

**SACC CAMP 2010**  
**REGISTRATION CHECKLIST**  
For Office Use

NAME \_\_\_\_\_ Site \_\_\_\_\_

**Completed and Signed:**

- \_\_\_ Application Form
- \_\_\_ Center Agreement
- \_\_\_ Parental Consent
- \_\_\_ Code of Conduct Policy
- \_\_\_ Emergency Contact Form
- \_\_\_ Health Appraisal Form
- \_\_\_ Calendar
- \_\_\_ CACFP Paperwork (YWCA/McCaskey only)

YWCA Membership: New or Renewal

\_\_\_\_\_ Expiration Date

Payment Information: Self Pay \_\_\_\_\_

Funded/co-pay \$ \_\_\_\_\_

Case worker \_\_\_\_\_

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

Enrollment processed by: \_\_\_\_\_

Date \_\_\_\_\_

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Method of Payment: Check Cash Credit

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

\$ \_\_\_\_\_ Registration- \$10 (waived for school year participants)

\$ \_\_\_\_\_ Activity Fee- \$30

\$ \_\_\_\_\_ 1<sup>st</sup> weeks tuition/CCIS Copay

\_\_\_\_\_

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

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

Check Number: \_\_\_\_\_

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

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

**SACC CAMP 2010  
APPLICATION FORM**

Name \_\_\_\_\_ DOB/Age \_\_\_\_\_ M/F

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

School \_\_\_\_\_ Grade Fall '10 \_\_\_\_\_

Ethnicity \_\_\_\_\_

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

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

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Parent/Guardian

Parent/Guardian

Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Address \_\_\_\_\_

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

Phone: H \_\_\_\_\_ C \_\_\_\_\_ H \_\_\_\_\_ C \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

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

**YWCA SACC Summer Camp Program  
Center Agreement  
55 PA CODE CHAPTERS 3270.123 &.181(c);3290.123 &.181(c)**

**Name of Child:** \_\_\_\_\_ **Site:** \_\_\_\_\_

**Weekly Fee Amount:** \$ \_\_\_\_\_ **Late Fee:** \$1.00 per minute before 6:30am & after 6pm  
**Shirt Fee:** \$7.00 for new camp shirt for field trip

**Day payment due:** Friday for the following week – Children will not be accepted Mondays if payment has not been received.

**Termination Policy:** Two weeks written notice.

**Services to be provided:** YWCA Programs as outlined in the Parent Handbook  
Field trips/swimming & Developmentally Appropriate Activities  
Morning and Afternoon Snack

**Child's Arrival Time:** \_\_\_\_\_ **AM** **Child's Departure Time:** \_\_\_\_\_ **PM**

**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 the 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 SACC Summer Program: Parental Consent/Release Form**

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

I grant permission for my child to:

- | YES  | NO    |  |
|--|-------|--|
| 1. _____   | _____ | <b>I. Permission to participate in Center activities:</b><br>Use Center play equipment & materials while under supervision of staff.   |
| 2. _____   | _____ | Participate in all Center activities.  |
| 3. _____   | _____ | Leave premises for walks/field trips, while under the supervision of staff.  |
| 4. _____   | _____ | Be included in pictures, & recordings connected with the program.  |
| 5. _____   | _____ | Swim in the YWCA pool & other pools.   |
| 6. _____   | _____ | Ride in the YWCA van & busses for field trips.   |
| 7. _____   | _____ | Allow YWCA staff to apply sunscreen throughout the day.  |
| 8. _____   | _____ | <b>II. 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. |
| 9. _____   | _____ | <b>Emergency Procedure:</b><br>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.  |
| 10. _____  | _____ | <b>III. Permission for administration of prescription medication.</b>  |
| 11. _____  | _____ | <b>IV. I understand that if my child damages any items at the SACC Program, the price of these items will be added to my weekly bill.</b>  |
| 12. <b>Individualized Education Plan (IEP) &amp; Individualized Family Service Plans (IFSP) Information Sheet:</b> Please indicate with a check mark one of the following:<br>_____ I am providing a copy of my child's IEP/IFSP<br>_____ I am not providing a copy of my child's IEP/IFSP<br>_____ This is not applicable to my child |       |  |

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

**SACC CAMP 2010**  
**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 take part in creating a safe environment.

I will do my personal best.

**Procedures:**

YWCA Child Care Programs define unacceptable behavior as:

- A child who continuously interrupts the flow and continuity of the program and requires constant one-on-one attention.
- A child inflicting physical or emotional harm on other children or staff.
- A child who is consistently unable to follow the rules and expectations of the program.
- A child/parent uses abusive language or threatens other children or staff members.
- A child continues to behave against the YWCA childcare policies explained in this packet.
- The Staff/Director feels that the program can no longer function effectively due to the unacceptable behavior of a child.

**Consequence Steps:**

1. Verbal warning
2. Take 5 Form – timeout – 1 minute per number of years old; up to 10 minutes
3. Consequence Form: requires child and parent signature
4. 2<sup>nd</sup> Consequence Form: result in a 1-3 day suspension
5. 3<sup>rd</sup> Consequence Form: result in a week suspension
6. A 4<sup>th</sup> Consequence Form will result in expulsion from the 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

\_\_\_\_\_  
Child Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
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), 33290.181 & .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>		<i>Cell:</i>
<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>		<i>Cell:</i>
<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>	

**PERIODIC REVIEW**

\_\_\_\_\_  
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 [WWW.AAP.ORG](http://WWW.AAP.ORG))

YES  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:

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

## SACC CAMP 2010 Calendar

Please fill out the calendar by placing a check mark next to the days your child will be using our program. All 3 months must be completed and submitted with your registration packet upon enrollment. We understand that your schedule may change, so vacation dates may be added with two weeks advance notice.

All vacation schedule changes should be called into our administrative assistant, Jenny Rosario at the YWCA (717-393-1735 ext 242). Billing question and/or concerns should be directed to Lisette Colon(ext 230).

**Vacation Weeks: \$15 (2 week limit for the entire summer)**

**\*\*WE DO NOT GIVE CREDIT FOR CANCELLATIONS\*\***

**Childs Name:** \_\_\_\_\_ **Group:** \_\_\_\_\_

**Site:** \_\_\_\_\_ **Start date:** \_\_\_\_\_

**(June)**

14 _____ (1 <sup>st</sup> Day Penn Manor)	5 <b>closed</b>	26 _____	16 _____
15 _____	6 _____	27 _____	17 _____
16 _____	7 _____	28 _____	18 _____
17 _____ (YW/Mc Start)	8 _____	29 _____	19 _____
18 _____	9 _____	30 _____	20 _____

21 _____	12 _____	<b>(Aug)</b> 2 _____	23 _____ <b>(Penn Manor Camp at</b>
22 _____	13 _____	3 _____	24 _____ <b>YWCA this week)</b>
23 _____	14 _____	4 _____	25 _____
24 _____	15 _____	5 _____	26 _____
25 _____	16 _____	6 _____	27 _____ <b>(Last day of Camp)</b>

28 _____	19 _____	9 _____
29 _____	20 _____	10 _____
30 _____	21 _____	11 _____
1 _____ <b>(July)</b>	22 _____	12 _____
2 _____	23 _____	13 _____

I understand and agree with the scheduling and billing policy:

X \_\_\_\_\_  
 (Parent signature) (Date)

**Our camp/child care needs are:**

Full time camper \_\_\_\_\_ Part time/Days \_\_\_\_\_

Drop off time \_\_\_\_\_ Pick up time \_\_\_\_\_

T-Shirt Size: Child: S M L XL Adult: S M L XL