YMCA OF WAYNE COUNTY WOOSTER SCHOOL AGE CHILD CARE PRICING

**Child's Name**

**Do you qualify for JFS assistance?** **YES** **NO**

Ohio Department of Job and Family Services is accepted at all locations.
Scan the QR code to apply for ODJFS assistance!

**For Pricing, contact Nathan at Nathanc@ymcawayne.org or call the Y**

| CHOOSE YOUR LOCATION | | Address |
|---|---|---|
| | Cornertsone Elementary School* | 101 W Bowman St<br>Wooster OH 44691 |
| | Kean Elementary* (BASP Only) | 432 Oldman Rd<br>Wooster OH 4491 |
| | Melrose Elementary* (BASP Only) | 1641 Sunset Lane<br>Wooster OH 44691 |
| | Parkview Elementary* (BASP Only) | 773 Parkview Dr<br>Wooster OH 44691 |

If you have any questions or concerns or need more information regarding our programs and contact information feel free to visit our website at -- ymcawayne.org/childcare -- We look forward to assisting you with your child care needs!

* School Out Days and Snow Days will be held at the Woodland YMCA Location

# Enrollment Packet Requirements

- Payment Policy and Terms of Enrollment
- Communicable Disease Policy
- Discipline Policy
- File Card
- EZ Pay Authorization Agreement
- Child Enrollment & Health Information


**All enrollment paperwork must be turned in a week in advance before your child's start date. If your paperwork is not turned in one week in advance, then you will not be able to start on your start date.**

**Start Date** _____ **Paperwork Due By** _____

## Payment Policy and Terms of Enrollment

I/We understand that childcare tuition is payable weekly and may pay by automated check or credit card. Returned checks, CC, or EFT will have a $30 NSF fee set by the YMCA.

I/We understand that weekly tuition will be pulled every Friday from our automated system through the YMCA.

I/We understand that a late pick-up fee of $10 for EACH child will be charged for the first fifteen minutes after 6:00 p.m. and after 6:15pm a fee of $1.00 per minute will be charged. The fee will then be added to the next tuition payment.

I/We agree that a two week written notice must be given prior to your child's withdrawal from the center. Otherwise I am/we are liable for those two weeks of tuition fees.

I/ We understand that the registration fee is non-refundable.

Tuition is charged as a weekly rate. Tuition may change if number of days increases or decreases. Tuition may also change if rates increase. Rates are evaluated yearly.

There are no sick days offered at The YMCA of Wayne County Before and After School Programs (BASP). If your child goes home sick and cannot return for 24 hours after sickness, the charge is still applied.

The YMCA may have times that they are shut down for holidays. No payment is due for those days. If the center shuts down due to weather or other unforeseen reasons- no payment is due for these days.

The YMCA of Wayne County BASP are open from 6:30 A.M. to 9:00 A.M. and 3:00 P.M. to 6:00 P.M.Monday through Friday from August - May. Summer Camp is offered at our Orrville, Wooster, and Shreve location from June-August.

The programs are closed for the following holidays: New Year's Eve, New Year's Day, Good Friday, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and the day after Thanksgiving, Christmas Eve, and Christmas. The programs may be closed additional days due to shut down, emergency staffing and emergency weather situations. You will be notified in advance of these days.
The center will also be closed for teacher in-service. Each year the center will close 1-2 days for in-service hours which are required by state laws.

**Days of Enrollment:**
Upon registration, parents must specify days of care if attending on a part-time basis. Once these days of care are specified, please follow them closely and check with your child's teacher if you need to change the day of care on any given week. If you need to add an additional day, please check with your child's teacher.

Child's Name: _____

Date of Enrollment: _____

Days of Care: Monday Tuesday Wednesday Thursday Friday ALL
(Please circle days of care)

Before AND AFTER SCHOOL Before School ONLY After School ONLY

I/ We have read, understand and agree to the above information.

_____ Date _____
Parents/ Guardian Signature

_____ Date _____
Parents/ Guardian Signature

_____

**PHOTO RELEASE**

I give permission for my child's photograph to be taken while participating in activities at The Learning Academy. The pictures taken may be used for the purposes of publicity; on The Learning Academy's private Facebook page, in advertisement, program brochures, media productions, newspaper articles and other marketing tools by The Learning Academy, YMCA of Wooster or Schaeffler.

_____ _____
Parents/ Guardian Signature Date

# Communicable Disease & Return to School Policy for The YMCA of Wayne County Child Care Programs

**No signs of illness for 24 hours-**

**If a child is sent home from school with an illness or fever, they cannot return until 24 hour period has passed.**

**Chickenpox - dry scabs**
**Lice/nit - free**
**Conjunctivitis (pink eye) – on medication 24 hours**
**No regular diarrhea or vomiting**

**I (We) have read and understand The YMCA of Wayne County's Before and After School Program's policy on communicable diseases and agree to its policies.**

Child's Name_____

Parents/Guardians Signature_____

Date _____

PLEASE SIGN AND RETURN TO THE OFFICE PRIOR TO ENROLLMENT

# Behavior Plan

A sense of classroom family/community is essential to provide a place where each child feels safe and welcome. We work with children on building one another up, communicating effectively during conflict, and taking responsibility for their actions. The time it takes to establish a positive classroom community depends on the personalities and social makeup of the class each year. It is important that as parents and teachers we work together with our children to be sure they feel comfortable communicating their concerns and conflicts. While we are aware or become aware of many conflicts and concerns by observation and communication with my students, there are always situations where a parent needs to reach out to the teacher so that they can be made aware of important situations. If your child feels a need to communicate something with you, it is important enough that it be addressed appropriately with us and we can decide a good way to help the situation together.

We will contact parents via Procare or phone if a situation arises. Parents are expected to pick up as quickly as possible if your child is needed to be. We will make every effort to work with parents of children having difficulties in our care. We use a 3 strike policy towards working with children and parents. Being sent home 3 times will lead to removal from our program. Reasons for being sent home included the following:

a.) Abusive (physical or verbal) towards another children or staff members
b.) excessive language directed at other children or staff members
c.) sexual actions/comments towards other children or staff members
d.) destroying of YMCA property
e.) anything else that may be deemed removable offense by staff or director

No child is subjected to corporal punishment or physical discipline at any time. Discipline will never be related to food, rest, or toileting.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____

## 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: _____

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 Friday of every week before the week of care.

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 – BASP AGREEMENT

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.
2. Draft will occur every the Friday previous to the week of attendance.
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 processing fee which will be added to your next week's draft for any returns.

# File Card

Child's Name _____ Child's Birthday _____

Class Enrolled _____

Mother_____ Employer_____ Work Phone #_____

Cell Phone # _____

Father_____ Employer_____ Work Phone #_____

Cell Phone # _____

Emergency Numbers (must have at least one and he/she MUST be within 1 hour drive of center)

Name _____ Phone _____

Name _____ Phone _____

## Pick-Up Permission Card

The following persons may pick up my child

NAME RELATIONSHIP TO CHILD

1._____

2._____

3._____

4._____

I understand that my child will not be released to anyone else unless written instructions (including date, signature, and name of person picking up) have been given by me to a staff member.

Parent's/Guardian'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 #1 | Relationship to Child | |
| Home Address ☐ Same as Child's | Home Telephone Number ☐ Same as Child's | |
| City | State / Zip | |
| Email Address *(if applicable)* | Cell Phone *(if applicable)* | |
| Parent's Work/School Name | Parent's Work/School Telephone Number | |
| Parent's Work/School Address | City | |

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information 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 #2 | Relationship to Child | |
| Home Address ☐ Same as Child's | Home Telephone Number ☐ Same as Child's | |
| City | State / Zip | |
| Email Address *(if applicable)* | Cell Phone | |
| Parent's Work/School Name | Parent's Work/School Telephone Number | |
| Parent's Work/School Address | City | |

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information 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 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 Medical Foods

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 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/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 to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or 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 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

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

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

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 file.

☐ N/A - program does not provide meals or snacks to the child.

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.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

| Child's Name |
|---|

**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** | | | **OR** Do not sign both | ***Do Not Give Permission* 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. | | | | **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, 5101:2-13-15, and 5101:2-14-04. 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

# DEVELOPMENTAL AND EDUCATIONAL GOALS FOR STEP UP TO QUALITY (SUTQ)

| Name of Child | Date of Birth |
|---|---|

*For Three to Five-Star Rated programs, the program must work with families to develop goals for children. These goals must be updated at least annually.*

Developmental/Educational Goal

| Action Steps | Person(s) Responsible | Resources Needed | Timeline | Comments on Progress |
|---|---|---|---|---|
| | | | | |

Developmental/Educational Goal

| Action Steps | Person(s) Responsible | Resources Needed | Timeline | Comments on Progress |
|---|---|---|---|---|
| | | | | |

| Lead Teacher's Name | Signature | Date |
|---|---|---|
| | | |

| Parent/Guardian's Signature | Date |
|---|---|
| | |

Ohio Department of Children and Youth

# FAMILY NEEDS SURVEY FOR STEP UP TO QUALITY (SUTQ)

***We want to support any needs you or your family may have. THE INFORMATION YOU PROVIDE ON THIS FORM IS CONFIDENTIAL***

Please circle Y (YES) or N (NO) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.

| Child's/Children's Name(s): | Caretaker's Name: | Date Completed: |
|---|---|---|
| | | |

| | | TOPICS | Briefly List CONCERN |
|---|---|---|---|
| **Child Development and Education-** Does anyone in your family have any need for resources or support in the areas listed below? | | | |
| Y | N | Information on child growth and development. | |
| Y | N | Guiding and supporting a child's behavior. | |
| Y | N | Medical or disabilities or possible conditions for any child or adult in the family. | |
| Y | N | Obtaining toys or activities to use to help any child in your home. | |
| Y | N | Preparing your child for kindergarten. | |
| **Child and Family Health-** Does anyone in your family have any need for resources or support in the areas listed below? | | | |
| Y | N | Health insurance and/or access to regular medical care, dental care, or medications. | |
| Y | N | Medical or health supplies or supports that anyone in your family needs. | |
| Y | N | Accessing immunizations. | |
| Y | N | Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner. | |
| Y | N | Concerns with depression, anger, anxiety, or mental health needs. | |
| Y | N | Concerns with alcohol, drug, or addiction problems. | |
| **Financial and Household Supports-** Does anyone in your family have any need for resources or support in the areas listed below? | | | |
| Y | N | Help paying for child care. | |
| Y | N | Help finding housing or safe housing. | |
| Y | N | Help paying your mortgage or rent. | |
| Y | N | Help with food expenses. | |
| Y | N | Finding household items such as furniture, clothing, or school supplies. | |
| Y | N | Access to transportation or transportation expenses. | |
| Y | N | Attending school (such as a GED, Certifications, or college degrees) | |
| Y | N | Help finding work or job training | |

| Are there other needs you or your family have that are not listed above: | |
|---|---|
| Parent Signature | Date: |
| Administrator or Designee Signature: | Date: |

For Staff Use:

| Bronze Rating Level | Silver Rating Level | Gold Rating Level |
|---|---|---|
| Resources provided to the family: | Resources provided to the family: | Resources provided to the family: |
| Administrator or Designee Signature & Date: | Administrator or Designee Signature & Date: | Administrator or Designee Signature & Date: |
| | Referrals provided to the family: | Referrals provided to the family: |
| | Administrator or Designee Signature & Date: | Administrator or Designee Signature & Date: |
| | | Follow-up provided to the family: |
| | | Administrator or Designee Signature & Date: |