

YWCA SACC Summer Camp Program  
Registration Checklist

\*Please include this form with your completed registration\*  
-FOR OFFICE USE ONLY-

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

- \_\_\_\_\_ Application Form
  - \_\_\_\_\_ Signed Center Agreement
  - \_\_\_\_\_ Signed Parental Consent and Release
  - \_\_\_\_\_ Emergency Contact form-MUST BE COMPLETE
  - \_\_\_\_\_ Signed Code of Conduct Policy
  - \_\_\_\_\_ Anti-Harassment Form
  - \_\_\_\_\_ Civil Rights Form
  - \_\_\_\_\_ Health Appraisal Form
  - \_\_\_\_\_ Calendar Received
  - \_\_\_\_\_ CACFP Forms (YWCA/McCaskey only)
- \_\_\_\_\_ On File  
\_\_\_\_\_ FT \_\_\_\_\_ PT

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

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

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

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

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

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

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

\$ \_\_\_\_\_ \$125 FT/\$95 PT 1<sup>st</sup> weeks tuition 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)**

**YWCA SACC Summer Camp Program**  
Application Form

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

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

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

School child attends: \_\_\_\_\_ Grade (Fall 2011): \_\_\_\_\_

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 the 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 SACC Summer 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 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 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		<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
		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

**SACC SUMMER CAMP 2011  
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



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

**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 \_\_\_\_\_

# 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 SUMMER CAMP 2011 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)**

13 _____ (1 <sup>st</sup> Day Penn Manor)	4 <b>closed</b>	25 _____	15 _____
14 _____	5 _____	26 _____	16 _____
15 _____ (1 <sup>st</sup> Day YWCA/Mc)	6 _____	27 _____	17 _____
16 _____	7 _____	28 _____	18 _____
17 _____	8 _____	29 _____	19 _____

20 _____	11 _____	<b>(Aug) 1</b> _____	22 _____ <b>(Penn Manor Camp at</b>
21 _____	12 _____	2 _____	23 _____ <b>YWCA this week)</b>
22 _____	13 _____	3 _____	24 _____
23 _____	14 _____	4 _____	25 _____
24 _____	15 _____	5 _____	26 _____ <b>(Last day of Camp)</b>

27 _____	18 _____	8 _____	
28 _____	19 _____	9 _____	
29 _____	20 _____	10 _____	
30 _____	21 _____	11 _____	
1 _____ <b>(July)</b>	22 _____	12 _____	

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