



FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# LEARN GROW THRIVE

## Education & Leadership

### 2023-2024 Preschool Packet

September 5th, 2023 -May 17th, 2024

Grace Cominsky  
Youth Enrichment Director

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

[akronymca.org](https://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!



**YMCA Preschool**

**2023-2024**

**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.

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## 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?

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What routines/actions or items do you use to comfort your child?

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What causes your child to feel angry or frustrated?

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

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What are your child's sleep habits? (Difficult to wake up, uses a comfort item to fall asleep, etc.)

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Does your child need assistance when using the toilet? If so, how?

---

What time(s), and for how long, does your child usually nap?

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What might you and/or your child be anxious about as he/she starts in this program?

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---

What are your expectations of this program?

---

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

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

\_\_\_\_\_ **T, TH morning**

- Swim Class
- 8:45- 11:45
- 3 and 4 year olds

\_\_\_\_\_ **M, W, F morning**

- Swim Class
- 9:00-12:00
- 4 and 5 year olds

\_\_\_\_\_ **M, T, W, TH, F morning**

- Swim/Gymnastics Combo
- 9:00-12:15
- 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**

| <b>Class</b>     | <b>YMCA Member<br/>Monthly Rate</b> | <b>Program<br/>Member<br/>Monthly Rate</b> |
|------------------|-------------------------------------|--|
| 2 days/week      | \$125                               | \$145                                      |
| 3 days/week      | \$155                               | \$175                                      |
| 5 days/week      | \$195                               | \$225                                      |
| Registration fee | \$40                                | \$40                                       |

**Payment Information**

Monthly Payment Amount: \_\_\_\_\_

Please draft payment on the \_\_\_\_\_ day of the month (must choose a date between the 1<sup>st</sup> and the 15<sup>th</sup>)

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 \_\_\_\_\_

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 2023-2024 school year for his or her class in water 18 inches or more in depth.

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 \_\_\_\_\_

Child's name \_\_\_\_\_

### 2023-2024 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 15<sup>th</sup> day of the month **via auto draft**. I can choose any day between the 1<sup>st</sup> and the 15<sup>th</sup> 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!



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 <input type="checkbox"/> Same as Child's   |                       |                       | Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No  |                       |                       |  |                           |  |
| If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email  |                       |                       |  |                           |  |
| Where can you be reached while your child is in this program/home?  |                       |                       |  |                           |  |
| Parent/Guardian Name #2   |                       |                       | Relationship to Child  |                           |  |
| Home Address <input type="checkbox"/> Same as Child's   |                       |                       | Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No   |                       |                       |  |                           |  |
| If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email  |                       |                       |  |                           |  |
| Where can you be reached while your child is in this program/home?  |                       |                       |  |                           |  |
| <b>Emergency Contacts:</b> Parents <b><u>cannot be listed</u></b> as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if <b><u>you cannot be reached</u></b> . 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 <b>medical personnel</b> in an emergency situation. |
| <input type="checkbox"/> 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.                              |
| <input type="checkbox"/> Not applicable  |
| List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.  |
| <input type="checkbox"/> Not applicable  |
| List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.  |
| <input type="checkbox"/> Not applicable  |

|              |
|--------------|
| Child's Name |
|--------------|

### Diapering Statement

|   |   |
|---|---|
| Is your child toilet trained? <input type="checkbox"/> Yes <i>(If yes, skip to Emergency Transportation Authorization section)</i><br><input type="checkbox"/> No <i>(If no, fill out the following:)</i> |   |
| The program's policy is to check diapers every ____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:  |   |
| <input type="checkbox"/> I agree with the program's schedule  | <input type="checkbox"/> I do not agree, please check my child's diaper every ____ hours. |

### Emergency Transportation Authorization

| Give <u>Permission</u> to Transport  | OR                 | Do Not Give <u>Permission</u> to Transport  |  |  |                    |      |
|--|--------------------|---|--|--|--------------------|------|
| Program or Home Name<br><br><b>has permission</b> to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported. | Do not sign both   | Program or Home Name<br><br><b>does not have permission</b> to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken: |  |  |                    |      |
| <table style="width: 100%;"> <tr> <td style="width: 80%;">Parent's Signature</td> <td style="width: 20%;">Date</td> </tr> </table>   | Parent's Signature | Date  |  | <table style="width: 100%;"> <tr> <td style="width: 80%;">Parent's Signature</td> <td style="width: 20%;">Date</td> </tr> </table> | Parent's Signature | Date |
| 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>      |      |
| This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care. |      |
| Parent/Guardian Signature(s)  | Date |
| Administrator/Designee Signature  | Date |

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

**Note:**

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 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  
**PERMISSION TO PARTICIPATE IN WATER AND SWIMMING ACTIVITIES  
FOR CHILD CARE**

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

- ☐ Water is directly accessible to child (no water activities planned)  
☐ Child swimming or playing in water 18 inches or more in depth  
☐ Infants and toddlers using wading pools

The program is providing additional adults or child care staff members that exceed the licensing ratio requirements for the water/swimming activity.

(The program is to meet the minimum ratio requirements outlined in rule).

☒ Yes      ☐ No

Swim Site  
Riverfront YMCA

Date(s)  
9/5/23-5/17/24

Departure/Arrival Times from Program  
N/A-Pool on site

Mode of Transportation (parents driving, provider vehicle, public transportation, school bus, etc.)  
N/A-Pool on site

**I give permission for my child to participate in the swimming/water activity listed above.**

Child's Name

Child's Date of Birth

My child is a      ☐ Swimmer      ☐ Non swimmer

Parent's Signature

Date

Ohio Department of Job and Family Services  
**DEVELOPMENTAL AND EDUCATIONAL GOALS**  
**FOR STEP UP TO QUALITY (SUTQ)**

|   |                       |                  |          |
|---|-----------------------|------------------|----------|
| Name of Child   |                       | Date of Birth    |          |
| <i>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.</i> |                       |                  |          |
| Developmental/Educational Goal  |                       |                  |          |
| Action Steps  | Person(s) Responsible | Resources Needed | Timeline |
|   |                       |                  |          |
| Developmental/Educational Goal  |                       |                  |          |
| Action Steps  | Person(s) Responsible | Resources Needed | Timeline |
|   |                       |                  |          |
| Lead Teacher's Name   |                       | Signature        |          |
|   |                       |                  |          |
| Parent/Guardian's Signature   |                       | Date             |          |
|   |                       |                  |          |

Ohio Department of Job and Family Services  
**CHILD MEDICAL STATEMENT FOR CHILD CARE**

|   |   |
|---|---|
| Child's Name ( <i>print or type</i> )   | Date of Birth   |
| <b>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):</b>  |   |
| <b>Section A- EXAMINATION</b>   |   |
| ✓ 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 ( <i>please list in space below</i> ):  |   |
|   |   |
| Check below, if applicable:   |   |
| <input type="checkbox"/> 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 _____ <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Weight _____  | Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| BMI _____   | Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No    |
|   | Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No     |
| Notes:  | Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | Other: _____  |
| 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.**

|  |  |
|--|--|
| <b>IMMUNIZATION (Complete ONLY ONE SECTION below)</b>  |  |
| <b>Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:</b>  |  |
| Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.   |  |
| <b>Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:</b><br><input type="checkbox"/> The above named child has been immunized against the diseases listed above.<br><br><i>If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):</i> | Initials of Examining Health Care Practitioner<br><br><br><hr/> Date |
| <b>Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):</b><br><input type="checkbox"/> 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<br><br><br><hr/> Date                            |