



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# A GREAT PLACE TO GROW

## School Age Care

2020-2021 Registration Packet  
Monday – Friday, 6:30 am – 6:00 pm  
Serving Grades K-6

### Our Dedicated Staff:

Derek Mercer, Executive Director  
Melanie Mayer, Youth Enrichment Director  
Angela Travarca, Assistant Child Care Director  
Beth Noga, Business Manager

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

[akronymca.org](http://akronymca.org)



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

Mission: To put Christian principles into practice through programs that build a healthy spirit, mind and body for all.

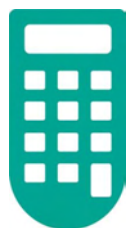
Connect with us!





# PARENT INFORMATION PAGE

Tear off and keep for your records!



## DATES TO REMEMBER

**Child Care Begins:** Tuesday, Sep 8

**Child Care Ends:** Thursday, May 27



## MEDICATIONS/MEDICAL NEEDS

-The forms "Child Medical/Physical Care Plan" & "Request for Administration of Medication" only need to be completed if your child has specific medical needs, such as asthma or allergies.

-We do not allow medications to be stored in the school nurse's office. YMCA staff must have additional medication, located at our Before and After School site.



## CHILD CARE AT THE YMCA

Non-school day care will be located at the Longwood Branch YMCA from 6:30 am – 6:00 pm.

\*Please send your child to the Y with a nut-free lunch (we are a nut-free facility)



## DO NOT BRING TO OUR PROGRAMS

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



## PARENT HANDBOOK

An electronic copy of our parent handbook will be emailed to you upon registration. It is also located on our website.

A paper copy will be provided upon request.



## PLEASE NOTE

\*Annual \$40 registration fee is due at the time of registration for all programs (waived for 2020-2021 school year)

\*Must be pre-registered for all child care programs.

\*Three or more days constitute a full week and corresponding weekly fees will be charged accordingly.



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 Executive Director, Derek Mercer, for processing at 330-467-8366 ext 2 or [derekm@akronymca.org](mailto:derekm@akronymca.org)



## WHO TO CALL:

**MELANIE MAYER**  
YOUTH ENRICHMENT DIRECTOR  
330-467-8366 EXT 3  
[MELANIEM@AKRONYMCA.ORG](mailto:MELANIEM@AKRONYMCA.ORG)

**ANGELA TRAVARCA**  
ASSISTANT CHILD CARE DIRECTOR  
330-467-8366 EXT 6  
[ANGELAT@AKRONYMCA.ORG](mailto:ANGELAT@AKRONYMCA.ORG)



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# Child Care Information

## Longwood Branch YMCA

CARE SITE	LOCATION	TIMES
Lee Eaton Elementary License #2190020099	115 Ledge Road Northfield, OH 44067	School dismissal - 6:00 pm (only after care available)
Ledgeview Elementary License #2190020126	9130 Shepard Road Macedonia, OH 44056	6:30 am - bell School dismissal - 6:00 pm
Northfield Elementary License #2190020129	9370 Olde 8 Road Northfield, OH 44067	6:30 am - bell School dismissal - 6:00 pm
Rushwood Elementary License #2190020127	8200 Rushwood Lane Sagamore Hills, OH 44067	6:30 am - bell School dismissal - 6:00 pm
Longwood Branch YMCA (for all non-school & snow days) License #103894	8761 Shepard Road Macedonia, OH 44056	6:30 am - 6:00 pm

2020-2021 RATES			
	Yellow Plan	Orange and Red Plan	Purple Plan
<b>Before Care Only</b>	\$50/week	\$40/week	N/A
<b>After Care Only</b>	\$70/week	\$45/week	N/A
<b>Before AND After Care</b>	\$95/week	\$55/week	N/A
<b>All Day Care (Virtual Days)</b>	N/A	\$120/week	\$190/week
<b>Blended Learning #1: 3 Virtual Days &amp; 2 Before Care Days</b>	N/A	\$160/week	N/A
<b>Blended Learning #2: 3 Virtual Days &amp; 2 After Care Days</b>	N/A	\$165/week	N/A
<b>Blending Learning: #3: 3 Virtual Days &amp; 2 Before &amp; After Care Days</b>	N/A	\$175/week	N/A
<b>Fun/Snow Days</b>	\$190/week; \$40/day	\$190/week; \$40/day	\$190/week; \$40/day
<b>*If you are a member at a YMCA membership branch, ask about our membership rates.</b>			



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# 2020-2021 Fun Days

Longwood Branch YMCA

## OCTOBER

9TH

## NOVEMBER

3RD

23RD, 24TH, 25TH

30TH

## DECEMBER

21ST, 22ND, 23RD

28TH, 29TH, 30TH

## JANUARY

18TH & 25TH

## FEBRUARY

15TH

## APRIL

2ND

5TH, 6TH, 7TH, 8TH, 9TH

Registration for Fun days will begin 2 weeks prior to each day off.

For information on the structure of Fun Days and what/what not to bring, please see the Fun Days FAQ sheet. Any additional questions can be directed to Melanie Mayer or Angela Travarca.



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# Child Care Selection

Longwood Branch YMCA

**Child's Name:** \_\_\_\_\_

**Admission/Start Date:** \_\_\_\_\_

## PLEASE SELECT YOUR CHILD'S SCHOOL

<input type="checkbox"/> Lee Eaton	<input type="checkbox"/> Ledgerview	<input type="checkbox"/> Northfield	<input type="checkbox"/> Rushwood
------------------------------------	-------------------------------------	-------------------------------------	-----------------------------------

## 2020-2021 BEFORE & AFTER CARE

Please indicate which days you will need Before and After Care below.

**Before Care Only**

☐ M ☐ T ☐ W ☐ Th ☐ F

**After Care Only**

☐ M ☐ T ☐ W ☐ Th ☐ F

**Before AND After Care**

☐ M ☐ T ☐ W ☐ Th ☐ F

## 2020-2021 ALL DAY CARE

Please indicate which days you will need All Day Care below.

**All Day Care**

☐ M ☐ T ☐ W ☐ Th ☐ F

**If there are any changes to your child's enrollment, please contact a member of the Longwood Branch YMCA administrative office.**

### Child's Information

Child's Name and Nick Name \_\_\_\_\_ ☐ male ☐ female  
Child's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Grade in September 2020 \_\_\_\_  
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 an issue.)

### Parent/Guardian Information

Parent Name _____	Parent Name _____
Primary Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W	Primary Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W
Secondary Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W	Secondary Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W
Email _____	Email _____
Date of Birth _____	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 (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W	Second Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W
Name _____	Relation _____
Primary Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W	Second Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W
Name _____	Relation _____
Primary Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W	Second Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W
Name _____	Relation _____
Primary Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W	Second Number (    ) <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> 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 \_\_\_\_\_  
=====

### Permission for Routine Walks

As part of our curriculum, and weather permitting, we routinely include outdoor walks and/or playground time. At any time you may request that your child remains inside during these routine walks. I give permission for my child \_\_\_\_\_ to accompany his/her class on routine walks outdoors and on the grounds of the program.

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

Sunscreen and insect repellent formulated for children may be brought to the center for your child. They require completion of a "Request for Administration of Medication by Child Care Personnel" form (#01217) that is included in this packet.

On non-school days, please provide a brown bag lunch that meets 1/3 of the recommended daily nutritional allowances per USDA guidelines. **THE Y IS A NUT FREE FACILITY. (Please do not pack your child peanut butter or anything including nuts)**

Child's Name \_\_\_\_\_

## 2020-2021 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 \$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 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 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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) 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				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. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) 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?					
<b>Emergency Contacts:</b> Parents <b>cannot be listed</b> 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 <b>if you cannot be reached</b> . 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 <b>or medical personnel</b> 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? <input 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	<b>OR</b>  <b>Do not sign both</b>	<u>Do Not Give Permission</u> to Transport
Program or Home Name Longwood Branch YMCA  <b>has permission</b> 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.  <div style="display: flex; justify-content: space-between;"> <span>Parent's Signature</span> <span>Date</span> </div>		<del>           Program or Home Name   <b>does not have permission</b> 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:   <div style="display: flex; justify-content: space-between;"> <span>Parent's Signature</span> <span>Date</span> </div> </del>

#### Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>	
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.



Ohio Department of Job and Family Services  
**CHILD MEDICAL/PHYSICAL CARE PLAN**  
**FOR CHILD CARE**

Use for Any  
**Additional Medical Needs**  
**Part 1**

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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete JFS 01217 "Request for Administration of Medication")</i> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Training Instructions <i>(Trainer must be a parent or certified professional)</i>			
Signature of Trainer			Date
Signature of trained providers, substitutes or child care staff members who have been made aware of the condition. <i>(There must always be a trained caregiver present when the child is present)</i>			
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
<i>(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)</i>			
Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> 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





Ohio Department of Job and Family Services  
**REQUEST FOR ADMINISTRATION OF MEDICATION  
 FOR CHILD CARE**

<b>Box 1</b>	The following section must always be completed by the parent/guardian.		
Check all that apply and complete all of the information.			
<input type="checkbox"/> Prescription Medication		<input type="checkbox"/> Nonprescription Medication	
<input type="checkbox"/> Topical Product or Lotion		<input type="checkbox"/> Refrigeration Required	
		<input type="checkbox"/> Food Supplement	
		<input type="checkbox"/> 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 Mon-Fri, 9 am - 12 pm; September 8, 2020 - May 21, 2021	
<input type="checkbox"/> 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
<b>Box 2</b>	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.





# TOGETHERHOOD STARTS HERE

## We will work together to reach my goals!

My name: \_\_\_\_\_ Parent name: \_\_\_\_\_

Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Goal for my Body:

Action Step 1:

Action Step 2:

Action Step 3:

Goal Accomplished

☐

Goal for my Mind:

Action Step 1:

Action Step 2:

Action Step 3:

Goal Accomplished

☐

Goal for Social Responsibility:

Action Step 1:

Action Step 2:

Action Step 3:

Goal Accomplished

☐

Goal for my Character:

Action Step 1:

Action Step 2:

Action Step 3:

Goal Accomplished

☐

These people will help me reach my goals:

This is how I will feel when I reach my goal (draw or write it):

My parent's goals for me:

Goal Accomplished

☐





FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

**AUTOMATIC DRAFT FORM  
2020-2021**

**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/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.

