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 23rd 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 AND 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.

KEEP THIS PAGE!

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

Laura Davisson – Cuyahoga Fall Schools
(330) 923-9622
laurad@akronymca.org

Cori Van Orman
Assistant Child Care Director
coriv@akronymca.org

Publically 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.

Parent/Guardian Consent Form – Release of Student Records

Akron Area YMCA is partnering with Cuyahoga Falls School District to promote the success and academic achievement of students in our After School Enrichment Programs at DeWitt Elementary and Richardson Elementary. A local evaluator contracted by Akron Area YMCA during the 2026-2027 academic year will provide program evaluation services. Data collection is necessary for Akron Area YMCA to improve programs and demonstrate that students are benefiting from our after-school services. To support student's academic and social success, Akron Area YMCA will be using Aperture Education to provide social-emotional screeners.

The Family Educational Rights and Privacy Act (FERPA) protects students and parents by prohibiting most third parties from accessing student records, information, or data without clear permission from a parent or guardian if the student is under 18 years of age.

This form requests your consent to allow Akron Area YMCA to share the name, date of birth, gender, grade level, and student demographics of the student with the contracted local evaluator. Additionally, you are consenting to allow the contracted local evaluator secure access to your child's Cuyahoga Falls Schools data, including test scores, grades, attendance records, SSID, and results from student surveys. This form also requests your consent to allow Akron Area YMCA to share your child's name, date of birth, gender, grade level, and school name with Aperture Education.

Data results collected and reported by the contracted local evaluator will be shared with the Ohio Department of Education redacting any personal student information such as name, gender, and date of birth. **Data reported to the Ohio Department of Education is not child specific and is reported as a program whole.**

Accessing or sharing records, information, or data will be done to promote and support your student's academic success and achievement, and to evaluate services being offered. **No records, information, or data will be used for any other purpose, and will not be shared with any party other than those listed in this release.**

Parent/Guardian Consent

_____ INITIAL HERE

I give consent for the contracted local evaluator to securely share my child's personally identifiable information between Akron Area YMCA and Cuyahoga Falls Schools. I understand the following information will be shared:

- Student name, grade level, date of birth, gender, and student demographics
- SSID
- School building name
- Course Grades and Grade Point Average
- National and State test results
- Attendance records (classroom and school absence totals, both excused and unexcused)
- Results of surveys administered at the building and/or district level
- Social Emotional Screening results

_____ INITIAL HERE

I give consent for Akron Area YMCA to securely share personally identifiable information with Aperture Education. I understand the following will be shared:

- Student name, gender, date of birth, and grade level

I understand that my child's information will only be shared between Akron Area YMCA, Cuyahoga Falls Schools, the contracted local evaluator, Aperture Education, and the Ohio Department of Education, and that this consent may be terminated at any time by my written request as the parent/guardian listed below. I also understand that this consent will remain in effect until my child is 18 years old, unless it is revoked by me in writing, or unless my child is no longer affiliated with Akron Area YMCA or registered as a student at Cuyahoga Falls Schools. As a parent or guardian, I have the right to revoke consent at any time. I also have the right to obtain copies of any information about my child that is shared because of this form.

Parent/Guardian Name (Print) _____ Date of Consent _____

Parent/Guardian Signature _____

Child's Name _____ Child's School District _____

Child's Date of Birth (MM/DD/YYYY) _____ Child's School Building _____

Data Sharing Consent is required for your child to participate in the 2026-2027 Akron Area YMCA After School Program at DeWitt ES and Richardson ES

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

Please check all types of care you will need

☐ Before Care ☐ After Care Anticipated Start Date:_____

☐ Full Time ☐ Part Time

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 _____ Relation_____

Primary Number ( ) ☐ C ☐ H ☐ W Secondary Number ( ) ☐ C ☐ H ☐ W

Name _____ Relation _____

Primary Number ( ) ☐ C ☐ H ☐ W Secondary Number ( ) ☐ C ☐ H ☐ W

Name _____ Relation _____

Primary Number ( ) ☐ C ☐ H ☐ W Secondary Number ( ) ☐ C ☐ H ☐ W

Name _____ Relation _____

Primary Number ( ) ☐ C ☐ H ☐ W 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	☐ Swimmer ☐ 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	
		Food Assistance			Help meeting the developmental needs of your child
		Housing			Family Counseling
		Nutrition			Parenting Education or Information
		Health/Immunizations			Dental
		Other:			Other:

Staff Use:

Referrals Made (date) _____ (to where) _____

Follow up (date) _____ (comments) _____

Ohio Department of Children and Youth

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

Child's Name	Date of Birth	First Day at Program
Address		
City	State	Zip Code

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

Check here if Not Applicable ☐	Parent #2 Name	Parent #2 Phone Number		
Parent #2 Address ☐Same as Child's		City	State	Zip Code
Parent #2 Email Address (if applicable)		Parent #2 Cell Phone (if applicable)		
Parent #2 Work/School Name (if applicable)		Parent #2 Work/School Phone Number (if applicable)		

Primary Emergency Contact #1 Name (cannot be parent/guardian)	Check here if Not Applicable ☐	Optional Emergency Contact #2 Name (cannot be parent/guardian)
Primary Emergency Contact #1 Phone Number		Optional Emergency Contact #2 Phone Number
Primary Emergency Contact #1 Other number or email address for emergency contact *(if applicable)*		Optional Emergency Contact #2 Other number or email address for emergency contact *(if applicable)*
My child may be released to this emergency contact ☐ Yes ☐ No		Optional My child may be released to this emergency contact ☐ Yes ☐ No

Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication?

☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

Child's Name	Date of Birth

Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes
☐ No

Name of service provider(s) and frequency

☐ N/A

Emergency Transportation Authorization

☐ **The program 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.

☐ **The program 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:

SIGNATURE

This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.

Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures

By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures (parent handbook).

Parent Signature	Date

Program Acknowledgement of Completion

By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.

Program Administrator/Designee Signature	Date

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

Ohio Department of Children and Youth

HEALTH CARE PLAN DOCUMENTATION & PERMISSION TO ADMINISTER MEDICATION FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance and update annually and as needed when a child has a special chronic health condition that may require the program to perform a medical procedure or administer medication. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

HEALTH CARE PLAN DOCUMENTATION

Child's Name	Date of Birth

If the child does not have a special chronic health condition or diagnosis check here: ☐
Skip to page 2 to give permission to administer medication/medical food.

Complete a new form or provide separate documentation for each condition that requires different actions to be taken.

☐ **Check here if additional information/documentation is attached from a licensed dentist, licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN).** This documentation may serve as a substitute for page 1.

Special Chronic Health Condition

What are the signs, symptoms, or situations which require staff to take action, perform a medical procedure and/or administer medication or medical food?

What are the activities, foods, conditions, etc. to avoid? ☐ Not Applicable

What are the instructions to care for the child or perform a medical procedure?

If the child's health condition does not improve or side effects to medication appear, trained staff will do one or more of the following:

☐ Call 9-1-1

☐ Call Parent

☐ Other:

Additional Information and/or what is needed if the child care program must be evacuated:

If the special health condition does not require administering medication/medical food: STOP HERE AND SKIP TO PAGE 3

Page 1 is completed to provide instructions for performing a medical procedure.

PERMISSION TO ADMINISTER MEDICATION

Instructions from a licensed dentist, licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) are required for administering:

- Medical foods.
- Prescription medications, including samples.
- Non-prescription medicines containing aspirin.
- Topical preventative products and lotions or non-prescription medications, when the instructions for use exceed or do not match the manufacturer's instructions or are not stored in original container.

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

What are the instructions to administer medication or medical food?

☐ **Not Applicable: Instructions are not required if the prescription medication is stored in the original container with prescription label that includes the child's full name, exact dosage, and directions for use.**

What actions are to be taken if the medication or medical food is not available?

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 ☐ Administer because symptoms are present	Time of Medication/Medical Food Administration ☐ Administer because symptoms are present	Time of Medication/Medical Food Administration ☐ Administer because symptoms are present

SIGNATURE PAGE	
Child's Name	
PARENT/GUARDIAN By signing this form I attest that: (check all that apply) ☐ I have provided information for care or implementing a medical procedure ☐ I have trained staff and have given permission to perform the procedure ☐ I have trained staff and have given permission to administer medication to my child	
Parent Signature	Date of Signature
LICENSED PHYSICIAN, PHYSICIAN ASSISTANT, ADVANCED PRACTICE REGISTERED NURSE, LICENSED DENTIST Health Care Professional's signature is only required in this box if their instructions have been provided on this form, prescribed medication does not have a prescription label, or as directed by the manufacturer's instructions.	
Physician Signature	Date of Signature
CERTIFIED PROFESSIONAL TRAINER **(A signature from a Certified Professional Trainer is not required if the parent/guardian has provided instructions for care, training, or administering medication)** If a Certified Professional Trainer provided instructions, my signature indicates that: ☐ I have provided instructions for care and/or training for the medical procedure. ☐ I have provided instructions for administering medication.	
Certified Professionals Name (please print)	Phone Number
Certified Professionals Signature	Date of Signature

PROGRAM STAFF

Signatures of all individuals who have received instructions for care, have been trained in performing the procedure for this child and/or administering medication. Additional names and signatures can be attached on a separate sheet.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

DOCUMENTATION OF ADMINISTRATION OF MEDICATION OR MEDICAL FOOD			
Child's Name			Name of Medication/Medical Food
Date	**Time**	**Dosage**	**Signature of person administering medication/medical food**