



Ages 3 - 5

Tuesday/Thursday Swim

8:45am - 11:45am

\$140/wk Members

\$160/wk Non-Members

Ages 4 & 5

(Entering Kindergarten 2027)

Monday/Wednesday/Friday

with swim lessons

9am - 12pm

\$170/wk Members

\$190/wk Non-Members

or

Monday - Friday

Swim/Gymnastics Combo

9am - 12:15pm

\$210/wk Members

\$240/wk Non-Members



Grace Cominsky, Director

330.923.9622

GraceC@akronymca.org

Riverfront Family YMCA Preschool 2026-2027

Registration Begins March 2, 2026

First Day of Class:

T,TH: September 8, 2026

M,W,F & M-F: September 9, 2026



Check out the
website
for more
information!



THE

Learn, Share, Grow

PLACE

YMCA Preschool

2026-2027

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.

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?

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?

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
- 8:45-11:45
- 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

Class	YMCA Member Monthly Rate	Program Member Monthly Rate
2 days/week	\$140	\$160
3 days/week	\$170	\$190
5 days/week	\$210	\$240
Registration fee	\$40	\$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 _____

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 2026-2027 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 _____

2026-2027 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 Grace to get started!

Ohio Department of Children and Youth
**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?					
Emergency Contacts: Parents cannot be listed 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 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 DCY 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 DCY 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 DCY 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 DCY 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a DCY 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 <u>Permission</u> to Transport		OR Do not sign both	<u>Do Not Give Permission</u> 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 5180:2-12-15, 5180:2-13-15, and 5180:2-14-04.

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 Children and Youth
**PERMISSION TO PARTICIPATE IN WATER AND SWIMMING ACTIVITIES
FOR CHILD CARE**

<p>Written parental permission is required for the water activities your child will be engaging in when: <i>(check all that apply for this activity)</i></p> <p><input type="checkbox"/> Water is directly accessible to child (no water activities planned) <input type="checkbox"/> Child swimming or playing in water 18 inches or more in depth <input type="checkbox"/> Infants and toddlers using wading pools</p>	
<p>The program is providing additional adults or child care staff members that exceed the licensing ratio requirements for the water/swimming activity. <i>(The program is to meet the minimum ratio requirements outlined in rule).</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
Swim Site	
Date(s)	
Departure/Arrival Times from Program	
Mode of Transportation <i>(parents driving, provider vehicle, public transportation, school bus, etc.)</i>	
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 <input type="checkbox"/> Swimmer <input type="checkbox"/> Non swimmer	
Parent's Signature	Date

Reset Form

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

Child's Name (<i>print or type</i>)	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 (<i>please list in space below</i>):	
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	
<i>Check below, if applicable:</i>	
<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 _____	Hearing _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
BMI _____	Dental _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lead _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
	Hemoglobin _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	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.

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
<input type="checkbox"/> The above named child has been immunized against the diseases listed above.	
<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>	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):	Signature of Parent
<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):	
	Date