



YMCA Younger Years Childcare Center

Phone: (814) 764-5413

Email: Childcare@clarionymca.net

Childcare Enrollment Form

Child's Name: _____ D.O.B. _____

Address: _____

Phone #: _____ Email: _____

Parent/ Guardian Signature _____ Date _____

Please check the program your child will attend. A separate form must be used for each child.
A \$30.00 Non-refundable registration fee will be required at the time of enrollment.

Infant Care

Full Time Care – four or five days a week\$153.00/Week

Half Time Care- three days or less a week.....\$103.00/Week

Toddler Care

Full Time Care – four or five days a week\$149.00/Week

Half Time Care- three days or less a week.....\$98.00/Week

Preschool Age Care

Full Time Care- four or five days a week.....\$141.00/Week

Half Time Care- three days or less a week.....\$93.00/Week

Preschool (Mon. Wed. Fri. 8:30am to 12:15pm)

Preschool Program only.....\$105.00/Month

School-Age Care

After School Hours Only

Full Time Care – four or five days a week\$55.00/Week

Half Time Care- three days or less a week.....\$40.00/Week

Before School Hours Only

Full Time Care – four or five days a week\$35.00/Week

Half Time Care- three days or less a week.....\$30.00/Week

Both-Before & After School Care

Full Time Care – four or five days a week\$77.00/Week

Half Time Care- three days or less a week.....\$50.00/Week

School Age Care

Daily Rate.....\$32.00/Day

Full Day- Full Time.....\$140.00/Week

Full Day- Part Time.....\$92.00/Week



Requested Hours of Care

Child's Name _____ D.O.B. _____

Address _____ Phone # _____

Parent/ Guardian Signature _____ Date _____

**\$30.00 Non-refundable registration fee is needed at time of enrollment.
Please list the hours of care needed below.**

	Drop off	Pick-Up
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

You will be charged for all hours requested. You MUST give two weeks written notice to permanently change your child's scheduled hours or withdraw your child from the program.

We staff based on the pick-up and drop off times listed above, late pickups will resolved in additional fees. For every minute late you will be charged an additional fee of \$1.00.

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(c); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT \$	PER-DAY-WEEK	DAY PAYMENT TO BE MADE
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)		
CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE \$	PER MIN-HR	
Extra services to be provided at an additional fee if applicable		

I, the parent/guardian;

received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (§ 3270.124, 3280.124, 3290.124)

_____ SIGNATURE-OPERATOR DATE _____ SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION
DATE OF WITHDRAWAL

PERIODIC REVIEW	
_____ SIGNATURE-PARENT OR GUARDIAN	_____ DATE

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182; 3280.124 (a)(b), 3280.181 & 182; 3290.124 (a)(b), 3290.181 & .182

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS
		TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)	
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST - AID PROCEDURES	
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY THE FACILITY	WADING	

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE



Escort Sheet

Child's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____

Parent's Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____

Periodic Updates:

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



YMCA Younger Years
Child Care Center

Field Trip Waiver



I hereby give permission for _____, to travel on a YMCA planned field trip via the YMCA bus designated vehicle. By signing this permission slip and waver, I hereby understand the description of the program and any complications that may arise.

Furthermore, I intent to be legally bound for myself, my heirs, personal representatives, successors and assigns do hereby waive and release the Clarion County YMCA and YMCA Younger Years for any and all liabilities arising from illness, injuries, and damage that the participant may suffer while being transported with.

Parent/ Guardian Name (Print)

Parent/ Guardian Signature

Date

Sunscreen Permission Slip



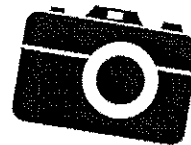
According to the Department of Public Welfare regulations, we are no longer allowed to apply sunscreen, first-aid cream, or Bactine without parental written permission. Therefore, we are asking parents to bring their own bottle of sunscreen from home and label the bottle with their child's name.

The YMCA Younger Years have my permission to apply sunscreen to my child _____ as needed during the summer months.

Parent/ Guardian Signature

Date

Media Release



Do you give Clarion County YMCA permission to use, without limitation or obligation, photographs, film footage or tape recordings that may include yours or your family member's image(s) or voice(s) for purposes of promoting or interpreting YMCA programs?

_____**YES, I give my permission** _____**NO, I do not give my permission**

Child's Name: _____

Signature _____

Date: _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:
<input type="checkbox"/> I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.		
PARENT'S SIGNATURE:		

Parents may write immunization dates; health professional should verify and complete all data.

DO NOT OMIT ANY INFORMATION
 This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
 NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
 NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
 NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
 NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
 YES NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.
	VISION (subjective until age 3)
	HEARING (subjective until age 4)
	LEAD

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

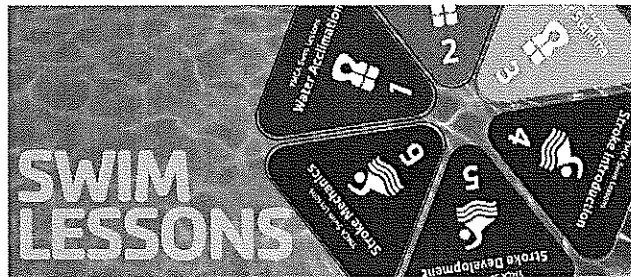
MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:



YMCA Younger Years Childcare Swim Release Form

Please release _____ from the YMCA Younger Years Program to swim at the Clarion County YMCA during scheduled swim times. I understand that the YMCA child care staff will not be responsible for my child while he/she is swimming and that he/she will be under the supervision of the Clarion County YMCA Aquatics staff.

Parent/Guardian Signature: _____ Date: _____



Periodic Update:

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

September 9, 2019

Dear Parent or Guardian:

YMCA Younger Years offers healthy meals and snacks to children as part of the Child and Adult Care Food Program (CACFP). Our center receives support from CACFP to serve those meals. CACFP gives more support if your household income is less than or equal to the limits on this chart:

Federal Income Standards for Reduced-Price Meals for July 1, 2019 - June 30, 2020		
Household size	Yearly Income	Monthly Income
1	\$23,107	\$1,926
2	\$31,284	\$2,607
3	\$39,461	\$3,289
4	\$47,638	\$3,970
5	\$55,815	\$4,652

Please fill out a *CACFP Meal Benefit Income Eligibility* form. It will help us find out how much support YMCA Younger Years receives. Please be sure to read the instructions carefully. Fill in all the information we request. We can only accept complete forms.

Thank you for taking the time to fill out the form. We hope your child enjoys CACFP meals!

In the operation of child nutrition programs, no person will be discriminated against because of race, color, national origin, sex, age, or disability.

If you have questions or need help, please contact **Michelle Miller** at **814-764-5413** or **Childcare@clarionymca.net**.

Sincerely,

Michelle Miller
Director of Child Care

This institution is an equal opportunity provider.

**Child and Adult Care Food Program
Child Enrollment Form (Sample)**

Sponsor/Center Name: _____
Agreement #: _____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	<input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____ Enrollment Date: _____ Withdrawal Date: _____								<input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME										
BIRTH DATE										
AGE										
SECOND CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____ Enrollment Date: _____ Withdrawal Date: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME										
BIRTH DATE										
AGE										
THIRD CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____ Enrollment Date: _____ Withdrawal Date: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME										
BIRTH DATE										
AGE										

Signature _____
 Signature of Parent or Guardian _____ Date _____ Telephone Number of Parent or Guardian _____

CHILD CARE REPRESENTATIVE USE ONLY: _____
 Name of Representative/Signature _____ Date _____
 The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

 In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member regularly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	Public Assistance/Alimony/Child Support	Pensions/Retirement/All other sources of income
<ul style="list-style-type: none"> Salary, wages, cash bonuses Net income from self-employment (farm or business) If you are in the U.S. Military: <ul style="list-style-type: none"> Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) Allowances for off-base housing, food, and clothing 	<ul style="list-style-type: none"> Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits 	<ul style="list-style-type: none"> Social Security (including railroad retirement and black lung benefits) Private Pensions or disability benefits Income from trusts or estates Annuities Investment income Earned income Rental income Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): Hispanic or Latino Not Hispanic or Latino

Race (check one or more): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FPIR) case number or other FDIPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication (e.g. Braille, large print, audiocassette, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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MAIL: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov

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*Only use this address if you are filing a complaint of discrimination.

DO NOT FILL OUT For official use only

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income How often? Weekly Bi-Weekly Monthly 2x-Monthly Household size

Eligibility	Free	Reduced	Denied
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Categorical Eligibility

Determining Official's Signature

Date

Confirming Official's Signature

Date

Follow-up Official's Signature

Date