Before and After School Enrichment General Information 2016-2017

Care Site	Schools Served	Location	Times
DeWitt YMCA BASE	DeWitt	DeWitt Elementary 425 Falls Ave Cuyahoga Falls, 44221	6:30-9:00am 3:00-6:00pm 2:00-6:00pm (Wed. only)
Lincoln YMCA BASE	Lincoln	Lincoln Elementary 3131 W Bailey Rd Cuyahoga Falls, 44221	6:30-9:00am 3:00-6:00pm 2:00-6:00pm (Wed. only)
Preston YMCA BASE	Preston	Preston Elementary 800 Tallmadge Rd Cuyahoga Falls, 44221	6:30-9:00am 3:00-6:00pm 2:00-6:00pm (Wed. only)
Price YMCA BASE	Price	Price Elementary 2610 Delmore St Cuyahoga Falls, 44221	6:30-9:00am 3:00-6:00pm 2:00-6:00pm (Wed. only)
Richardson YMCA BASE	Richardson	Richardson Elementary 2226 23rd St Cuyahoga Falls, 44223	6:30-9:00am 3:00-6:00pm 2:00-6:00pm (Wed. only)
Silver Lake YMCA BASE	Silver Lake	Silver Lake Elementary 2970 Overlook Rd Silver Lake, 44221	6:30-9:00am 3:00-6:00pm 2:00-6:00pm (Wed. only)
Echo Hills YMCA BASE	Echo Hills	Echo Hills Elementary 4405 Stow Rd Stow, 44224	7:00-9:00am 3:00-6:00pm
Fishcreek YMCA BASE	Fishcreek	Fishcreek Elementary 5080 Fishcreek Rd Stow, 44224	7:00-9:00am 3:00-6:00pm
Highland YMCA BASE	Highland Lakeview	Highland Elementary 1843 Graham Rd Stow, 44224	7:00-9:00am 3:00-6:00pm 2:45-6:00pm (Lakeview)
Indian Trail YMCA BASE	Indian Trail	Indian Trail 3512 Kent Rd Stow, 44224	7:00-9:00am 3:00-6:00pm
Riverview YMCA BASE	Riverview	Riverview Elementary 240 North River Rd. Munroe Falls, Ohio 44262	7:00-9:00am 3:00-6:00pm
Woodland YMCA BASE	Woodland	Woodland Elementary 2908 Graham Rd Stow, 44224	7:00-9:00am 3:00-6:00pm
Woodridge YMCA BASE	Woodridge Primary Woodridge Intermediate	Woodridge Primary 3313 Northampton Rd Cuyahoga Falls, 44223	6:30-9:00am 3:00-6:00pm

Before and After School Enrichment Fees

$40.00 registration fee waived if enrolled before July 15th, 2016

Weekly Fees Full Time (3 days or more) Weekly Fees Part Time (2 days or less)

There are no sibling discounts.

Program	Member Rate	Program Member Rate
Before OR After Care	$ 57.00	$ 65.00
Before AND After Care	$ 82.00	$ 90.00
Before OR After Care, part time	$ 25.00	$ 30.00
Before AND After Care, part time	$ 36.00	$ 42.00
Registration Fee (waived if registered by 7/15/16)	$ 40.00	$ 40.00

BASE Fun Day Calendar 2016-2017

Fun Days are from 6:30am-6:00pm at the Riverfront YMCA

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Fun Day	Cuyahoga Falls	Stow	Woodridge
September 5th Labor Day	No Care - YMCA CLOSED	No Care - YMCA CLOSED	No Care - YMCA CLOSED
October 14th Waiver Day	Fun Day	Fun Day	Fun Day
October 21st Conferences	Fun Day	Early Release, Morning Care Only	Regular Care
November 8th Election Day	Fun Day	Fun Day	Fun Day
November 23rd Day Before Thanksgiving	Regular Care	No School, No Fun Day	Regular Care
November 25th Day After Thanksgiving	Fun Day	Fun Day	Fun Day
December 22st-January 2nd Winter Break	Winter Break Fun Days	Winter Break Fun Days	Winter Break Fun Days
January 3rd	School in Session	No School, No Fun Day	No School, No Fun Day
January 16th MLK Day	Fun Day	Fun Day	Fun Day
February 17th	School in Session	No School, No Fun Day	No School, No Fun Day
February 20th President's Day	Fun Day	Fun Day	Fun Day
March 27th-31st Spring Break	Spring Break Fun Days	Spring Break Fun Days	Spring Break Fun Days
April 14th Good Friday	Fun Day	Fun Day	Fun Day

School Year Start and End Dates

Cuyahoga Falls: 8/17/2016-5/24/2017
Stow: 8/18/2016-5/25/2017
Woodridge: 8/17/2016-5/25/2017

Fun Days correspond with Cuyahoga Falls City School District's schedule. Fun Days are held at the Riverfront YMCA. There is no After Care for Early release days other than Cuyahoga Falls on Wednesdays.

Early Release Days (no after care, morning care only)

Cuyahoga Falls: 10/13/2016, 3/10/2017
Stow: 10/21/2016, 3/10/2017

Snow Days – In the event of a Snow Day, care is provided at the Riverfront YMCA from 8:30 am – 6:00pm. Your child must be pre-registered for Snow Days to attend. Snow Day sign-up slips will go out to before & 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.

Child's name _____

2016-2017 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 have read the YMCA BASE/Day Camp Registration Packet 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 TITLE XX RECIPIENTS ONLY

_____ I understand that my Title XX co-pay is due every Friday via auto draft prior to care.

_____ I understand that if my Title XX authorization is not current and/or not for the correct location, I will be responsible for private pay rates.

_____ I understand that I must swipe my Title XX card daily. I understand there is a two-week back swipe period if daily swipes are missed. If I miss the back swipe 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 swipe.

Parent/Guardian Signature _____ Date _____

Riverfront YMCA Before and After School Enrichment

Please check all types of care you will need

☐ Before Care ☐ After Care Anticipated Start Date:_______________

☐ Full Time ☐ Part Time

If Part Time, what days? ____

Child's Name and Nick Name ____ ☐ male ☐ female

Child's Birth date ____________________ Age _______

Street Address ____

City ______________________________ State __________ Zip___________

School Child Attends____

YMCA Member? ☐ yes ☐ no

Parent Name______________________________	Parent Name ______________________________
Primary Number ( ) ☐ C ☐ H ☐ W	Primary Number ( ) ☐ C ☐ H ☐ W
Secondary Number ( ) ☐ C ☐ H ☐ W	Secondary Number ( ) ☐ C ☐ H ☐ W
Email ______________________________	Email ______________________________
Birth date ______________________________	Birth date ______________________________
YMCA Employee? ☐ yes ☐ no	YMCA Employee? ☐ yes ☐ no

Child lives with ____

Name and ages of siblings ____

Person responsible for tuition ____________________ Do you have Title XX ______________________

Non-Parental 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
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.

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: _____

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: _____

Permission to Participate in Swimming Activities - *Includes 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 2016-May 2017)
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 _____

Child/Family Information Form

In an effort to understand your child and to meet his/her needs, we would like you to complete the following:

Child's Name: _____

Brothers and sisters (names and ages):

_____

Child lives with:

_____

What is the primary language spoken in your child's home? _____

Does your child have any particular fears such as dogs, storms, etc.?

_____

What are your child's special interests?

_____

_____

Have there been any changes or transitions in your child's life recently, such as divorce, new home, death, etc.?

_____

_____

Are there additional personality and behavior characteristics that would be useful to know about your child?

_____

_____

How do you reassure or reward your child?

_____

_____

How do you discipline your child?

_____

_____

Please list the three most important things you would like your child to work on while in our program:

_____

_____

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

_____

_____

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. ☐ 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?

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?

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 type A 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 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 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 *Permission* to Transport			**Do Not Give Permission 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.		**OR** 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 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

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

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

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

Administrator's Signature	Date

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:

- ☐ Prescription medication
- ☐ Nonprescription medication
- ☐ Refrigeration required
- ☐ Topical product or lotion
- ☐ Food supplement
- ☐ 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 _____
(name of child) (name of medication, vitamin, diet)

as follows: _____
(include dosage and instructions)

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

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Auto Draft Payment Authorization

Child's Name _____

Parent's Name _____

Billing Address _____

Payment Amount _____

Please draft payment: ___ Weekly on Fridays

___ Other (please contact Director for options)

Auto draft is the required method of payment!

Please draft payment from the following type of account (circle)

Checking Savings Credit card

Name on account _____

Credit card number _____ Expiration _____

Checking/Savings Routing number _____

Checking/Savings Account number _____

I authorize the Riverfront YMCA to set up an auto draft method of payment using the information above. This will remain in effect as long as my child is enrolled or until a request to stop the draft is made in writing.

Signature of account holder: _____ Date: _____

RIVERFRONT YMCA
544 BROAD BLVD
CUYAHOGA FALLS, OH 44221
(330) 923-9622

akronymca.org

The Y strives to make programs and membership available to all. Financial assistance may be available to those who qualify.