the YMCA

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LEARN GROW THRIVE

Education & Leadership

2021-2022 Preschool Enrollment Packet

Natalie Frantz
Youth Enrichment Director
(330)923-9622 ext. 1914
Natalief@akronymca.org

RIVERFRONT YMCA
544 BROAD BLVD
CUYAHOGA FALLS, OH 44221
(330) 923-9622

akronymca.org

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

YMCA Preschool

Enrollment Packet

Admission Date (first day attending) _____/_____/_____

Child's Name _____Child's Birthdate

_____/_____/_____ Age_____

Child's Nickname _____ _____ Male _____

Female

How you would like your child's name to appear on name tag/learn to write

_____

Parent/Guardian Name _____ Parent Date of Birth

_____

Parent/Guardian Name _____ Parent Date of Birth

_____

Street Address

_____

City _____ State _____ Zip _____ Home Phone (___-

____) _____-_____

Parent e-mail address (will be used for important information only)

_____

Authorized Persons to Pick Up Child

Persons authorized to pick up my child:

Parent/Guardian _____

Relationship_____

Phone: Home _____ Work _____ Cell

_____

Description

_____

_____

Parent/Guardian _____ Relationship

_____

Phone: Home _____ Work _____ Cell

_____

Description _____-

_____

Name _____ Relationship

_____

Phone: Home _____ Work _____ Cell

_____

Description

_____

_____

Name _____ Relationship

_____

Phone: Home _____ Work _____ Cell

_____

Description

_____

_____

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

Class Attending (Please check the class you wish to enroll your child)

_____ **T, TH morning**
- Swim Combo
- 8:45- 11:30
- 3 and 4 year olds

_____ **T, TH morning**
- Gymnastics Combo
- 9:00-11:45
- 3 and 4 year olds

_____ **M, W, F morning**
- Swim combo
- 8:45-11:30
- 4 and 5 year olds

_____ **M, T, W, TH, F morning**
- Swim/Gymnastics Combo
- 9:00-12:00
- Child MUST be entering Kindergarten the following school year

--Please note that a class may be cancelled due to low enrollment. If this occurs, you will be notified and we will work with you to choose a different class.

Monthly Rates

Class	YMCA Member Monthly Rate	Program Member Monthly Rate
2 days/week	$110	$130
3 days/week	$140	$160
5 days/week	$180	$210
Registration Fee	$40	

Payment Information

Monthly Payment Amount: _____

Please draft payment on the _____ day of the month (must choose a date between the 1st and the 15th)

Account: ☐ Use account on file ending in _____ (verify at front desk)

☐ Provide account info at front desk

$40 Registration fee:

☐ Check is attached

☐ Cash is attached

☐ Draft from account ending in _____ on ____/____/____ (date)

Person responsible for tuition: _____

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

If yes, what is his/her name? _____

Child's name _____

2021-2022 Center Policies Agreement

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

☐ I understand there is a **$40.00 nonrefundable registration fee** per child due upon registration.

☐ I understand that preschool tuition is due by the 15th day of the month **via auto draft**. I can choose any day between the 1st and the 15th of the month for the tuition to be drafted from my account.

☐ I understand that if my preschool tuition falls two weeks behind I will be asked to withdraw my child until payment is made.

☐ I understand that 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 membership until balance is paid.

☐ I understand that there will be a $10 fee assessed for any and every returned payment.

☐ I understand that state licensing requires a **Child's Medical Statement**, which must be signed by a physician, to be on file with the YMCA Preschool within 30 days of the first day of school.

☐ I understand that staff will contact Summit County Children Services if my child remains at the Center 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 if I withdraw my child from the preschool program, I will be responsible for the current month's tuition. If my child attends one or more days during the month, I am responsible to pay that month's tuition in-full. The director must be notified of the child's withdrawal.

☐ 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 have read the YMCA Preschool Registration Packet and agree to all terms therein for my child to receive child care.

☐ I understand that I forfeit the privilege of preschool at the Center if all policies are not followed.

☐ **I understand that my child must be fully potty trained and able to use the restroom by his or herself without assistance.**

Parent/Guardian Signature _____ Date _____

Want to access and manage your account online?
Call the YMCA and ask for Natalie to get started!

Child's Name _____

Please read carefully and respond to the following permission forms:

Photograph Consent

I **give** my permission to have my child _____to be in photographs, slides or videotapes for promotion of the YMCA, as well as photos on the class website.
I **do not give** permission for my child _____ to be photographed for promotion of the YMCA.

Parent/Guardian Signature _____ Date _____

Child Drop-Off Policy/Pick-Up Policy

*When you enroll your child(ren) at any YMCA Preschool, it is to be understood that our policy is for you to bring your child(ren) into the Center each morning and let one of the staff members know that your child(ren) has arrived.
*We are not legally responsible for your child(ren) when they are dropped off outside the building. We are especially concerned about this with bad weather.
*As a parent or guardian, I am aware that the YMCA staff is not responsible for my child unless I bring my child(ren) into the classroom when arriving each morning.
*I understand that state law requires me to sign my child in and out each day.
*I also understand that state law requires that I notify staff that my child is leaving for the day.

Parent/Guardian Signature _____ Date _____

Permission for Swimming

As part of our curriculum, and for our Swim combo and Swim Gym Combo, we include swimming in our program.
I **give** permission for my child _____ to swim throughout the 2021-2022 school year for his or her class.

Parent/Guardian Signature _____ Date _____

Permission for Gymnastics

I give permission for my child, _____, to participate in the gymnastics portion of his/her YMCA preschool class.

Parent/Guardian Signature _____
Date_____

Ohio Department of Job and Family Services

PERMISSION TO PARTICIPATE IN SWIMMING ACTIVITIES FOR CHILD CARE

Written parental permission is required for the water activities your child will be engaging in (check all that apply for this activity)

- ☑ Child swimming in water 18 inches or more in depth
- ☐ Child participating in activities near water 18 inches or more in depth (no water activities planned)
- ☐ Infants and toddlers using wading pools

I give permission for my child to participate in the following swimming/water activities

Swim Site
Riverfront YMCA

Date(s)
9/7/2021-5/13/2022

Departure/Arrival Times from Center
N/A - pool on site

Mode of Transportation (parent's driving, provider vehicle, public transportation, school bus, etc.)
N/A - pool on site

Child's Name	Child's Date of Birth

My child is a ☐ Swimmer ☐ Non swimmer

Parent's Signature	Date

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:

Child's Name: _____

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?

_____

Ohio Department of Job and Family Services

DEVELOPMENTAL AND EDUCATIONAL GOALS FOR STEP UP TO QUALITY (SUTQ)

Name of Child	Date of Birth

For Three to Five-Star Rated programs, the program must work with families to develop goals for children. These goals must be updated at least annually.

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Developmental/Educational Goal

Action Steps	Person(s) Responsible	Resources Needed	Timeline	Comments on Progress

Lead Teacher's Name	Signature	Date

Parent/Guardian's 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			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			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.		**OR** 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. ☐ 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.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

Signature of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner	Date of Examination

Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner	Telephone Number

Street Address

City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS

Exceptions to Immunization requirements pursuant to 5104.014 ORC (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

Signature of Parent	Date of Signature

Optional

Recommended Assessments/Screenings

Vision	☐ Yes ☐ No	Lead	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Hemoglobin	☐ Yes ☐ No
Dental	☐ Yes ☐ No	Other	

Measurements		**Notes**
Height		
Weight		
BMI		

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

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.