SUMMER ADVENTURE AWAITS

Summer Day Camp Enrollment Packet

May 31 – August 12

Serving children who have completed Kindergarten through age 12.

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.

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!

CAMP FEES

Registration Fee: $40.00 per child
YMCA Member: $180/ Week
Program Member: $200/week

Auto draft is REQUIRED. Account information must be provided at the front desk upon registration.

CAMP TIMES

Before Care: 6:30-9:00 am
Camp: 9:00 am-4:00 pm
After Care: 4:00-6:00 pm

Before and After Care are provided at no extra charge for children attending day camp. The child needs to arrive at camp by 8:45 am each day.

WHAT TO BRING

- Camp t-shirt
- Closed toe shoes (tennis shoes)
- Packed lunch
- Water bottle
- Backpack
- Swimsuit and towel

****LABEL ALL ITEMS****

WHAT NOT TO BRING

-Open toe shoes (flip flops)
-Crocs
-Cell phones and other electronics
-Toys from home
-Valuables
-Two Piece Bathing Suits

DATES TO REMEMBER

First Day of Camp: May 31
Last Day of Camp: August 12
No Camp: May 30th and July 4th

Open house on May 25, 2022 from 6:30 pm- 8:30 pm

PASSPORT PROGRAM

Register your child for 6 or more weeks of Day Camp and receive 20% off a week of Adventure Camp (Overnight) at Camp Y-Noah! To take advantage call Camp Y-Noah at 877-GOT-CAMP!

From exercise to education, from volleyball to volunteering, from preschool to preventive health, the Y doesn't just strengthen bodies- we strengthen community! The YMCA strives to make programs and memberships available to all. Financial Assistance is available to those who qualify.

WHO TO CALL: 330-923-9622

Laura Davisson:
Youth Enrichment Director
laurad@akronymca.org

Grace Cominsky
Assistant Child Care Director
gracec@akronymca.org

Natalie Frantz:
Youth Enrichment Director
natalief@akronymca.org

Summer Day Camp 2022

Please select the weeks and/or service you need:

☐ Week 1: May 31-June 3 (no camp 5/30)
☐ Week 2: June 6-June 10
☐ Week 3: June 13-June 17
☐ Week 4: June 20-June 24
☐ Week 5: June 27-July 1
☐ Week 6: July 4-July 8 (no camp 7/4)
☐ Week 7: July 11-July 15
☐ Week 8: July 18-July 22
☐ Week 9: July 25-July 29
☐ Week 10: August 1-August 5
☐ Week 11: August 8-Augut 12

Payment Information:

Weekly Payment Amount: ☐ $180 (YMCA Members) ☐ $200 (Non-Y Members) ☐ Other (contact director)
Please draft payment: ☐ Weekly on Fridays ☐ Other (contact director)
Account: ☐ Use account on file (ending in _____) ☐ Provide account info at registration ☐ FLEX (contact director)
Person responsible for tuition: _____
Do you have Title XX? ☐ Yes ☐ No
Are you or another parent/guardian currently an employee of the YMCA? ☐ Yes ☐ No
If yes, what is his/her name? _____

Child and Family Information:

Child's Name and Nick Name _____ ☐ male ☐ female
Child's Birth date _____ Age _____
Street Address _____
City _____ State _____ Zip _____
School child is attending in Fall 2022 _____
Grade child is entering in Fall 2022 _____
Shirt Size (please circle) YS YM YL AS AM AL AXL

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

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

Authorized Persons to Pick Up Child

Your child will only be released to a parent/guardian or persons listed in this section. Staff will require a government issued identification before releasing your child.

Name _____ Relation _____
Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Name _____ Relation _____
Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Name _____ Relation _____
Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Name _____ Relation _____
Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

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.

****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 _____

2022 Center Policies Agreement

Please read the policies carefully and **INITIAL** all lines.

_____ 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 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.

_____ CANCELLATION POLICY: 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 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/Medina 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 BASE/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 not 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 _____

Program Waiver

I/We understand that there is a risk of serious injury associated with the use of the YMCA facilities, participation in YMCA programs and use of exercise and other equipment. As a condition of my membership I agree to assume the risk of injury arising from my use of the facilities, programs, equipment and for all other matters at all YMCA locations or programs whenever occurring. On behalf of myself and my heirs, administrators and agents and contractors harmless from all such claims for injury and damage. I understand that I would not be permitted to participate in any YMCA program or use any YMCA facility or equipment without signing this agreement. I authorize the Akron Area YMCA or its designees, agencies and contractors to create, have and use photographs, slides and videotapes containing my image for its recordkeeping or marketing/public relations programs.

Parent/Guardian Signature _____ Date _____

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Photograph Consent

I give my permission for my child _____ to be photographed 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 group on routine walks in the neighborhood of the YMCA.

Parent/Guardian Signature _____ Date _____

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Permission for Routine Field Trips

I give permission for my child _____ to accompany his/her group on routine field trips throughout the week from 9:00am-4:00pm May 31- August 12, 2022. Transportation is provided by school busses (CF City Schools Transportation Services). Specific dates and trip locations will be available by May 25, 2022.

Parent/Guardian Signature _____ Date _____

Permission for Rock Wall

I give permission for my child _____ to climb the rock wall at the Riverfront YMCA from June 1- August 13, 2021.

Parent/Guardian Signature _____ Date _____

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Permission to Participate in Swimming Activities

I give permission for my child to participate in swimming activities near water two feet or more in depth – and/or water activities planned in water two feet or more in depth, including wading pools/splash pads

The center will be providing 1 additional adult above the required staff/child ratio.

Swim Site	Riverfront YMCA Pool (544 Broad Blvd., Cuyahoga Falls, OH 44221) Wadsworth YMCA Outdoor Pool (623 School Drive, Wadsworth, OH 44281)
Date(s)	May 31- August 12, 2022
Departure/Arrival Times from Center	9:00 am-4:00 pm
Mode of Transportation	Pool on site Transportation is provided by school busses (CF City Schools Transportation Services)
My child is a	☐ Swimmer ☐ Non Swimmer

I give permission for my child to participate in the swimming/water activities listed above:

Child Name: _____ Date of birth:_____

Parent/Guardian Signature _____ Date _____

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Child Drop-Off/Pick-Up Policy

When you enroll your child in any YMCA Day Camp, 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 _____

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: _____

Brothers and sisters (names and ages):

_____

Child lives with:

_____

What is the primary language spoken in your child's home? _____

Does your child have any particular fears such as dogs, storms, etc.?

_____

What are your child's special interests?

_____

_____

Have there been any changes or transitions in your child's life recently, such as divorce, new home, death, etc.?

_____

_____

Are there additional personality and behavior characteristics that would be useful to know about your child?

_____

_____

How do you reassure or reward your child?

_____

_____

How do you discipline your child?

_____

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

_____

_____

Please list the three most important things you would like your child to work on while in our program:

_____

_____

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

_____

_____

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 #1		Relationship to Child	
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City		State	Zip
Email Address *(if applicable)*		Cell Phone *(if applicable)*	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information 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 #2		Relationship to Child	
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City		State	Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address		City	

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information 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 able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ 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 Riverfront 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, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition

Does this health condition require medication or medical food? ☐ Yes (If Yes, complete Part II) ☐ No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid? ☐ Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

Part II: Conditions Requiring Medication or Medical Food

Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

(If no medications or medical foods are required for the condition, skip Part II).

If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name	Date of Birth	Weight *(if needed to determine dosage)*

Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date

☐ **Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature

Part III: Administration of Medication or Medical Food Training Authorization

Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)

Part III must be completed

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure	**Complete Only One Section**	**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided instructions for care and/or training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the proced for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.	Administrator/Provider Signature	Date of Signature

This 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, a new form must be completed.

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
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Part IV: Documentation of Administration of Medication or Medical Food

Completed by child care staff member, family child care provider or in-home aide for the child listed on this form

All medication or medical food must be documented when administered. Document each medication or medical food on its own page. Incomplete information elevates the level of risk to children. If more than one medication or medical food is needed, make a copy of this page for each medication or medical food.

This medication or medical food is not to be administered until after the child has received the first dose or application at least once prior to the program administering a dose to avoid unexpected reactions. Emergency medications for the child are exempt from this requirement.

Child's Name	Name of medication/medical food

Date	Time	Dosage	Signature of designated person administering medication