YMCA OF WAYNE AND HOLMES
WEST HOLMES SCHOOL AGE CHILD CARE

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!

CHOOSE YOUR LOCATION		ADDRESS
☐	West Holmes Elementary	6000 State Route 754 Millersburg, OH 44654

BEFORE	☐
AFTER	☐
BOTH	☐

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

For program questions
Email nathanc@ymcawayne.org

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 Friday for the following week of care.
2. If I wish to terminate my EZ Pay payment, I must give the YMCA 2 week's written notice.
3. The YMCA may, at their discretion, adjust the weekly rate applicable to my childcare category. I understand I will receive at least 4 weeks' notice prior to such change.
4. 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 up to a $30 processing fee each attempt which will be added to your balance due.

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 Children and Youth

CHILD ENROLLMENT FORM FOR EARLY CARE AND EDUCATION PROGRAMS

Parents: Complete this form or an electronic version in its entirety prior to the child's first day of attendance, review annually, and update as needed. The program may supplement or substitute this document with their own content equivalent form and request additional information from the parent/guardian.

Child's Name	Date of Birth	First Day at Program
Address		
City	State	Zip Code

Parent #1 Name	Parent #1 Phone Number		
Parent #1 Address ☐Same as Child's	City	State	Zip Code
Parent #1 Email Address (if applicable)	Parent #1 Cell Phone (if applicable)		
Parent #1 Work/School Name (if applicable)	Parent #1 Work/School Phone Number (if applicable)		

Check here if Not Applicable ☐ / Parent #2 Name	Parent #2 Phone Number		
Parent #2 Address ☐Same as Child's	City	State	Zip Code
Parent #2 Email Address (if applicable)	Parent #2 Cell Phone (if applicable)		
Parent #2 Work/School Name (if applicable)	Parent #2 Work/School Phone Number (if applicable)		

Primary Emergency Contact #1 Name (cannot be parent/guardian)	Check here if Not Applicable ☐ / Optional Emergency Contact #2 Name (cannot be parent/guardian)
Primary Emergency Contact #1 Phone Number	Optional Emergency Contact #2 Phone Number
Primary Emergency Contact #1 Other number or email address for emergency contact *(if applicable)*	Optional Emergency Contact #2 Other number or email address for emergency contact *(if applicable)*
My child may be released to this emergency contact ☐ Yes ☐ No	Optional My child may be released to this emergency contact ☐ Yes ☐ No

Does your child have a chronic health condition or diagnosis that requires the program to: observe or monitor symptoms, administer medication, serve medical foods, perform medical procedures, avoid specific foods/environmental conditions/activities, or allow a school age child to carry and administer their own medication?

☐ Yes (complete or provide a Health Care Plan, documentation from a licensed physician, or an electronic equivalent)
☐ No

Child's Name	Date of Birth

Information on my child's development: (personal, behavior, patterns, habits, and individual needs, etc.)

☐ N/A

The following accommodation(s) may be helpful to most effectively meet my child's needs while at the program:

☐ N/A

My child will receive specialized/individual services at the program:

☐ Yes
☐ No

Name of service provider(s) and frequency

☐ N/A

Emergency Transportation Authorization

☐ **The program 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.

☐ **The program 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:

SIGNATURE

This form should be reviewed 12 months from the date the parent acknowledges accuracy and receipt of policies and procedures.

Parent Acknowledgement of Accuracy and Receipt of Policies and Procedures

By signing this form, I attest that the information is accurate and that I have reviewed and received a copy of the program's policies and procedures (parent handbook).

Parent Signature	Date

Program Acknowledgement of Completion

By signing this form, I attest that I have reviewed for completeness and that this form has been signed by the parent/guardian. This form is to be completed prior to the child receiving care.

Program Administrator/Designee Signature	Date

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

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	

YMCA of Wayne and Holmes County Orrville 330-683-2153 Wooster 330-264-3131

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:

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