FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

# A GREAT PLACE TO GROW

## SCHOOL AGE PROGRAM

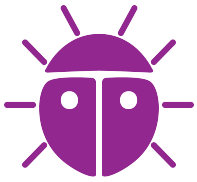
2021-2022 Registration Packet
Monday – Friday 6:30 am – 6:00 pm
Serving Grades K-6

**Our Dedicated Staff:**
Derek Mercer, Executive Director
Melanie Mayer, Youth Enrichment Director
Angela Travarca, Assistant Child Care Director

**Longwood Branch YMCA**
8761 Shepard Road, Macedonia OH 44056 • akronymca.org/longwood • 330.467.8366

# PARENT INFORMATION PAGE

Tear off and keep for your records!



## DATES TO REMEMBER

**Child Care Begins:** Thursday, Aug. 26

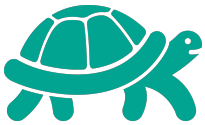
**Child Care Ends:** Tuesday, June 7

****Register by July 15th to get the $40 registration fee waived!!****

## 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.



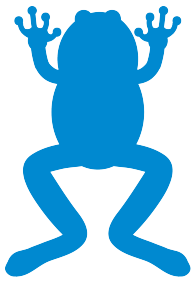
## CHILD CARE AT THE YMCA

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

- Please send your child with a nut-free lunch (we are a nut-free facility).

## DO NOT BRING TO OUT PROGRAMS

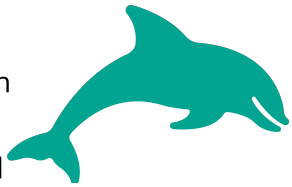
- Nuts of Any Kind
- Open Toe Shoes of Any Kind (ex. Flip Flops, Crocs)
- Electronics or Cell Phones
- Toys from Home
- Money
- Valuables



## 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.

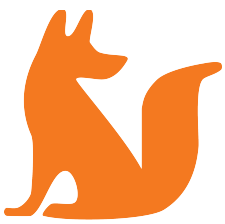


## PLEASE NOTE

- Annual $40 registration fee is due at the time of registration for all programs (waived prior to July 15).

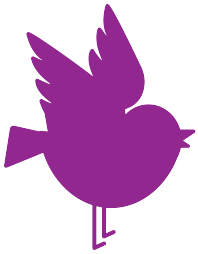
- Children must be pre-registered for all child care programs.

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



## FINANCIAL ASSISTANCE

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 or contact Executive Director, Derek Mercer, for processing at 330-467-8366 ext 2 or derekm@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

the YMCA

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# Child Care Information

## Longwood Branch YMCA

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

| 2021-2022 RATES | |
|---|---|
| **Before Care Only** | $50/week; $20/day |
| **After Care Only** | $75/week; $25/day |
| **Before AND After Care** | $100/week; $35/day |
| **Fun/Snow Days** | $190/week; $45/day |

***If you are a member at a YMCA membership branch, ask about our membership rates.**

| 2021-2022 FUN DAYS | |
|---|---|
| **SEPTEMBER** | **JANUARY** |
| 17TH | 17TH, 21ST |
| **OCTOBER** | **FEBRUARY** |
| 8TH | 18TH, 21ST |
| **NOVEMBER** | **MARCH** |
| 2ND, 24TH, 29TH | 25TH, 28TH - 31ST |
| **DECEMBER** | **APRIL** |
| 20TH - 23RD, 27TH - 30TH | 1ST, 15TH, 18TH |

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# Child Care Selection

## Longwood Branch YMCA

**Child's Name:** _____

**Admission/Start Date:** _____

| PLEASE SELECT YOUR CHILD'S SCHOOL | | | |
|---|---|---|---|
| ☐ Lee Eaton | ☐ Ledgeview | ☐ Northfield | ☐ Rushwood |

| 2021-2022 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 |

**PLEASE NOTE:**

- Enrollment for three or more days constitute a full week and corresponding weekly fees will be charged accordingly.
- Any changes to your child's enrollment must be submitted prior to the Thursday before attendance; payments are pulled early Friday and may not be refundable.

_____ _____

**Signature** **Date**

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

# School Year 2021-2022

## Child's Information

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

Child's Date of Birth_____/_____/_____Age _____ Grade in September 2021_____

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( ) ☐ 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 _____

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

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 _____

==========

## Permission for Routine Walks

As part of our curriculum, the Y routinely includes outdoor walks and/or playground time. Weather permitting, I give permission for my child _____ to accompany his/her class/group 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**_____

# 2021-2022 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 (6:00 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 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** | | | **Do Not Give *Permission* to Transport** | |
|---|---|---|---|---|
| Program or Home Name<br>Longwood Branch YMCA | | **OR**<br>**Do not sign both** | 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.

Use for Any Additional Medical Needs

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")*<br>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?<br>☐ 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?<br>☐ 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

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 |
|---|---|
| | |

☐ 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 |
| | | | |
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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

## 2021-2022

**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**