

Cuyahoga Falls Before and After School Enrichment General Information 2026-2027

Care Site & License #	Schools Served	Location	Times
DeWitt YMCA BASE 100341	DeWitt	DeWitt Elementary 425 Falls Ave Cuyahoga Falls, 44221	7:00-8:30am 3:00-6:00pm
Lincoln YMCA BASE 100344	Lincoln	Lincoln Elementary 3131 W Bailey Rd Cuyahoga Falls, 44221	7:00-8:30am
Price YMCA BASE 100342	Price	Price Elementary 2610 Delmore St Cuyahoga Falls, 44221	7:00-8:30am
Richardson YMCA BASE 102888	Richardson	Richardson Elementary 2226 23 rd St Cuyahoga Falls, 44223	7:00-8:30am 3:00-6:00pm
Silver Lake YMCA BASE 100316	Silver Lake	Silver Lake Elementary 2970 Overlook Rd Silver Lake, 44221	7:00-8:30am

*Your child's **completed** packet must be turned in to the YMCA at least two business days before your child can start care.

Before and After School Enrichment Fees

\$40.00 registration fee waived if enrolled before July 15th, 2026

Weekly, Flat-rate Fees (Cuyahoga Falls)

Cancellation notification must be given no later than one week in advance.

There are no sibling discounts.

Program subject to change.

Program	Cuyahoga Falls School District	
	Y Member Rate	Non-Member Rate
Before Care Only	\$40.00	\$45.00
After Care Only	FREE	FREE
Before <u>AND</u> After Care	\$40.00	\$45.00
Registration Fee	\$40.00	\$40.00

Before and After School Enrichment General Information 2026-2027 (cont.)

Parent Handbook – The “Riverfront YMCA Child Care Parent Handbook” is available at the following link:
<https://www.akronymca.org/locations/riverfront-ymca/and-after-school>

A paper copy will be provided upon request.



Directors – Please feel free to contact a director with questions or concerns.

Laura Davisson – Cuyahoga Fall Schools

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laurad@akronymca.org

Cori Van Orman

Assistant Child Care Director

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Publicly Funded Child Care Recipients (PFCC) – Your TAPs authorization must be for the correct location. The YMCA and each Before and after School site is considered a different location to ODJFS. Please be sure to change locations for Fun Days/Snow Days to license 301735. Please see above for each location’s Licensing Number.



To apply for Publicly Funded Child Care (PFCC), please scan the QR Code to be taken to the ODJFS website. If you are denied, the YMCA may be able to help you with the cost of child care, please contact the director of your school district.

Medications/Medical Conditions – We do not allow medications to be stored in the school nurse’s office. In order for the YMCA to provide safe care to your child, we must have additional medication stored in our care, at our Before and After school sites. We will not accept medication left in the school nurses office as we cannot guarantee access to it. Inhalers/diabetes medications may be brought with your child, however they must be kept on your child’s person, not in a backpack. Before turning in your child’s packet, please contact a director to obtain DCY01236 and/or DCY01217 if your child requires the form.

Fun Days – You may drop off your child as early as 7:00am and your child must be picked up by 6:00pm. Pre-registration is required, a form for each Fun Day must be filled out and submitted to the YMCA or BASE staff. Forms will be available two weeks prior to each Fun Day at the YMCA front desk and BASE sites – there is also a blank form on our website.

Each Fun Day costs \$50 per day per child for participants. Registration is on a first come first serve basis. Fun Day Calendar can be found at: <https://www.akronymca.org/locations/riverfront-ymca/fun-day>

Snow Days – In the event of a Snow Day, care is provided at the Riverfront YMCA from 8:30am-6:00pm. Your child must be pre-registered for Snow Days in order to attend. Snow Day sign-up slips will go out to Before and After care sites in November. If registering your child after November, please contact a Youth Enrichment Director for assistance in signing up for Snow Days.

School Year Start and End Dates

Cuyahoga Falls: 8/19/2026-5/27/2027

Early Release Dates (after care is provided):

10/16/2026 3/12/2027 5/27/2027

Program and dates subject to change.

Riverfront YMCA Cuyahoga Falls Before and After School Enrichment 2026-2027

Please check all types of care you will need

- Before Care After Care
- Full Time Part Time

Anticipated Start Date: _____

If Part Time, what day/s? _____

Registration Fee:

A non-refundable \$40 registration fee is due at time of registration.

Payment: Draft from debit/credit card on file (ending in____)

Payment Information:

Please draft payment: Weekly on Fridays Other (contact Director)

Account: Account on file (ending in ____) FLEX (contact Director)

Person Responsible for tuition: _____

Do you have Publicly Funded Child Care (PFCC) (formerly known as Title XX)? Yes No

Child's Name and Nick Name _____ male female

Child's Birth date _____ Age _____

Street Address _____

City _____ State _____ Zip _____

School Child Attends _____ Grade _____

YMCA Member? yes no

Parent Name _____

Primary Number () C H W

Secondary Number () C H W

Email _____

Birth date _____

YMCA Employee? yes no

Parent Name _____

Primary Number () C H W

Secondary Number () C H W

Email _____

Birth date _____

YMCA Employee? yes no

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 _____

Primary Number () C H W

Relation _____

Secondary Number () C H W

Name _____

Primary Number () C H W

Relation _____

Secondary Number () C H W

Name _____

Primary Number () C H W

Relation _____

Secondary Number () C H W

Name _____

Primary Number () C H W

Relation _____

Secondary 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 publically funded child care, all authorized persons to pick up will be required to use the mobile TAPs system.****

Child's name _____

2026-2027 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 understand that my child must be fully toilet trained to attend this program.

_____ I have read the YMCA BASE/Day Camp Registration Packet and Parent Handbook (which can be found on our website at <https://www.akronymca.org/locations/riverfront-ymca/and-after-school>) 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 PUBLICALLY FUNDED CHILD CARE RECIPIENTS ONLY

_____ I understand that my Publically Funded Child Care co-pay is due every Friday via auto draft prior to care.

_____ I understand that if my Publically 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 tap 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 _____

Permissions

Photograph Consent

I give my child _____ permission to be in photographs, slides, or videotapes for promotion of the Akron Area YMCA.

I do not give my child _____ permission to be in photographs, slides, or videotapes for promotion of the Akron Area YMCA.

Parent/Guardian signature: _____ Date: _____

Program Waiver

I 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.

Parent/Guardian signature: _____ Date: _____

Child Drop-Off/Pick-Up Policy

When you enroll your child in any YMCA Before and After School Enrichment program, it is to be understood our policy is for you to bring your child into the center each morning, sign and list the arrival time on the sign in 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 state law requires me to sign my child in and out each day as well as notify staff that my child is leaving.

Parent/Guardian signature: _____ Date: _____

FUN DAYS

Permission to Participate in Swimming Activities - *Fun Days*

I give permission for my child _____ to participate in swimming activities near water two feet or more in depth – or water activities in water two feet or more in depth.

The center will be providing two (2) additional adults above the required staff/child ratio.

Swim Site	Riverfront YMCA Swimming Pool
Date(s)	Fun Days (August 2026-May 2027)
Departure/Arrival Times from Center	On site, 9:00-3:00pm
Mode of Transportation	Walking in building to indoor pool facility
My child is a	<input type="checkbox"/> Swimmer <input type="checkbox"/> Non Swimmer

Parent/Guardian signature: _____ Date: _____

Permission for routine walks - *Required for Fun Days*

Weather permitting, I give permission for my child _____ to accompany their group on routine walks to DeWitt Playground. The playground is located at 425 Falls Ave., Cuyahoga Falls, OH 44221

Child/Family Information Form

In an effort to understand your child and to meet their 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.)

What causes your child to feel angry or frustrated? _____

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

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? _____

Would you like information or referrals for any of the following?

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Food Assistance	<input type="checkbox"/>	<input type="checkbox"/>	Help meeting the developmental needs of your child
<input type="checkbox"/>	<input type="checkbox"/>	Housing	<input type="checkbox"/>	<input type="checkbox"/>	Family Counseling
<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	Parenting Education or Information
<input type="checkbox"/>	<input type="checkbox"/>	Health/Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	Other:

Staff Use:

Referrals Made (date) _____ (to where) _____

Follow up (date) _____ (comments) _____

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
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 DCY 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
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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? <i>(Check all that apply)</i>				
<input type="checkbox"/> Medication		<input type="checkbox"/> Supplies		
<input type="checkbox"/> Assistance		<input type="checkbox"/> 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	
<i>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.</i>			<i>My signature indicates I have provided instructions for care and/or training for the medical procedure</i>	
Parent Signature			Certified Professional's Name <i>(please print)</i>	
Date of Signature			Certified Professional's Signature	
		Date of Signature	Phone Number	
		<i>My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.</i>		
		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 procedure 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
<i>My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.</i>		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

