

Before and After School Child Care 2024/2025 Paperwork Checklist

- Registration
 - Make sure to indicate AM, PM, or Both
 - Make sure Billing/Payment Information are filled out
- Child Enrollment & Health Information Form
- General Permission
- Permission to Pick-Up
- Child Care Agreement

- All forms must be turned in to Kathy.Joiner@LakotaYMCA.com yearly. Emailing the forms will not hold your spot. A confirmation email will be sent once paperwork is processed and spot is secured.

Email Lindsay Miller, Child Care Director with any questions at Lindsay.Miller@LakotaYMCA.com



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LAKOTA FAMILY YMCA

REGISTRATION FORM for Before and After School 2024-2025

Student Information (please print legibly or type)

PROGRAM START DATE: _____

___ LAKOTA FAMILY YMCA MEMBER (student must be member) ___ NON-MEMBER

STUDENTS FIRST NAME: _____ STUDENTS LAST NAME: _____

STUDENT ADDRESS: _____

CITY: _____ ZIP CODE: _____ PHONE: _____

DATE OF BIRTH _____ GENDER (check one) Male Female

GRADE FOR 2024/2025 SCHOOL YEAR (check one)

K-AM K-Full Day 1st 2nd 3rd 4th 5th 6th

PROGRAM DESIRED (check one)

AM ONLY PM ONLY BOTH AM/PM

SCHOOL YOUR CHILD WILL BE ATTENDING (check one)

___ Adena ___ Cherokee ___ Creekside ___ Endeavor ___ Freedom
___ Heritage ___ Hopewell ___ Independence ___ Liberty ___ Shawnee
___ Union ___ Van Gorden ___ Woodland ___ Wyandot

BILLING INFORMATION: PARENT(S)/GUARDIAN(S) INFORMATION

PARENT/GUARDIAN 1: NAME: _____ RELATIONSHIP TO CHILD: _____ ADDRESS: _____ CITY: _____ ZIP CODE: _____ *PRIMARY NUMBER: _____ SECONDARY NUMBER: _____ *EMAIL : _____	PARENT/GUARDIAN 1: NAME: _____ RELATIONSHIP TO CHILD: _____ ADDRESS: _____ CITY: _____ ZIP CODE: _____ *PRIMARY NUMBER: _____ SECONDARY NUMBER: _____ *EMAIL : _____
---	---

Office Use ONLY: GIVE COPY TO PARTICIPANT

Registration Paid on Date: ___/___/___ Completed: _____

Staff Member Receiving: _____ Date Received: _____ Time Received: _____



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LAKOTA FAMILY YMCA

BILLING FORM for Before and After School Child Care 2024-2025

STUDENTS NAME: _____ School: _____ AM PM Both

PAYMENT INFORMATION (If using multiple payment options, both credit cards need to be available at time of registration or it will not be completed. We will collect an imprint of all credit cards.)

Card 1:	Visa	MasterCard	Discover	AMEX
CARD HOLDER NAME: _____				
CREDIT CARD NUMBER(if not on file) _____			EXP DATE: _____	
STREET NUMBER: _____		ZIP CODE: _____	% OF CHARGES TO THIS CARD (E, 100%, or 50%): _____	

Card 2:	Visa	MasterCard	Discover	AMEX
CARD HOLDER NAME: _____				
CREDIT CARD NUMBER(if not on file) _____			EXP DATE: _____	
STREET NUMBER: _____		ZIP CODE: _____	% OF CHARGES TO THIS CARD (E, 100%, or 50%): _____	

- Who is the Primary Responsible Parent/Guardian for Billing?: _____
- Do you need your Child Care Split between Parents/Guardians: _____
If yes, please verify how your bill needs split: _____
**Note: if one credit card does not process, the full payment will be taken out of the other credit card.*

Fees, Billing Policies and Procedures

Fees: This is a FULL-TIME service whether you use it or not. We prorate on Lakota School Districts calendar and calamity days. Snow Days will be accumulated to one credit the last month of school. If you withdraw before this, it is your responsibility to remind billing of your credit due.

Non-Refundable Registration Fee:	\$55		
Member Rates:	AM ONLY: \$62	PM ONLY: \$80	BOTH AM & PM: \$96
Non-Member Rates:	AM ONLY: \$77	PM ONLY : \$96	BOTH AM & PM: \$126

- Payments:**
- Credit Card(s) MUST be on file with the Lakota Family YMCA. It is your responsibility to keep this information up to date with the Lakota Family YMCA. You can not register without a valid credit card.
 - By registering for this program you authorize any and all child care related fees to be charged to your credit card.
 - Payments will be deducted from your account on the Friday prior to the week registered.
 - Withdrawal forms must be received 1 week prior to the withdrawal date
 - There will be no balances on accounts carried over from week to week.

Credit Card Declines: Credit cards may decline up to 3 times with no additional fees. The 4th time and all other declines there after will be charged a \$15.00 fee.

*Compromised credit cards will be waived a declined fee until it becomes abused.

I have read and understand the above policy and procedures:

Parent/Guardian Signature: _____ Date: _____

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth	First Day at Program/Home	
Home Address			City	
State	Zip Code	Home Telephone Number		
Parent/Guardian Name #1		Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's		Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip	
Email Address (if applicable)		Cell Phone (if applicable)		
Parent's Work/School Name		Parent's Work/School Telephone Number		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email				
Where can you be reached while your child is in this program/home?				
Parent/Guardian Name #2		Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's		Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip	
Email Address (if applicable)		Cell Phone		
Parent's Work/School Name		Parent's Work/School Telephone Number		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email				
Where can you be reached while your child is in this program/home?				
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached . Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.				
Name		Name		
City		State	City	
State		State		
Telephone Number	Relationship to Child		Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital				
Street Address				
City		State	Telephone Number	

Child's Name
Allergies, Special Health or Medical Conditions, and Medical Foods
<p>Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.</p>
<p>Does your child have any food, medication or environmental allergies? <i>(check all that apply)</i></p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>check all that apply</i> <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Environmental Please list and explain: </p>
<p>Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? <i>(check one)</i></p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed. </p>
<p>Does your child have a developmental delay or special health or medical condition? <i>(check one)</i></p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes - please explain </p>
<p>Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? <i>(check one)</i></p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed. </p>
<p>Is your child currently using any medication or medical food? <i>(check one)</i></p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes - please explain </p>
<p>If yes, does this medication or medical food need to be administered at the child care program/home?</p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food. </p>
<p>Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? <i>(check one)</i></p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes - please explain </p>
<p>Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?</p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes - written instructions from the child's health care provider must be on file. <input type="checkbox"/> N/A - program does not provide meals or snacks to the child. </p>

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or **medical personnel** in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? Yes (If yes, skip to Emergency Transportation Authorization section)

No (If no, fill out the following:)

The program's policy is to check diapers every ____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

I agree with the program's schedule I do not agree, please check my child's diaper every ____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport		OR Do not sign both	<u>Do Not Give Permission</u> to Transport	
Program or Home Name Lakota Family YMCA			Program or Home Name Lakota Family YMCA	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. Yes No (check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.



LAKOTA FAMILY YMCA

CHILD CARE AGREEMENT

I agree to the following statements regarding the Before and After School Child Care program ran by the Lakota Family YMCA.

- This is a full time service whether you use it or not. There is no vacation time granted in this program. Prorates will occur based on the Lakota School District calendar and calamity days.
- Payments for service will be deducted from your account on the Friday prior to the week of service.
- I understand that if I do withdrawal my child I must pay the \$55 registration fee to re-enroll in the program.
- A \$30 late fee per child will be assessed to you account if we do not receive payment by Monday at 8:00am the week of service. Your child(ren) will not be permitted to use our services until the account is paid in full.

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____



LAKOTA FAMILY YMCA

CHILD CARE GENERAL PERMISSION FORM

- I hereby grant permission for my child to:
 - Use all indoor/outdoor play equipment and participate in all activities at the center.
 - Be included in pictures, media print, electronic media and evaluations connected with any of the other child care programs.
 - Participate in field trips taken by the center. Prior information will be given to the parent/guardian about the trip.
- I hereby grant permission for the Child Care Director, Site Administrator or Camp Arrowhead Directors to take whatever steps that may be necessary to obtain emergency medical/dental care if warranted as stated on the Health Enrollment Form.
- I understand that all expenses incurred in obtaining medical/dental treatment are my responsibility and not the Lakota Family YMCA's.
- I understand that the Lakota Family YMCA is not responsible for anything that happens as a result of false information given by the parent/guardian at the time of enrollment.
- I understand the Lakota Family YMCA will not assume responsibility for a child who has not been signed in upon arrival or signed out when they depart for the day. I understand that the person dropping off and/or picking up must be 16 years of age or older and on the Permission to Pick Up Form.

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____



LAKOTA FAMILY YMCA

CHILD CARE PERMISSION TO PICK UP

I give permission for the following people to pick up my child,

from the Lakota Family YMCA Child Care Programs. I understand that the person picking up my child must be at least 16 years of age or older. They may also be asked for identification when picking up my child.

- Please make us aware of any custody issues.
- Please let us know right away if there are any changes to the above list.

NAME

RELATION TO CHILD

PHONE NUMBER

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____