



# Enrollment Packet Requirements

- Payment Policy and Terms of Enrollment
- Communicable Disease Policy
- Discipline Policy
- File Card
- EZ Pay Authorization Agreement
- Child Medical Statement

**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 and Holmes 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 Orrville and Wooster 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)

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

\_\_\_\_\_  
Parents/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parents/ Guardian Signature

\_\_\_\_\_  
Date

**PHOTO RELEASE**

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

\_\_\_\_\_  
Parents/ Guardian Signature

\_\_\_\_\_  
Date

# **Communicable Disease & Return to School Policy for The Learning Academy**

**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 and Holmes 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 as parents and teachers we work together with our children to be sure they feel comfortable communicating their concerns and conflicts.

We are aware or become aware of many conflicts and concerns by observation and communication with 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 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 from the program as quickly as possible if requested to do so. 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 cause removal from our program. Reasons for being sent home included the following:

- a.) Abusive (physical or verbal) towards other 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.) Destruction of YMCA property
- e.) Anything else deemed a 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 and Holmes 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: Master Card      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 and Holmes County BASP/Summer Camp 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 (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.

# File Card

Child's Name \_\_\_\_\_ Child's Birthday \_\_\_\_\_

Class Enrolled \_\_\_\_\_

Mother \_\_\_\_\_ Employer \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_

Mother \_\_\_\_\_ Employer \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_

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 from The Learning Academy.

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 <input type="checkbox"/> Same as Child's		Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which information 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 #2		Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's		Home Telephone Number <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which information 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?				
<b>Emergency Contacts:</b> Parents <b>cannot be listed</b> as emergency contacts. List the name of <b>at least one person</b> 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		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**

<b>Give <u>Permission</u> to Transport</b>		<b>OR</b>  <b>Do not sign both</b>	<b>Do Not Give <u>Permission</u> to Transport</b>	
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	
<p><i>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.</i></p>			
Developmental/Educational Goal			
Action Steps	Person(s) Responsible	Resources Needed	Timeline
Developmental/Educational Goal			
Action Steps	Person(s) Responsible	Resources Needed	Timeline
Lead Teacher's Name		Signature	
Parent/Guardian's Signature		Date	

Name of Child		Date of Birth	
<b>Additional goals or updates to currently listed goals</b>			
Developmental/Educational Goal			
Action Steps	Person(s) Responsible	Resources Needed	Timeline
Developmental/Educational Goal			
Action Steps	Person(s) Responsible	Resources Needed	Timeline
Lead Teacher's Name		Signature	
Parent/Guardian's Signature		Date	