The Spot Summer Camp

For your child to attend this camp they must be on Free and Reduced lunch. Provide a copy of your approved application with your enrollment packet.

*Pricing

$15.00 Registration fee per family to start the program

$10.00 per child per week

You will also be required to purchase a YMCA membership or a city pool pass for your child as we swim multiple times a week. Proof of either membership or pool pass must be turned in with your registration packet. See below for pricing options.

YMCA Membership Pricing

Youth: $25.56 per month

1 Adult Family: $53.25 per month

2 Adult Family: $ 63.90 per month

Wooster City Pool Pass Pricing

Resident Youth: $65.00

Non-Resident Youth: $75.00

Free/Reduced Lunch: $20.00 (must provided approved application)

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 <u>cannot be listed</u> as emergency contacts. List the name <u>of at least one person</u> who can be contacted in the event of an emergency or illness **If you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

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.

Child's Name: _____ Child's Date of Birth: _____

Y N I give permission for my child to be included in publicity pictures connected with the program, including those used in online media such as on our website and Facebook page.

I, the undersigned parent/guardian, do hereby accept all responsibility for, and assume the risk of any injury or damage to my person or dependent children which might arise directly or indirectly as a result of, and/or participation in a YMCA of Wayne County program. I hereby expressly release, discharge and hold harmless from any liability whatsoever the YMCA, the various branches and subdivisions expressly including but not limited to the Board of Trustees of the YMCA, except for injuries caused intentionally, or by willful misconduct. I certify that I am familiar with the contents of the release, that I have read and understand the same, and that it is my intention by signing this release that the same be binding not only on me, but my heirs, administrators, executors, successors, and assigns. The YMCA of Wayne County is not responsible for misplace or stolen items.

_____ _____

Parent/Guardian signature Date

the YMCA
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

EZ Pay Authorization Agreement for Direct Payments (ACH Debits)

I (we) hereby authorize the YMCA of Wayne County, hereinafter called Young Men's Christian Association, Inc., to initiate debit entries to my (our) account indicated below at the depository financial institution named below and to debit the same to such account. I (we) acknowledge that the organization of ACH transactions to my (our) account must comply with the provisions of U.S. Law.

Depository Financial Institution Name (Bank Name):_____

Checking or Savings Account
9 Digit Bank Routing Number: _____

Checking account Number: _____

Please attach a copy of your deposit slip or cancelled check.

Or

Credit/Debit Card _____ _____ _____ _____

Expiration date: _____/_____

Type of Card: MasterCard Visa Discover American Express

This authorization is to remain in full force and effect until YMCA has received written notification from me (or either of us) of its termination. I must give the YMCA two weeks' notice for withdrawal.

Name(s) on the account: _____Date:_____

Signature: _____

I understand my draft will be taken on Tuesday of every week.

Note: Debit Authorizations must provide that the received may revoke the authorization only by notifying the originator in the manner specified in the authorization.

YMCA of Wayne County

1. I understand that the EZ Pay is a continuous payment for care plan. I understand that my payment will automatically be taken out weekly (every Tuesday).
2. Draft will occur every Tuesday of each week.
3. If I wish to terminate my EZ Pay payment, I must give the YMCA 2 week's written notice.
4. The YMCA Board of Directors may, at their discretion adjust the weekly rate applicable to my childcare category. I understand that I will receive at least 4 weeks' notice prior to such change.
5. Should my childcare payment not be honored by my bank for any reason, I realize that I am still responsible for that payment. The YMCA will continue to attempt to collect the childcare payment after they receive notice from the bank. Please remember due to bank fees charged to the YMCA, there is a $25 processing fee which will be added to your next week's draft for any returns.