

**YWCA School Age Child Care Program
Registration Checklist- SDOL**

Child's name: _____

Site: YWCA Lancaster

- _____ Application Form
- _____ Signed Center Agreement
- _____ Signed Consent/Release Form
- _____ Emergency Contact Form – MUST BE COMPLETE
- _____ Health Appraisal Form ___ on file
- _____ Signed Code of Conduct Policy
- _____ Signed Anti-Harassment Form
- _____ Civil Rights Form
- _____ Getting to Know Your Child Form
- _____ CACFP Form (Food Program)
- _____ Calendar Received

Child's School: _____

_____ BSP _____ FT _____ PT

_____ ASP _____ FT _____ PT

___/___/___ Membership Expiration Date

Payment Information: _____ Funded Caseworker: _____

_____ Self Pay Record Number: _____ - _____

Checked By: _____ Date _____

-For Office Use Only-

\$ _____ Membership (\$15 if not current)

\$ _____ Registration (\$10 per family – fee waived if currently in our program)

\$ _____ \$50 deposit/copy

\$ _____ **Total**

Receipt Number: _____

Cash Check # _____ Money Order # _____ Credit Card

Initials: _____ Date: _____

(Registration fee, membership fee and first week's tuition are non-refundable)

YWCA School Age Child Care Program
Application Form

Child's Name: _____ Birth Date: _____

Gender (circle one): Male Female Ethnicity (White, Black, etc.) _____

School child attends: _____ Child's Teacher: _____

Grade (2011-2012 school year): _____

Marital Status of Parents: _____ Married _____ Single _____ Divorced

Are there any custody issues we should be aware of? _____ Yes _____ No

	<u>Parent 1</u>	<u>Parent 2</u>
Name	_____	_____
Home Address	_____ _____	_____ _____
Home Telephone	_____	_____
Cell Phone	_____	_____
Social Security #	_____	_____
Date of Birth	_____	_____
Employer	_____	_____
Occupation	_____	_____
Business Address	_____ _____	_____ _____
Business Phone	_____	_____
E-mail Address	_____	_____

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

Name of Child: _____ Site: _____
 Fee Amount: \$ _____ Per: _____ Day _____ Week

Early/ Late Fee: \$1 per minute after 6:00pm or before 6:30am

Day payment due: _____ 20th of each month _____

Termination Policy: Two weeks written notice.
 Services to be provided: YWCA Programs as outlined in the Parent Handbook
 Developmentally Appropriate Activities
 Afternoon Snack

Child's Arrival Time Before School: _____ Child's Departure Time After School: _____

TERMINATION and DAMAGES POLICIES

I understand that in order to terminate my child from the program, I must give **two weeks** notice to the Director. If two weeks notice is not given, **you will be charged two weeks of fees from the time of the withdrawal. THERE ARE NO EXCEPTIONS TO THIS POLICY.** My signature below indicates that I agree to abide by the termination policy and understand that I will be charged two weeks fees if adequate notice is not given.

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.

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

I, parent/guardian;			
_____	Received complete written program information/parent handbook 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: (please check yes or no)

- | | YES | NO | |
|----|------------|-----------|--|
| 1. | _____ | _____ | I. Permission to participate in Center activities:
Use Center play equipment & materials while under supervision of staff. |
| 2. | _____ | _____ | Participate in all Center activities. |
| 3. | _____ | _____ | Leave premises for walks and field trips, while under the supervision of staff. |
| 4. | _____ | _____ | Be included in pictures, & recordings connected with the program for publicity/marketing campaigns, promotional publications, media coverage, or other purposes. |
| 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. _____ **II. Permission for emergency medical treatment:**
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. _____ **Emergency Procedure:**
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. _____ **III. Permission for administration of prescription medication and special dietary needs.**

11. _____ **IV. Individualized Education Plan (IEP) & Individualized Family Service Plans (IFSP) Information Sheet:** Please indicate with a check mark one of the following:
_____ I am providing a copy of my child's IEP/IFSP
_____ I am not providing a copy of my child's IEP/IFSP
_____ This is not applicable to my child

Parent's Signature: _____ 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

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		Cell:
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		Cell:
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 PROCEEDURES
WALKS AND TRIPS	SWIMMING	
TRANSPORTATION BY THE FACILITY	WADING	
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) <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>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.</p> <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.

**SACC 2011-2012 School Year
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. 2nd Consequence Form: result in a 1-3 day suspension
5. 3rd Consequence Form: result in a week suspension
6. A 4th 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



YWCA Lancaster
110 North Lime Street
Lancaster, PA 17602
ywca@ywcalancaster.org
(717) 393-1735
(717) 396-0513 (fax)

YWCA Anti-Harassment Policy

The YWCA is committed to protecting the rights and dignity of each individual it serves and of every employee who provides those services. Any offensive physical, written, or spoken conduct including conduct of a sexual nature is prohibited.

The YWCA Lancaster strives to create and maintain a work environment in which people are treated with dignity, decency and respect. Mutual trust and the absence of intimidation, oppression, and exploitation should characterize the environment in the child care center. Employees should be able to work and learn in a safe, yet stimulating atmosphere. The accomplishment of this goal is essential to the mission of the YWCA. For that reason, the YWCA **will not tolerate** unlawful discrimination or harassment of any kind.

Harassment may be defined as unwelcome or unsolicited verbal, physical or sexual conduct that creates an intimidating, hostile or offensive working environment. If any of the following behaviors are exhibited by a parent/guardian in the child care center, their child care services will immediately be suspended for three days. We reserve the right, depending on the severity of the harassment to terminate child care services completely.

1. **Use of inappropriate language or profanity**
2. **Exhibiting behavior that is believed to be hostile**
3. **Disrespecting the child care staff or director**
4. **Initiating a verbal or physical threat towards a YWCA child care employee. (Immediate termination of child care services can occur)**

I understand the above listed policies and agree to abide by them while my child I in the care of the YWCA. I also understand that if I engage in any of the aforementioned behaviors, my child care services may be terminated.

Parent's Signature

Date

Staff Signature

Date

**CIVIL RIGHTS COMPLIANCE
PARENT AWARENESS**

In accordance with applicable Federal and State civil rights laws and regulatory requirements, you and your child(ren) as a client of this facility, have the right:

To be provided services at this facility and to be referred for services at other facilities without regard to your race, color, religious creed, disability, ancestry, national origin, age, or sex.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery location. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and/or their guardian) who believes they have been discriminated against, may file a complaint of discrimination with:

YWCA of Lancaster
Attention: Cheryl Gahring
110 North Lime Street
Lancaster, PA 17602

Department of Public Welfare
Bureau of Equal Opportunity
Room 223 Health & Welfare Building
P.O. Box 2675
Pennsylvania Human Relations Commission

Pennsylvania Human Relations Commission
Harrisburg Regional Office
Riverfront Office Center
Office for Civil Rights
Harrisburg, PA 17104-1260

Harrisburg Regional Office
U.S. Department of Health & Human Services
1101 South Front Street, 5th Floor
Suite 372, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-9111

Bureau of Equal Opportunity
Central Regional Office
Building 56, Patton House
Cameron & Maclay Street
P.O. Box 61260
Harrisburg, PA 17106-1260

Parent/Guardian Signature: _____

Date _____

Staff Signature: _____

Date _____

Childs 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 you child have any strong fears?**
- 7. If there are any other issues/concerns that our staff should be aware of please write them below.**

Child and Adult Care Food Program -- Child Enrollment Form

Enrollment Date: _____

Child _____ Address _____ Birth date _____	Parent/Guardian _____ Address _____ Telephone (home) _____ (work) _____
--	---

Sponsoring Organization <u>YWCA of Lancaster - SACC</u> Address <u>110 N. Lime St.</u> <u>Lancaster, PA 17602</u>	Center/Home _____ Address _____
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Normal Hours of Care: (write in times*) *If more than 8 hours of care per day, please attach an explanation to this form.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start: _____	Start: _____	Start: _____	Start: _____	Start: _____	N/A	N/A
End: _____	End: _____	End: _____	End: _____	End: _____		

Daily Expected Meal Service Participation (please check box)

Breakfast	AM Snack	Lunch	PM Snack	Supper	Eve Snack
	n/a			n/a	n/a

Is this child of school age? Yes No If yes, will additional meals be provided when school is not in session? Yes No
 If yes, please specify the meal: Breakfast Lunch Snack Supper

Household Contacts: This child care facility participates in the Child and Adult Care Food Program. In order to receive federal funds, representatives of the sponsoring organization or the State Agency may contact you to verify your child's participation. Please indicate what time and method of contact you prefer:

Day	Evening	Time	Letter	Telephone:	(home)	(work)
-----	---------	------	--------	------------	--------	--------

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ Date _____

Signature Center Administrator/Home Provider _____ Date _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ Date _____

Signature Center Administrator/Home Provider _____ Date _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ Date _____

Signature Center Administrator/Home Provider _____ Date _____

Annual Time Period Covered by Signature: _____ to _____

Signature Parent/Guardian _____ Date _____

Signature Center Administrator/Home Provider _____ Date _____

"In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs). " "To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer."

For Sponsor Use Only

Child withdrew on _____

Part 1. Children or adults enrolled to receive day care. (Use a separate application for each foster child)					
Names (First, Middle Initial, Last)	Food Stamp, TANF or FDPIR case # for <u>children only</u> . All the above or SSI or Medicaid case # for <u>adults only</u> . Skip to Part 4 if you listed a case #.				
Part 2. Foster Child: In certain cases, foster children are eligible for free and reduced-price meals regardless of household income. If foster children live with you, please contact [name] and [phone number] . Skip to Part 4.					
Part 3. Total Household Gross Income—You must tell us how much and how often					
A. Name (List everyone in household, including children) (Example) Jane Smith	B. Gross income and how often it was received Example: \$100/monthly \$100/twice a month \$100/every other week \$100/weekly				C. Check if NO income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
	\$200/weekly	\$150/weekly	\$100/monthly	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
	\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>
Part 4. Signature and Social Security Number (Adult must sign) An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) <i>I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.</i>					
Sign here: X _____ Print name: _____ Date: _____					
Address: _____ Phone Number: _____					
Social Security Number: _____ <input type="checkbox"/> I do not have a Social Security Number					
Part 5. Participant's ethnic and racial identities (optional)					
Mark one ethnic identity:		Mark one or more racial identities:			
<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Asian			
<input type="checkbox"/> Not Hispanic or Latino		<input type="checkbox"/> American Indian or Alaska Native			
		<input type="checkbox"/> White			
		<input type="checkbox"/> Black or African American			
		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander			
Don't fill out this part. This is 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: _____ Per: <input type="checkbox"/> Week, <input type="checkbox"/> Every 2 Weeks, <input type="checkbox"/> Twice A Month, <input type="checkbox"/> Month, <input type="checkbox"/> Year Household size: _____					
Categorical Eligibility: _____ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___ Tier I ___ Tier II ___					
Reason: _____					
Temporary: Free ___ Reduced ___ Time Period: _____ (expires after ___ days)					
Determining Official's Signature: _____					Date: _____
Confirming Official's Signature: _____					Date: _____
Follow-up Official's Signature: _____					Date: _____