

**YWCA Penn Manor Kindergarten Wrap Program  
Registration Checklist**

CHILD \_\_\_\_\_

Home School \_\_\_\_\_

- \_\_\_\_\_ Application Form
- \_\_\_\_\_ Signed Center Agreement
- \_\_\_\_\_ Signed Parental Consent/Release Form
- \_\_\_\_\_ Getting to know your child form
- \_\_\_\_\_ Signed Behavior/Conduct Policy
- \_\_\_\_\_ YWCA Membership Form
- \_\_\_\_\_ Health Appraisal Form
- \_\_\_\_\_ Calendar
- \_\_\_\_\_ Completed Emergency Contact Form- MUST BE COMPLETE

Payment Information: Self Pay \_\_\_\_\_ Funded/co-pay \$ \_\_\_\_\_

Caseworker \_\_\_\_\_

Verified by \_\_\_\_\_

Enrollment processed by \_\_\_\_\_ Date \_\_\_\_\_

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For Office Use

Method of payment: Check Cash Credit

Wrap Site: Pequea / Hambright  
(Circle One)

\$ \_\_\_\_\_ Membership- \$15

\$ \_\_\_\_\_ Registration- \$10

\$ \_\_\_\_\_ Deposit - \$85

\$ \_\_\_\_\_ Total

Receipt Number \_\_\_\_\_

Initials: \_\_\_\_\_

Date: \_\_\_\_\_

**YWCA Penn Manor Kindergarten Wrap Program  
APPLICATION FORM**

NAME \_\_\_\_\_ DOB/Age: \_\_\_\_\_ M/F

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Home School \_\_\_\_\_ Wrap Site: Pequea / Hambright  
(Circle One)

Ethnicity \_\_\_\_\_

Health concerns/medications taken/allergies \_\_\_\_\_  
\_\_\_\_\_

Siblings in the program \_\_\_\_\_

**Parent/Guardian**

**Parent/Guardian**

**Name:** \_\_\_\_\_

**Relationship to child:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/Zip:** \_\_\_\_\_

**Phone #s** H- \_\_\_\_\_ Cell \_\_\_\_\_ H- \_\_\_\_\_ Cell \_\_\_\_\_

**Social Security#** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

Is there a court order for the child's file? – Yes or No

**YWCA SCHOOL AGE CHILD CARE PROGRAM  
CENTER AGREEMENT  
55 PA CODE CHAPTERS 3270.123 &.181(c);3290.123 &.181(c)**

Name of Child: \_\_\_\_\_

Wrap Site: \_\_\_\_\_

Fee Amount: \$ \_\_\_\_\_

Per: \_\_\_\_\_ Day \_\_\_\_\_ Week

Late Fee: \$1 per minute after 6:00pm

Day payment due: \_\_\_\_\_ 15<sup>th</sup> of each month

Termination Policy: Two weeks written notice.

Services to be provided: YWCA Programs as outlined in the Parent Handbook  
Developmentally Appropriate Activities

Child's Arrival Time: Kindergarten Dismissal      Child's Departure Time: 3:30pm

**Civil Rights Compliance Parent Awareness**

In accordance with applicable Federal and State civil rights laws and regulatory requirements, you and your children, as clients of the YWCA have the right to be provided services by YWCA and to be referred for services at other facilities without regard to your race, color, religious creed, disability, ancestry, national origin, age or sex. If you feel you have been discriminated against, complaints of discrimination may be filed with any of the following:

YWCA of Lancaster Attn: Maureen Powers 110 N. Lime St. Lancaster, PA 17602

Department of Public Welfare  
Bureau of Equal Opportunity  
P.O. Box 2675  
Harrisburg, PA 17105

US Dept. of Health & Human Services  
Office of Civil Rights  
Suite 372 Public Ledger Bldg.  
150 S. Independence Mall West  
Philadelphia, PA 19106

PA Human Relations Comm.  
Riverfront Office Center  
1101 S. Front St. 5<sup>th</sup> Fl.  
Harrisburg, PA 17104

Payment responsibility: Please list person(s) who will be responsible for payments: \_\_\_\_\_

I, parent/guardian;			
_____ Received complete written program information at the time of enrollment (3270.121, 3280.121, 3290.121) I agree to abide by all policies and procedures stated.			
_____ Agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at minimum. (3270.124, 3280.124, 3290.124)			
Staff Signature	Date	Parent/Guardian Signature	Date

Date of Child's Admission	Periodic Review	
Date of Withdrawal	Signature of Parent or Guardian	Date

## YWCA Penn Manor Kindergarten Wrap Program Parental Consent/Release Form

Child's Name: \_\_\_\_\_

- |     | YES   | NO    |  |
|-----|-------|-------|--|
|     |       |       | I grant permission for my child to:  |
| 1.  | _____ | _____ | Use all Center play equipment and materials while under the supervision of Center staff.   |
| 2.  | _____ | _____ | Participate in all Center activities.  |
| 3.  | _____ | _____ | Leave Center premises for walks/field trips, while under the supervision of Center staff.  |
| 4.  | _____ | _____ | Be included in evaluations, pictures, and recordings connected with the Center's program.  |
| 5.  | _____ | _____ | Swim in pools.   |
| 6.  | _____ | _____ | Ride the YWCA van and school busses for field trips.   |
| 7.  | _____ | _____ | <p><b>Permission for emergency medical treatment:</b><br/>I authorize the treatment of my child _____ by a qualified and licensed physician in the event of a medical emergency, which in the opinion of the attending physician, may endanger the child's life, cause disfigurement, physical impairment, or undue discomfort if delayed. I grant permission for Center staff to administer first aid and to take whatever action necessary to obtain or administer emergency care.</p> |
| 8.  | _____ | _____ | <p><b>Emergency Procedure:</b> An ambulance is called (911) if the need is indicated. Please indicate your choice of hospital _____. The parent is notified immediately thereafter. If parent cannot be reached, contact person is called. If both parent and contact person cannot be reached, the child's physician is called. Center staff accompanies child to hospital and remains until authorized person arrives.</p>   |
| 9.  | _____ | _____ | <p><b>Permission for administration of prescription medication and/or special dietary needs:</b> *Please use the medication log at the site for administration of prescription medication. *Please list any special dietary needs.</p>   |
| 10. | _____ | _____ | <p><b>I understand that if my child damages any items at the Wrap Program, the price of these items will be added to my monthly bill.</b></p>  |
| 11. | _____ | _____ | <p><b>Individualized Education Plan (IEP) &amp; Individualized Family Service Plans (IFSP) Information Sheet:</b> Please indicated with a check mark one of the following:</p> <p style="margin-left: 40px;">_____ I am providing a copy of my child's IEP/IFSP</p> <p style="margin-left: 40px;">_____ I am not providing a copy of my child's IEP/IFSP</p> <p style="margin-left: 40px;">_____ This is not applicable to my child</p>  |

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Child's Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### **Getting to Know Your Child**

Please take time to answer a few questions about your child and your family. This will help our child care staff better care for your child.

1. What kinds of things do you and your child like to do together?
  
2. Are there any custody issues that our staff need to be aware of?
  
3. Who is included in your household? Please include names and relation to the child.
  
4. Is this your child's first childcare experience? If so, how often has your child been away from you or his primary care giver?
  
5. Does your child strongly dislike any foods?
  
6. Does your child have any strong fears?
  
7. If there are any other issues/concerns that our staff should be aware of please write them below.

**YWCA Penn Manor Kindergarten Before & After School  
CODE OF CONDUCT & BEHAVIOR POLICY**

The following will be our framework for creating a positive environment.

**Code of Conduct for Children & Staff**

I will show respect for myself, others and property.

I will show kindness to others.

I will follow all the rules, be cooperative and helpful.

I will listen and follow directions.

I will take responsibility for my actions.

I will be part of creating a safe environment.

I will do my personal best.

**Consequence Steps:**

1. Verbal warning
2. A Take 5 Form - timeout --1 minute per number of years old up to 10 minutes.
3. A Consequence Form which requires child and parent signature.
4. A 2<sup>nd</sup> Consequence Form will result in a 1-3 day suspension.
5. A 3<sup>rd</sup> Consequence Form will result in a 1 week suspension.
6. A 4<sup>th</sup> behavior report will result in expulsion from camp.
7. In extreme cases SACC Directors may suspend or terminate care the same day.
8. The Child Care Director must approve all terminations from care.

We agree to follow the Code of Conduct & Behavior Policies:

\_\_\_\_\_  
Parent signature

# 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

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

\_\_\_\_\_  
SIGNATURE OF PARENT or GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT or GUARDIAN

\_\_\_\_\_  
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:		

**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 <a href="http://WWW.AAP.ORG">WWW.AAP.ORG</a> ) <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>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.</b>						
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
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/ID						
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:

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