

YWCA Penn Manor Kindergarten Wrap Program  
Registration Checklist

\*Please include this form with your completed registration\*

Child's Name: \_\_\_\_\_ Home School: \_\_\_\_\_

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

- \_\_\_\_\_ Application Form
- \_\_\_\_\_ Signed Center Agreement
- \_\_\_\_\_ Anti-harassment Form
- \_\_\_\_\_ Signed Parental Consent and Release
- \_\_\_\_\_ Emergency Contact form-MUST BE COMPLETE
- \_\_\_\_\_ Health Appraisal Form
- \_\_\_\_\_ Civil Rights Form
- \_\_\_\_\_ Getting to Know Your Child Form
- \_\_NA\_\_ Calendar Received

\_\_\_\_\_ BSP \_\_\_\_\_ FT \_\_\_\_\_ PT  
\_\_\_\_\_ ASP \_\_\_\_\_ FT \_\_\_\_\_ PT  
\_\_\_\_\_ WRAP \_\_\_\_\_ FT \_\_\_\_\_ PT

\_\_\_/\_\_\_/\_\_\_ Membership Expiration Date

Part-time Days: \_\_\_\_\_

Payment Information: \_\_\_\_\_ Funded Caseworker: \_\_\_\_\_

\_\_\_\_\_ Self Pay Record Number: \_\_\_-\_\_\_\_\_

Checked By: \_\_\_\_\_

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**-FOR OFFICE USE ONLY-**

\$ \_\_\_\_\_ Membership (\$15.00 Child)

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

\$ \_\_\_\_\_ \$85 WRAP Deposit or CCIS Co-pay

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

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

Cash    Check # \_\_\_\_\_    Money Order # \_\_\_\_\_    Credit Card

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

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

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

Site Notified: \_\_\_\_\_

**YWCA Penn Manor Kindergarten Wrap Program**  
Application Form

Child's Name: \_\_\_\_\_ Birthday/Age: \_\_\_\_\_

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

School child attends: \_\_\_\_\_

Marital Status of Parents: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced

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

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Siblings in program: \_\_\_\_\_

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





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 is 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

\_\_\_\_\_  
YWCA Representative Signature

\_\_\_\_\_  
Date

**YWCA Kindergarten Wrap Program: Parental Consent/Release Form**

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

I grant permission for my child to: (please check yes or no)

- |     | <b>YES</b> | <b>NO</b> |  |
|-----|------------|-----------|--|
| 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 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.   |
| 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 and special dietary needs.</b>  |
| 11. | _____      | _____     | <b>IV. 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: \_\_\_\_\_

## 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		
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)
<b>PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT</b>		
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

## Child Health Assessment

Parents &amp; Child Care Providers 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:

*To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.*

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at <www.aap.org> or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): <input type="checkbox"/> NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
IN/CM    % ILE	LB/KG    % ILE	(Birth to Age 2) IN/CM    % ILE	(Beginning at age 3) /

PHYSICAL EXAMINATION	<input checked="" type="checkbox"/> = NORMAL	IF ABNORMAL - COMMENTS
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (attach additional sheets if necessary)

NONE

Medical care Provider: Address:	NEXT APPOINTMENT - MONTH/YEAR: Signature of Physician or CPNP:
Phone:	License Number:
	Date Form Signed:

Parents may write immunization dates, health professionals should verify and complete all data.

**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 Gahrng  
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, 5<sup>th</sup> 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.**