Summer Day Camp 2020

Child's Information

Child's Name and Nick Name _____ ☐ female ☐ male
Child's Date of Birth_____/_____/_____ Age _____ Grade attending in Fall 2020_____
Child must have completed at least one full year of Kindergarten in order to attend
Street Address _____
City _____ State _____ Zip _____

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

Weeks Child Will Be Attending Summer Child Care

☐ Week 1: June 8 – June 12
☐ Week 2: June 15 - June 19
☐ Week 3: June 22 - June 26
☐ Week 4: June 29 - July 3
☐ Week 5: July 6 – July 10
☐ Week 6: July 13 - July 17
☐ Week 7: July 20 – July 24
☐ Week 8: July 27 – July 31
☐ Week 9: Aug. 3 – Aug 7
☐ Week 10: Aug. 10 - Aug 14
☐ Week 11: Aug. 17 - Aug. 21
☐ Week 12: Aug. 24 - Aug. 28

A $10 non-refundable deposit per week per child is due upon registration.

Parent/Guardian Information

Parent Name _____
Primary Number ( ) ☐ C ☐ H ☐ W
Secondary Number ( ) ☐ C ☐ H ☐ W
Email _____
Date of Birth _____

Parent Name _____
Primary Number ( ) ☐ C ☐ H ☐ W
Secondary Number ( ) ☐ C ☐ H ☐ W
Email _____
Date of Birth _____

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. (Do not forget to include yourselves). 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

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 videotapes for the promotion of the Akron Area YMCA.

Parent/Guardian Signature _____ Date _____

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Permission for Routine Walks

Weather permitting, I give permission for my child _____ to accompany his/her class/group 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 _____

Please Note

The Y will provide sunscreen and bug spray as needed to your child. If you choose not to use the provided supply, the following may be brought to the center for your child:

- Sunscreen (seasonal) must be age-appropriate
- Insect Repellent formulated for children

They require completion of the "Request for Administration of Medication by Child Care Personnel" form (#01217) that is included in this packet.

Child's Name _____

2020 Center Policies Agreement

Please read the policies carefully and **initial** in each box.

☐ 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 $15.00 for every 15 minute increment per family will be imposed if my child(ren) is picked up after the center's designated closing time (6:30 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 Day Camp Registration Packet and agree to all terms therein for my child(ren) to receive childcare. I 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 a mobile device 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** _____

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.) _____

Are there personality and behavior characteristics that would be useful to know about your child? (shy, energetic, sensitive, etc.) _____

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

_____

What routines/actions or items do you use to comfort your child? _____

_____

What causes your child to feel angry or frustrated?_____

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

_____

What are your child's sleep habits? (difficult to wake up, uses a comfort item to fall asleep, etc.)

_____

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? _____

What other information would be helpful for the staff caring for your child to know? _____

_____

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	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/home?

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/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 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 family child care 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, 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 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 and 5101:2-13-15. 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.

Allows the Y to Provide Sunscreen

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☑ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage
Sunscreen (Equate SPF 50)	quarter sized

To be administered at the following times	For the following period of time
prior to outdoor play	M-F 6:30 am - 6:30 pm; June 8, 2020 - August 14, 2020

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement
Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.

Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Allows the Y to Provide Insect Repellent

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☑ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage
Insect Repellent (Cutter)	even spray

To be administered at the following times	For the following period of time
prior to outdoor play	M-F 6:30 am - 6:30 pm; June 8, 2020 - August 14, 2020

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.		
Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Use for Any Additional Medical Needs Part 1

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth

Special Health Conditions

Symptoms to watch for and emergency action to be taken if the following symptoms occur

Activities/foods/environmental conditions to avoid, if applicable

Medical procedures to be followed and expected benefit of treatment, if applicable

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

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

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

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

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

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No
Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Use for Any Additional Medical Needs Part 2

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

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
	M-F 6:30 am - 6:30 pm; June 8, 2020 - August 14, 2020

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.

Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

AUTOMATIC DRAFT FORM
2020-2021

Child's Name: _____

Parent's Name: _____

Program: _____

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

___ Checking Account (please attach a voided check)

Bank Name: _____

Routing Number: _____

Account Number: _____

___ Debit/Credit Card (circle: 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/month of service.**
- **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**

LONGWOOD BRANCH YMCA
8761 Shepard Rd.
Macedonia, OH 44056
330 467 8366

akronymca.org

The Y strives to make programs and membership available to all. Financial assistance may be available to those who qualify.