

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 (2010-2011 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: _____

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. 5th Fl.
Harrisburg, PA 17104

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 Program: Parental Consent/Release Form

Child's Name _____

I grant permission for my child to:

- | YES | NO | I. Permission to participate in Center activities: |
|----------|-------|---|
| 1. _____ | _____ | 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. _____ | _____ | 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. |
|-----------|-------|---|

- | | | |
|-----------|-------|---|
| 11. _____ | _____ | 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. |
|-----------|-------|---|

12. **Individualized Education Plan (IEP) & Individualized Family Service Plans (IFSP) Information Sheet:** Please indicated 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 _____

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.**

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		<i>Cell #:</i>
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		<i>Cell #:</i>
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
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	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.