



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

**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 <small>(If applicable)</small>	

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 _____

Marital 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 <small>(Including City, State, Zip)</small>	
Home Phone	
Cell Phone	
Email Address	
Employer	
Employer's Address <small>(Including City, State, Zip)</small>	
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 <small>(Including City, State, Zip)</small>	
Home Phone	
Cell Phone	
Email Address	
Employer	
Employer's Address <small>(Including City, State, Zip)</small>	
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 <small>(Including City, State, Zip)</small>	
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 <small>(Including City, State, Zip)</small>	
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!

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:	Current Medications	
	Address:		
	Phone:	Dietary Modifications	
Designated Preferred Dentist	Name:	Operations Serious Injury	
	Address:	Disabilities	
	Phone:		
Designated Preferred Hospital	Name:	Chronic Illnesses Reoccurring Illnesses	
	Address:		
	Phone:	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.	

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	
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- 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

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 than 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

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. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? (if yes, a swimming permission slip is required) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Child's Information	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 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)	
<input type="checkbox"/> Child swimming in water 18 inches or more in depth <input type="checkbox"/> Child participating in activities near water 18 inches or more in depth (no water activities planned) <input type="checkbox"/> Infants and toddlers using wading pools	
I give permission for my child to participate in the following swimming/water activities	
Swim Site <div style="text-align: center; font-size: 1.2em;">Clippard YMCA</div>	
Date(s) <div style="text-align: center; font-size: 1.2em;">Out School day 2017-2018 School Year</div>	
Departure/Arrival Times from Center	
Mode of Transportation (parent's driving, provider vehicle, public transportation, school bus, etc.) <div style="text-align: center; font-size: 1.2em;">Walking</div>	
Child's Name	Child's Date of Birth
My child is a <input type="checkbox"/> Swimmer <input type="checkbox"/> 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. <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/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. <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/home?					
Emergency Contacts: Parents <u>cannot be listed</u> 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? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> 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:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport	OR	<u>Do Not Give Permission</u> to Transport
Program or Home Name		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		Parent's Signature
Date		Date

Acknowledgement of Policies and Procedures
I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>

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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete JFS 01217 "Request for Administration of Medication")</i> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Training Instructions <i>(Trainer must be a parent or certified professional)</i>			
Signature of Trainer		Date	
Signature of trained providers, substitutes or child care staff members who have been made aware of the condition. <i>(There must always be a trained caregiver present when the child is present)</i>			
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
<i>(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)</i>			
Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	
<input type="checkbox"/> Prescription Medication <input type="checkbox"/> Nonprescription Medication <input type="checkbox"/> Food Supplement <input type="checkbox"/> Topical Product or Lotion <input type="checkbox"/> Refrigeration Required <input type="checkbox"/> 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
<input type="checkbox"/> 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.
<ol style="list-style-type: none"> 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.



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: _____

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: _____

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