FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

A GREAT PLACE TO GROW

PRESCHOOL PROGRAM

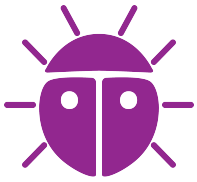
2022-2023 Registration Packet
Monday – Friday 9:00 am – 12:00 pm
Serving Preschool, 3-5 years old

Our Dedicated Staff:
Derek Mercer, Executive Director
Angela Travarca, Youth Enrichment Director
Olivia Gombert, Assistant Child Care Director
Amy Crawford, Lead Preschool Teacher

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!



PRESCHOOL & PRE-K

M-F, 9 am – 12 pm; Ages 3-5

5-day rate (M-F): $255/month

3-day rate (MWF): $185/month

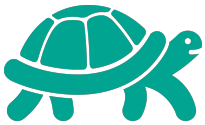
2-day rate (TuTh): $145/month

DATES TO REMEMBER

Preschool Begins: Tuesday, Sept. 6

Preschool Ends: Friday, May 26

*We follow the Nordonia Hills School District calendar for all days off. Preschool will be closed on all scheduled school days off, as well as snow days.



BRING TO THE Y

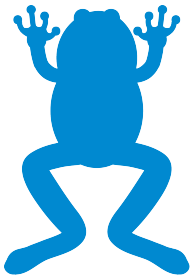
- Small Bag or Backpack
- Extra Clothes (Underpants, Pants/Shorts, Shirts, Socks)
-Take Home Folder (provided by the Y)

DO NOT BRING TO THE Y

- Nuts of Any Kind (Nut-Free Facility)
- Open Toe Shoes of Any Kind

(ex. Flip Flops, Crocs)

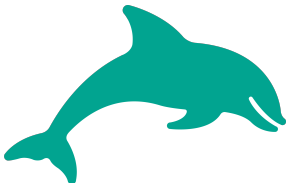
- Electronics or Cell Phones
- Toys from Home
- Money
- Valuables



NOTES ON COMPLETING PAPERWORK

-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

-The “Child Medical Statement for Child Care” needs to be completed by your child’s physician and returned within 30 days of their start date



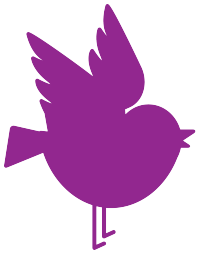
PLEASE NOTE

*Annual $40 registration fee is due at the time of registration for all programs.

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

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

ANGELA TRAVARCA
Youth Enrichment Director
330-467-8366 ext 3
angelat@akronymca.org

OLIVIA GOMBERT
Assistant Child Care Director
330-467-8366 ext 6
oliviag@akronymca.org

Preschool Year 2022-2023

Program Selection: ☐ 2-Day (TuTh) ☐ 3-Day (MWF) ☐ 5-Day (M-F)

Child's Information

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

Child's Date of Birth_____/_____/_____Age _____

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

Weather permitting, I give permission for my child _____ to accompany his/her class/group on routine walks on Akron Area YMCA grounds.

Parent/Guardian Signature _____Date _____

==========

Child Drop-Off/Pick-Up Policy

When you enroll your child in any YMCA Child Care Program, it is to be understood that our policy is for you to bring your child into the center each morning, sign the attendance sheet, and let one of the staff members know your child has arrived. Please note: we are not legally responsible for your child when he/she is dropped off without completing the above procedure.

I understand that state law requires me to sign my child in and out each day, as well as notify staff that my child is leaving for the day.

Parent/Guardian Signature _____Date _____

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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.

WE ARE A NUT FREE FACILITY. (Please do not pack your child peanut butter or anything including nuts)

Child's Name_____

2022-2023 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 #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 Longwood Branch YMCA			~~Program or Home Name~~	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			~~**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:~~	
Parent's Signature	Date		~~Parent's Signature~~	~~Date~~

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

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

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 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 STATEMENT FOR CHILD CARE

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

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A - EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following *(please list in space below)*:

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below*)

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:	**Initials of Examining Health Care Practitioner**
☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent** Date

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

Use for Any Additional Medical Needs

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This form is to be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

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

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

Name of medication	Dosage	
	☐ See attached	
To be administered at the following times	For the following period of time	Medication expiration date

I understand:

1. *This form expires twelve months from the date of my signature, if box 2 has not been completed.*
2. *That my child must receive at least one dose of medication at home prior to the program administering the medication (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 when any of the following apply:

1. The nonprescription medication contains codeine or aspirin;
2. A physician's instruction is needed for a nonprescription medication;
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication;
4. The nonprescription 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

Instructions

☐ See Attached

Possible side effects to watch for are

☐ See Attached

The child is under my care and should receive the above medication as written. I understand this form expires twelve months from the date of my signature.

Signature of licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant	Date of Signature
Phone Number	

The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name	Name of Medication

Date	Time	Dosage	Signature of designated person administering medication

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

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

AUTOMATIC DRAFT FORM

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**