Tax ID 31-0537178

For Youth Development
For Healthy Living
For Social Responsibility

Tuition/Fees SACC

Fee: **$30 per child / $50 maximum per family**
$15 per child / $30 maximum per families receiving assistance
$25 North Dearborn, IN

SCHOOLS:	TAYLOR, WEIGEL, STRUBLE
FULL TIME	AM only: $30/Week PM only: $55/Week Both: $82/Week
PART TIME	AM only: $21/Week PM only: $39/Week Both: $58/Week

SCHOOLS:	COLERAIN, MONTFORT HEIGHTS, PLEASANT RUN, WELCH
FULL TIME	AM only: $38/week PM only: $47/week Both: $82/week
PART TIME	AM only: $28/week PM only: $32/week Both: $58/week

SCHOOLS:	ST JOHNS
FULL TIME	AM only: $35/week PM only: $45/week Both: $70/week
PART TIME	AM only: $22/week PM only: $32/week Both: $45/week

SCHOOLS:	NORTH DEARBORN (PM ONLY SITE)
FULL TIME	PM only: $50/week
PART TIME	PM only: $35/week

Full Time: 4 days or more per week

Part Time: 3 days or less per week

2017 - 2018 CHILD CARE ENROLLMENT APPLICATION

the YMCA

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

The Enrollment Application consists of a number of forms that must be completed **prior** to your child starting any of our childcare programs. Also part of the enrollment is to provide a certified copy of your child's up-to-date immunizations.

Today's Date: _____ /_____ /_____

Membership #: _____

Name of Child	
Name of Parent	
School Attending (If applicable)	

Programs Registered For (Check all that apply)

☐ Preschool ☐ Extended Kindergarten Care ☐ SACC Before School ☐ SACC After School

Emergency Contact Information

Child lives with: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other _____

Martial Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Other

Additional Siblings Enrolled in YMCA Childcare: ☐ Yes ☐ No *(If answered yes, please list below)*

If applicable, please print the name and age of any sibling(s) who would also be enrolled.

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

1st Called	This person will be called first in the event of an illness/emergency. This must be a parent/guardian.
Parent/Guardian Name	
Address (Including City, State, Zip)	
Home Phone	
Cell Phone	
Email Address	
Employer	
Employer's Address (Including City, State, Zip)	
Employer's Phone	

2nd Called	If the main parent/guardian cannot be reached, this person will be the second to be called
Parent/Guardian Name	
Address (Including City, State, Zip)	
Home Phone	
Cell Phone	
Email Address	
Employer	
Employer's Address (Including City, State, Zip)	
Employer's Phone	

3rd Called	In the event that a parent/guardian cannot be reached, this person would be the next to call.
Contact Person	
Relationship to Child	
Address (Including City, State, Zip)	
Home Phone	
Cell Phone	
Employer	
Employer's Phone	

4th Called	This person will be the fourth person to be contacted in the event of an illness/emergency.
Contact Person	
Relationship to Child	
Address (Including City, State, Zip)	
Home Phone	
Cell Phone	
Employer	
Employer's Phone	

Please note that individuals listed on this emergency contact list will also be approved to pick up your child!

the YMCA
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

2017 - 2018 CHILD CARE

Emergency Medical Authorization

A parent/guardian must provide the YMCA consent for emergency medical treatment to be initiated for their child in the event of an emergency. A parent/guardian may also refuse to grant consent. If you would like to deny consent, please see your Program Director.

In the event reasonable attempts to contact me or the noted second contact at the numbers listed in my Emergency Contact information, have been unsuccessful, I hereby give my consent for: **(1)** the administration of any treatment of physician or dentist I have listed below, or in the event the designated preferred physician is not available, by another licensed physician or dentist; or **(2)** the transfer of the child to the designated preferred hospital I have listed or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such action, are obtained prior to the performance of the surgery.

_____ _____ / _____ / _____
Parent/Guardian Signature Date

Health History

This section allows parents to indicate your preferences in doctors/medical facilities and also allows you to communicate any of your child's health history information that can help us ensure a safe and happy experience at school for your child. Please list any information regarding special medical issues, special dietary needs, possible allergies, etc. for your child in this section. If applicable, an *Administration of Medication form* is available upon request if your child is to take medications during program time. **Please fill out ALL requested information!**

Designated Preferred **Physician**	Name: Address: Phone:	Current Medications	
		Dietary Modifications	
Designated Preferred **Dentist**	Name: Address: Phone:	Operations Serious Injury	
		Disabilities	
Designated Preferred **Hospital**	Name: Address: Phone:	Chronic Illnesses Reoccurring Illnesses	
		Allergies (Foods, Meds, Insects, etc)	

Student History/Information:

Please answer the following questions concerning your child.

What are your child's favorite indoor activities?	
Are there any special circumstances in the family, which may be a factor in your child's behavior?	
In what ways would you like to see your child develop during his/her participation in our program?	
Please add any additional comments that you feel might help us understand your child better.	

the YMCA FOR YOUTH DEVELOPMENT FOR HEALTHY LIVING FOR SOCIAL RESPONSIBILITY

2017 - 2018 CHILD CARE

Pick Up Authorization Code

As part of our safety and security measures, all students must have a code word. Please fill out and review all of the following:

Code Word Choice #1		Code Word Choice #2	

- Code words are used as an added assurance and security measure when your child is being picked up.
- It is imperative that your codes be confidential, and only told to adults who pick up your child; Do not tell your child their codes!
- If your code words are compromised, please see the Program Director to change it.
- Adults authorized to pick up your child must be at least 18 years of age.
- The adult picking up your child must know and use the code words. This includes the parents/guardians.
- Parent/Guardian must provide legal documents upon any custody agreements/arrangements made within the court system, etc. regarding who can and cannot pick up the child/children.

Permission to Participate

Please indicate by checking yes or no to what activities that you will provide permission for your child during child care programming.

□ Yes	□ No	I give my permission for my child to use all of the equipment and participate in all activities involved in the program.
□ Yes	□ No	I give my permission for my child's image, voice, or written comments to be included in evaluations, pictures, newsletters, and marketing pieces associated with the program. The YMCA of Greater Cincinnati may use these indefinitely, without limitation or obligation for the purpose of promoting or interpreting YMCA programs.

Understanding of YMCA Policies

Your child's safety, security, and health is our number one priority! Our staff goes through extensive training to help ensure the wellbeing of your child. However, through no negligence on anyone's part, accidents may happen. All parents of child care program participants must agree to the following:

- I understand that the YMCA is not responsible for personal property lost or stolen while participating in the program. My child is responsible for all of his/her belongings. I understand that lost and found is reviewed every Friday and that any items left over at the end of each week will be sent to Goodwill®.
- I understand that the YMCA or Greater Cincinnati is not responsible for anything that occurs as a result of false information given by a parent or guardian.
- I understand that any medical expenses resulting from any illness or injury incurred while in the program or attending any YMCA program is my responsibility.
- I understand that the YMCA of Greater Cincinnati assumes no responsibility for injuries or illnesses which may occur as a result of my child's physical condition or resulting from his/her participation in any athletic events, sports programs, the use of any equipment, exercise or other activities.

Parent Handbook:

I have read and understand the contents of the **2017-2018 Parent Handbook** and agree to all the terms that are covered in the manual.

I understand that my signature indicates that I have been previously made aware of all policies, procedures, and guidelines referenced in the handbook concerning this program.

I have read and fully understand these policies and authorization statements. I do hereby give such authorization as indicated or document understanding of specified policies.

_____
Name of Child (Please Print)

_____
Parent/Guardian Name (Please Print)

_____
Parent/Guardian Signature

_____ /_____ /_____
Date

the YMCA
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

2017 - 2018 CHILD CARE

Parent Acknowledgment

By signing and dating below, you are acknowledging the knowledge of and the adherence to all of the below policies and procedures associated with these programs. These policies and procedures are outlined in detail in the 2017-2018 Parent Handbook.

- I understand that my child must be potty-trained before the start date of any YMCA Child Care program.
- I understand that payment is due by 6:00 pm Friday, for the following week. If my payment is not received by then, I understand that it is my responsibility to add a $10.00 late fee to my payment. If my payment is more than one week late, I understand that it will result in the removal of my child from the program, and I will be charged an additional registration fee upon return. I understand that a credit/debit card **must** be on file and no cash payments will be accepted at the Center.
- **I understand that tuition is a FLAT weekly fee and will NOT be prorated for days not attended such as sick days, vacation, staff training, special holidays, snow days, etc.** The only time the weekly fee will be prorated is if the program is closed more then three days a week. (Example: Spring Break Week)
- I understand that there is a late fee of $1.00 per minute/per child for any child left after the time they are registered for. This payment will be made upon my arrival, in cash and given to the staff person who remains after scheduled work hours to be with my child.
- I understand that if I withdraw from the program I must provide the Program Director with notice in writing at least 2 weeks prior. Also, changes to my child's program attendance schedule must be made in writing no less than two weeks prior to the date of the scheduled change using a *Change of Program* form.
- I understand that if my child will be absent from the program I need to call the YMCA Welcome Center prior to the start of the program.
- I understand that the Director or acting Director will take whatever steps necessary to obtain emergency medical care if warranted.
- I understand that the YMCA Child Care programs will follow the public school schedule of my county/district. If the children are scheduled to be off from school for the day and you still need childcare, I must register my child/children for the Schools Day Out program for an additional charge. I am aware that this information is outlined in the Parent Handbook.
- I understand that under no circumstances will my child bring their own toys or other personal items, which include but are not limited to: personal electronic devices, cell phones, card games, etc. If my child does so, the staff will confiscate the item and return it to the parent at the end of the day.
- I understand that the YMCA is not responsible for my child until the parent/guardian signs them into the program.
- I understand that my child(ren) must be signed in and out of the program they are registered for. This is a state law and must be done everyday. If someone else picks my child up they will need to complete the sign in/out sheet, and also provide the staff with the correct code words in order for the child to be released.
- I acknowledge the receipt of the Parent Handbook. I understand that I am responsible for reading the handbook and understanding all of its content. I agree to follow all of the terms that are covered in the manual.
- I understand that I MUST provide a certified copy of my child's immunization form and turn in all requested paperwork completed in full, **prior** to the start of the program.

Agreement to Terms and Conditions:

I have read and fully understand the information provided in this Enrollment Application. I agree with all terms and conditions presented.

_____
Parent/Guardian Name (Please Print)

_____
Parent/Guardian Signature

_____ /_____ /_____
Date

For Office Use Only
Application has been reviewed by:

_____
Member Services Initials

_____
File Complete/Entered in Access

_____ /_____ /_____
Date

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FOR SOCIAL RESPONSIBILITY

2017 - 2018 CHILD CARE

Y's Kids Enrollment Form

Enrollment Date: _____ School Name: _____

SCHEDULE INFORMATION

My child will be attending the Y's Kids program on these days:

AM: M T W R F AND/OR PM: M T W R F

CHILD'S INFORMATION	
Child's Name:	
Birth date & Age:	
Grade:	
Phone #:	
Teacher's Name & Room #:	
Parent Birthdate:	
Child lives with:	
Marital Status of Parents:	

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

My child may be released ONLY to the following person(s):

Name	Address	Phone Number	Relationship to Child

**Anyone, including myself, who is not listed on this form will not be able to pick up the child.

Date: __/__/__

Parent/Guardian Signature: _____

Family Information (School-Age)

Child's Name (Last)	First	Nickname (if any)
By providing complete information about your child, you will be assisting the staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff who care for your child.		
Members of child's immediate family		
Who lives at home with your child?		
Languages spoken in your home/Primary language		
Are there any special family arrangements, such as shared parenting or custody specifications, etc?		
Changes or transitions that your child recently experienced or is experiencing? (ie. new home, birth of sibling, divorce, school issues, death of family member, friend, pet)		
Any cultural or religious practices of your family of which we should be aware? (dietary restrictions, head coverings, clothing, language, etc)		
Do you have any pets at home? If so, type of pet and pet's name		
What are your child's favorite foods?		

Please circle all of the words that best describe your child's personality and general behavior:

active adventurous affectionate anxious bossy calm cautious cheerful content creative curious emotional energetic excitable friendly happy insecure likes structure/routine loud loving outgoing quiet prefers adult attention sensitive serious stubborn talkative

What makes your child laugh?

Is there anything that is making your child excited about starting in this program?

Is there anything that is making you or your child anxious about starting in this program?

Please rank from 1-10 (10 most important) the importance of After-School activities:

Snack____ Art&Drama_____ Physical Activity_____ Structured Play_____ Friends_____

Rest____ Homework_____ Free Play_____ Safe Environment_____ Learning Activities_____

Has your child had a previous care arrangement? If so, what type (center based, in-home, with family, summer camp, youth program)

What are your expectations of this program?

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

Does your child have an I.E.P (Individualized Care Plan) or an IFSP (Individualized Family Service Plan)

Yes No

If yes, would you be willing to provide the program a copy, so the teachers can support your child and family.

Yes No

Do you or anyone in your family have a hobby, skill, or area of expertise you would be interested in sharing with school age youth?

Parent/Guardian Signature Date

Ohio Department of Job and Family Services

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information

Routine Trip Destination(s): Kaboom Playground

Date of Permission *(valid for one year)*: School day out - 2017-2018 School Year

Mode of Transportation *(walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*: Walking

During this trip children will have access to water that is 18 inches or more in depth.
☒ Yes ☐ No

Are water activities planned in water that is 18 inches or more in depth? ☒ Yes ☐ No
(if yes, a swimming permission slip is required)

Child's Information

Child's Name

My child is
☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 8 years and/or over 4' 9"

Signature

I grant permission for my child to participate in the routine trips described above.

Parent's Signature	Date

Ohio Department of Job and Family Services

PERMISSION TO PARTICIPATE IN SWIMMING ACTIVITIES FOR CHILD CARE

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

- ☐ Child swimming in water 18 inches or more in depth
- ☐ Child participating in activities near water 18 inches or more in depth (no water activities planned)
- ☐ Infants and toddlers using wading pools

I give permission for my child to participate in the following swimming/water activities

Swim Site: Clippard YMCA

Date(s): Out School day 2017-2018 School Year

Departure/Arrival Times from Center:

Mode of Transportation (parent's driving, provider vehicle, public transportation, school bus, etc.): Walking

Child's Name	Child's Date of Birth

My child is a ☐ Swimmer ☐ Non swimmer

Parent's Signature	Date

Ohio Department of Job and Family Services

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			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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ 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 at least one person 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

Allergies, Special Health or Medical Conditions, and Food Supplements

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 family child care 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, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ 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.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

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 the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

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 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 *Permission* to Transport			***Do Not Give Permission*** **to Transport**	
Program or Home Name		**OR**	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.		**Do not sign both**	**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 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth
Special Health Conditions	
Symptoms to watch for and emergency action to be taken if the following symptoms occur	
Activities/foods/environmental conditions to avoid, if applicable	
Medical procedures to be followed and expected benefit of treatment, if applicable	
Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")* If yes, what medications?	
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	
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	
Training Instructions *(Trainer must be a parent or certified professional)*	
Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving		
Who provides the above services?		
Name	Phone Number	May we contact? ☐ Yes ☐ No
Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: ***A separate plan must be written for each condition that requires different actions to be taken***

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

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

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.		
Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

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2017 - 2018 CHILD CARE

Clippard Family YMCA SACC Program

Mandatory Automatic Payment Enrollment

* Automatic payment enrollment is now required for all Clippard YMCA childcare participatins, including those receiving financial assistance. Please read the policies carefully.

Payment Policies:

- ✓ **A valid credit/debit card must be on file for all weekly payments.** Only the registration fee and deposits may be paid by other means.
- ✓ **My credit/debit card will be charged in full for any programs I have selected, on the Friday *before* the selected week.**
- ✓ I will be charged in full (whether or not my child attends) unless I withdraw mny child from the selected program using the Status Change Form and return it no later than 2 weeks before the start of the selected week. **No verbal or over the phone withdrawals are accepted.**
- ✓ If my card is rejected, I will be notified no later than the Monday of the week of service. **My child will not be able to return to the selected program until the fee is paid and a valid card is on file.**

*The information on this form will be kept in a locked safe in a secure location

Parent Name: _____

Phone #: _____ Membership #: _____

Child(ren)'s Name(s): 1. _____ 2. _____

3. _____ 4. _____

☐ I understand that my card will be charged on the Friday before each week of the program.

Select Card Type: ☐ Visa ☐ MasterCard ☐ American Express

Card Holder Name: _____ Card # _____ Exp. _____

Billing Address: _____ City: _____ Zip: _____

I understand and agree to the above payment policies. I authorize Clippard Family YMCA to charge the full fee for all programs selected on the registration form to the credit/debit card listed above.

Signature: _____ Date: _____

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FOR SOCIAL RESPONSIBILITY

2017 - 2018 CHILD CARE

YMCA of Greater Cincinnati Voucher Agreement

Please read the following policies for families using vouchers and the Ohio ECC swipe card system for child care.

Your responsibilities in this process are as follows:

- You are responsible for paying your parent fee as designated by Hamilton County Department of Job and Family Services. The fee must be paid no later than **6 pm on Friday** prior to the week of service.
- You are responsible for your card and your pin numbers.
- You are responsible for swiping your child in and out **EVERY day**. **Do not wait to swipe your child in and out on Friday, this causes a long wait at the voucher machine and is unfair to other parents.**
- If you miss a swipe, you are responsible for doing a previous swipe and correctly recording the time your child arrived/departed. Back swipes can be made up to 2 weeks after the attended week, manual claims will not be given out because of forgotten back swipes, and you are responsible for making sure they are made.
- Each child has a total of 10 absences to use within a 6 month period. Each absence is worth 5 hours, it is up to our registrar to decide when it is appropriate to use 1 or possibly 2 to ensure payment for that week.
- You are responsible for telling your child care caseworker if you change your address or phone number.
- It is your responsibility to call your caseworker and adding the school site as an authorized provider before your child attends the program. For School's Day Out, add the YMCA as the authorized provider.
- If you receive an error or denied message when swiping your card, it is your responsibility to notify the registrar immediately.
- For part time programs such as before and after school, if the child does not attend **at least 7 hours** and does not have any absences left to reach the 7 hour minimum, **the parent is then held responsible for the full program price**. For full time programs you must reach 25 hours for payment to be received.

I, _____, have read and understand my responsibilities in regards to the Ohio ECC Swipe Card System.

Signature: _____ Date: _____

the YMCA FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

2017 - 2018 CHILD CARI

If you will be using Hamilton County Vouchers for Y's Kid's before and/or after school program, please fill out the information below to ensure that your child is authorized before the first day of care. If we do not receive the information we need, you will be responsible for full payment until the information is provided.

☐ If you plan to make the child care connection on your own, prior to your child beginning Y's Kid's, please check this box. Note, when making a connection it takes 5-7 business days to complete.

Case Number **	
Parent SSN	
Parent Name (First and Last)	
Child Name (First and Last)	
First day attending	

** Case number begins with 600

If you have any questions or concerns regarding your voucher or swipes, you can contact our registrar, Rebecca Vonallmen, via email at rvonallmen@myy.org