

Y's Kids Tuition Agreement

As a Y's Kids parent/guardian, I agree to make my tuition payment on each Friday for the following week's schedule. I understand that if I fall behind on my payment, my child(ren) will be temporary withdrawn from the program, until my account is paid in full. Registration fee is non-refundable.

I understand that tuition is based on a part-time (3 days or less/week) or a full-time rate (4 days or more/week). A tuition chart for the program is enclosed in the enrollment packet. A \$20 service charge is assessed for all checks returned for insufficient funds.

Parent/Guardian

Date

Y's Kids Permission Form

I hereby grant permission for my child to use all the play equipment and participate in all of the activities of the center.

I hereby grant permission for my child to be included in evaluations and pictures connected with the childcare program.

I hereby grant permission for the director or acting director to take whatever steps may be necessary to obtain emergency medical care if warranted as stated on the Emergency Medical Authorization form.

I understand that expenses incurred in obtaining medical treatment are my responsibility.

I understand that the Center is not responsible for anything that may happen as a result of false information given by the parent/guardian.

I understand that the YMCA of Greater Cincinnati and the Center will not assume responsibility for a child who is not signed in when he/she arrives for the day, if enrolled in the SACC program.

Parent/Guardian

Date

Payment Option Form

Dear Families,

Tuition is due weekly on the **Friday** prior to the Monday of attendance:

- Weekly Credit Card Draft (complete the form below)**

BANK DRAFT AUTHORIZATION

I authorize my bank to honor pre-authorized drafts by the YMCA on my account for program fees. It is understood that my draft will continue through the program enrollment period. If at any time there is to be change, deletion, or cancellation of my program, it is to be submitted in writing to the YMCA ten (10) days prior to my scheduled, monthly bank draft. Failure to do so will result in that month's draft being non-refundable. A voided check is required with all bank draft applications. When the bank honors the draft by charging my account, such drafts constitute my receipt for the payment. Should any draft not be honored by said bank when received by them, it is understood that the payment is to be made by me in the amount of said payment plus a service charge. **Credit/Debit Card information must be completed. This information will be used in the event of any past-due balances, non-payments or late fees. Past due balances will be applied to this card at 6 pm the first day of the program.**

All drafts will automatically end upon last week of camp attendance.

Credit/Debit Card will be debited the Tuesday of Attendance Week	
Name on Account _____	Address and Zip Code _____
\$ _____ <input type="checkbox"/> Am. Express	<input type="checkbox"/> Visa <input type="checkbox"/> Mastercard
Weekly Amount _____	Exp date _____
Card # _____	
Signature _____	Date _____



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Y's Kids
Clippard Family YMCA SACC
Enrollment Form

Enrollment Date: _____ School Name: _____

SCHEDULE INFORMATION

My child will be in attendance in the Y's Kids program:

M T W TH F AM AND/OR M T W TH F PM

CHILD'S INFORMATION

Child's Name: _____

Birthdate: _____ Age: _____

Grade: _____ Phone: _____

Teacher's Name & Room #: _____

Child lives with: Both Parents ___ Mother ___ Father ___ Other ___

Marital Status of Parents: Married ___ Div. ___ Single ___ Other ___

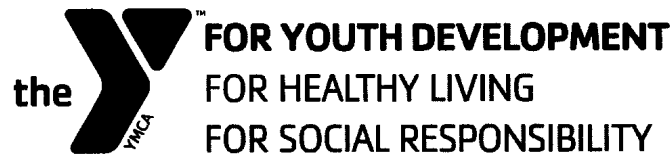
****Note: In the case of divorce, adoption, foster parenting or other court-ordered activity, attach a copy of the court order granting custody.**

IN ADDITION TO PARENT/GUARDIAN, MY CHILD MAY BE RELEASED ONLY TO THE FOLLOWING PERSON (S):

NAME:	ADDRESS	PHONE	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date: __/__/__

Parent/Guardian signature _____



Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE CENTERS AND TYPE A HOMES**

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 Center	
Home Address				City
State	Zip Code	Home Telephone Number		
Parent/Guardian Name			Relationship to Child	
Home Address		Home Telephone Number		
City		State	Zip	
Email Address (if applicable)		Cell Phone		
Parent's Work/School Telephone Number		Parent's Work/School Name		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which number(s) 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?				
Parent/Guardian Name			Relationship to Child	
Home Address		Home Telephone Number		
City		State	Zip	
Email Address (if applicable)		Cell Phone		
Parent's Work/School Telephone Number		Parent's Work/School Name		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which number(s) 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?				
Emergency Contacts: Parents <u>cannot be listed</u> 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 within one hour of the center/home, 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
<p align="center">Allergies, Special Health or Medical Conditions, and Food Supplements</p> <p>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 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A home.</p>
<p>Does your child have any food, medication or environmental allergies? <i>(check all that apply)</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes - check all that apply <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Environmental Please list and explain:</p>
<p>Does your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? <i>(check one)</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.</p>
<p>Does your child have a special health or medical condition? <i>(check one)</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes - please explain</p>
<p>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? <i>(check one)</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.</p>
<p>Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? <i>(check one)</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes - please explain</p>
<p>If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.</p> <p><input type="checkbox"/> N/A - program does not administer any medications.</p>
<p>Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? <i>(check one)</i></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes - please explain</p>
<p>Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."</p> <p><input type="checkbox"/> N/A - child does not attend a full time program.</p>

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.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

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 center/type A home'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	Do <u>Not Give Permission</u> to Transport	
Center or Type A Home Name			Center or Type A 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 center's or type A 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. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.

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 centers and type A homes to meet the requirements of rules 5101.2-12-37 and 5101.2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services
**CHILD CARE PLAN FOR HEALTH CONDITIONS OR MEDICAL PROCEDURES
 FOR CHILD CARE CENTERS AND TYPE A HOMES**

If care is provided for a child who has an ongoing health condition that requires child specific care or may require a medical procedure, the parent/guardian shall complete this form. The center staff shall implement the plan. This requirement does not include short term illnesses, unless the child care staff member needs to perform a medical procedure for the child. A separate plan must be written for each condition that requires different actions to be taken.

Child's Name	Date of Birth
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Describe the health condition.

Describe the medical procedure to be completed and expected benefits of treatment, or N/A, no medical procedure required.

List activities/foods/environmental conditions to avoid or N/A, nothing to avoid.

Symptoms to watch for and actions to be taken if the symptoms are observed.

Is any medication required? Yes No
 (If yes, complete JFS 01217 "Request for Administration of Medication", in addition to this form.)

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? Yes No If yes, please describe:

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? Yes No If yes, please describe:

Signature of Trainer (Trainer must be a parent/guardian or certified professional)	Date
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Signature of child care staff members who have been informed about the child's condition so they can care for the child according to this care plan or trained to perform the medical procedure.
There must always be a trained staff member present when the child is present.

Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>

I give my permission for the staff listed above to perform the procedures in my child's care plan as described above.

Parent's Signature	Date
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Administrator's Signature	Date
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This form may be used for children with health conditions as defined in Rules 5101: 2-12-38 and 5101: 2-13-38.

Ohio Department of Job and Family Services
REQUEST FOR ADMINISTRATION OF MEDICATION
Child Care Centers and Type A Homes

This form is valid for no longer than twelve (12) months. One form must be used for each medication.

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

Check all that apply:	
<input type="checkbox"/> Prescription medication	<input type="checkbox"/> Topical product or lotion
<input type="checkbox"/> Nonprescription medication	<input type="checkbox"/> Food supplement
<input type="checkbox"/> Refrigeration required	<input type="checkbox"/> Modified diet
Complete all of the following information:	
Name of child: _____ Date of birth: _____ Weight _____	
Name of medication: _____ Exact dosage: _____	
To be administered at the following times: _____	
For the following period of time: _____	
Parent/Guardian signature: _____	Date: _____

Box 2 -The following section must be completed by a **licensed physician, a licensed dentist or an advance practice nurse** when:

1. A physician's instruction is needed for a nonprescription medication (e.g. child is underage or underweight per the label instructions); or
2. It is a sample medication without a prescription label; or
3. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period or is a topical product or lotion that is being used for a skin ailment and is to be given no longer than fourteen consecutive days; or
4. The child is on a modified diet (an entire food group is eliminated); or
5. The medication contains codeine or aspirin.

_____ is under my care and should receive _____		
<small>(name of child)</small>		<small>(name of medication, vitamin, diet)</small>
as follows: _____		
<small>(include dosage and instructions)</small>		
Possible side effects to watch for are: _____		
Expiration date: _____ (may not exceed 12 months from the date of this request for medications or food supplements)		
Signature of physician, dentist or advance practice nurse _____	Date of signature _____	Phone number _____

This form must be used by child care centers and type A homes to meet the requirement of rules 5101:2-12-31 and 51-1:2-13-31.

St. John Y's Kids Tuition/Fees

Full – Time Rates: 4 or more days a
week

\$32 AM

\$45 PM

\$60 Both

Part – Time Rates: 3 days or less a
week

\$22 AM

\$35 PM

\$45 Both