FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA BUFFALO NIAGARA
CHILD CARE ENROLLMENT FORM

PHOTO

Name _____

School _____

Grade _____

Age _____

Site _____

Start Date _____

☐ AM Program ☐ PM Program

ALLERGIES/MEDICATION

Will your child require prescription medications while in the program? ☐ Yes* ☐ No
(* if yes please complete an Individual Health Care plan)

Does your child have allergies? ☐ Yes* ☐ No
(* if yes please describe in detail inside)

BEHAVIOR MANAGEMENT POLICY

The safety and well-being of each child in our care is our number one priority. When behavior expectations are not met, YMCA staff will implement our behavior management policy to help correct the undesired behavior. Listed below are the steps utilized by our staff:

a. Verbal warning given: explain why behavior is inappropriate.
b. Time out - time to refocus and redirect.
c. Verbal communication between parent and site coordinator.
d. Parent conference with site coordinator and program director, followed by a written summary of meeting. Child, parent and site coordinator sign a written contract agreeing to acceptable behavior and alternative solutions.
e. If inappropriate behavior continues, child may be suspended from program for up to one week.
f. Prolonged disruptive and inappropriate behavior will result in dismissal from the SACC program.

Extreme Behavior Issues
In extreme cases, a child's behavior may warrant immediate suspension or expulsion from the program. Such cases include the use of profane or abusive language or any aggressive behavior which threatens or causes physical harm to other participants or staff.

CHILD INFORMATION

Name _____ Nick Name _____ ☐ Male ☐ Female

Grade in Fall_____ Date of Birth _____ Phone_____

Home Address_____ City _____ State _____ Zip_____

APPLICANT INFORMATION

Name of person applying for child _____ Relationship to child _____

Address _____ City _____ State _____ Zip_____

Employer_____ Day Phone_____

Cell Phone _____ E-mail Address _____

In case of an emergency, notify: (List contact information for hours during Day Care - for example work address and phone if at work)

Mother _____ DOB_____ Address_____

Day Phone_____ Cell Phone _____

Father _____ DOB_____ Address_____

Day Phone_____ Cell Phone _____

Other _____ Address _____

Day Phone_____ Cell Phone _____

Physician or Medical Svc_____ Address _____ (p)_____

Names of individuals authorized to pick up child who are NOT listed above:

Name _____ Address_____ (p)_____

Name _____ Address_____ (p)_____

Name _____ Address_____ (p)_____

Name _____ Address_____ (p)_____

HEALTH INFORMATION

The following information must be filled in by the parent/guardian. The intent of this information is to provide staff the background to provide appropriate care. Provide complete information so that we can be aware of your child's needs.

Allergies Describe reaction and management of the reaction

- Medications (e.g., penicillin) _____ _____
- Food (e.g., eggs, dairy) _____ _____
- Other (e.g., insect stings, hay fever) _____ _____

Medications

Medications require a separate form. Please contact the Child Care Program Director for more information.

Insurance

Is participant covered by family medical/hospital insurance? ☐ Yes ☐ No Carrier/plan name _____

Name of insured _____ Relationship to child _____

Policy holder SS# or insurance ID # _____ Group # _____ Carrier Address _____

Health History

Any activities that child cannot participate in or needs one-on-one assistance? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

Is your child currently being treated or followed by a medical professional for any of the following:

Asthma	☐ Yes	☐ No	Diarrhea/constipation	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Seizures/Convulsions	☐ Yes	☐ No

Please explain any "YES" answers _____

_____

_____

_____

Any additional information about the child's behavior and physical, emotional or mental health the staff should be aware of?

_____

_____

_____

Special Information – AFO's, walkers, wheelchairs, assistance with toileting, behavior issues, Diets, habits, etc.

_____

_____

_____

Publicity Photographs

May we use your child in publicity photographs? ☐ Yes ☐ No

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, give permission for _____ to discuss my child's medical
(Mother, Father, Guardian) (Health care provider)
information, diagnosis and treatment, including medications with a representative of the YMCA's School Age Child Care program.

Signature of parent or guardian _____ Date _____

Health Care Provider's phone _____ Fax _____

As the Y is for youth development, we would like to know why you chose the YMCA. (Ex: I wanted my child to improve his or her social skills. I wanted to help my child stay healthy by being more physically active. I wanted my child to improve his or her academic performance.)

_____

_____

_____

_____

AGREEMENT

- **Enrollment:** I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding fees (late fee of $20/child), transportation and the services provided by the facility and the New York State Department of Social Services regulations under which it operates.
- **Field Trips and Transportation:** My child ☐ **is** ☐ **is NOT** permitted to take part in field trips or excursions away from the facility under proper supervision, including transportation provided by or arranged for by the School Age Child Care program.
- **Swimming:** My child ☐ **is** ☐ **is NOT** permitted to participate in swimming activities from September to June. All children are swim tested and only approved swimmers are permitted in the deep end.
- **Homework:** Do you wish your child to work on his/her homework each day while in the program? ☐ **Yes** ☐ **No** Although, the YMCA assists children with homework daily, time limitations may not allow for completion of all work.
- **Emergency Medical Care:** I agree that in the case of accident or injury, emergency medical care may be given in the event I or the person(s) designated cannot be reached.
- **Correct Information provided:** I have provided special information on this registration to assist the facility in caring for this child (diet, habits, allergies, medical issues, etc)
- **Parent Handbook:** I accept the policies and procedures contained in the School Age Child Care parent handbook. I have read and fully understand all policies and procedures contained within and agree to abide by them. I further understand that failure to abide by the policies and procedures contained in this handbook could result in dismissal from the program.

Signature of Parent/person(s) legally responsible: _____ Date:_____

OFFICE USE ONLY

_____ Received Parent Handbook

_____ Program Director notified of allergies & medication

_____ Form is complete (check boxes, allergy/medications)

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INDEPENDENT HEALTH FAMILY BRANCH YMCA
2019-2020 SCHOOL AGE CHILD CARE TUITION AGREEMENT

Please select from two tuition options for the entire year, **part-time (1-3 days per week)** or **full-time (4 or 5 days per week)**. The tuition payment is based on the price of the program for the year and then divided into 10 equal payments. Each month you will pay 1/10th of your total child care bill, regardless of the number of school days actually occurring in that month.

HOW DID YOU HEAR ABOUT THE YMCA?

☐ Radio ☐ Billboard ☐ Newspaper / Magazine ☐ Social Media
☐ Mail ☐ E-mail ☐ Word of Mouth ☐ Other

REGISTRATION INFORMATION

Child Last Name		Child First Name
Parent Last Name		Parent First Name
Address		
City	State	Zip
Cell Phone		Work Phone
E-mail Address		
Signature		

SELECT TUITION PLAN

☐ Part-time (1-3 days per week)
☐ Full-time (4-5 days per week)

SELECT SITE

☐ Independent Health Family Branch YMCA
☐ Clarence Center
☐ Harris Hill
☐ Ledgeview
☐ Sheridan Hill

SELECT PM PROGRAM

☐ **PM PART-TIME**
Member - $166/month; Program Member - $183/month

☐ **PM FULL-TIME**
Member - $255/month; Program Member - $293/month

SELECT DAYS: ☐ M ☐ T ☐ W ☐ Th ☐ F

PAYMENT INFORMATION

For your convenience, we will automatically draft your account on the first of the month. We can accept your Visa, MasterCard, Discover, or American Express debit or credit cards, as well as a checking account. By signing, you agree to authorize the YMCA to charge your account for each month enrolled and give the YMCA 30 days written notice when cancelling.

☐ Checking Account ☐ MasterCard ☐ Visa ☐ Discover ☐ AMEX

Last 4 digits of Credit Card/Checking Number	Exp. Date
Signature	Date

Reminder, the YMCA does not give credits for snow days, illnesses, or family vacations taken during school days. What you are paying is a yearly tuition broken into 10 monthly payments. Snow days are accounted for in the price, as it is based on the number of days school must provide services.

Please fill out and return this form to:
INDEPENDENT HEALTH FAMILY BRANCH
150 Tech Drive, Amherst, NY 14221
P: 716.839.2543 F:716.839.2352 IndependentHealthFamilyYMCA.org

FOR OFFICE USE ONLY
Date Received _____
Verified By _____
Member Number_____