Before and After School Child Care

2022/2023 Paperwork Checklist

☐ Registration
- Make sure to indicate AM, PM, or Both
- Make sure Billing/Payment Information are filled out

☐ Child Enrollment & Health Information Form

☐ Administration of Medication

- If applicable, if not needed put N/A

☐ Child Medical/Physical Care Plan

- If applicable, if not needed put N/A

☐ General Permission

☐ Permission to Pick-Up

☐ Child Care Agreement

- All forms must be turned in to HelpCenter@LakotaYMCA.com yearly to hold your spot for Before & After School Child Care

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 2022-2023

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 2022/2023 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 2:

NAME: _____

RELATIONSHIP TO CHILD: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

*PRIMARY NUMBER: _____

SECONDARY NUMBER: _____

*EMAIL : _____

Office Use ONLY: GIVE COPY TO PARTICPANT

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

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

LAKOTA FAMILY YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

BILLING FORM for Before and After School Child Care 2022-2023

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%):_____

SIGNATURE:_____

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%):_____

SIGNATURE:_____

- 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: $59	PM ONLY: $76	BOTH AM & PM: $93
Non-Member Rates:	AM ONLY: $73	PM ONLY: $91	BOTH AM & PM: $122

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.

Multiple Card Changes: You will be able to change your credit card up to 3 times with no additional fees. The 4th time and all other request to change a credit card there after will be charged a $15.00 fee.

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

Late Fee: A $30 late fee per child will be accessed to your account(s) if we do not receive your payment by Monday at 8:00am the week you will attend. Your child(ren) will not be permitted to use our services until account is paid in full.

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 ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ 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 at least one~~ person 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
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

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure	**Complete Only One Section**	**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have been trained in performing the procedure for this child.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.

Administrator/Provider Signature	Date of Signature

This 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, a new form must be completed.

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

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

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.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

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? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

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? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ 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.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

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 *Permission* to Transport			**Do Not Give *Permission* to Transport**	
Program or Home Name Lakota Family YMCA		**OR**	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.		**Do not sign both**	**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.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods
- Procedures which require staff training
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication or medical food is documented on this form, then a JFS 01217 is not required.

Child's Name

Special Health Condition

Does this health condition require medication or medical food? ☐ Yes (If Yes, complete Part II) ☐ No

A. What are the signs, symptoms, or situations which require staff to take action?

B. What are the activities, foods, environmental conditions, etc. to avoid? ☐ Not applicable

C. What are the training instructions for the procedures staff have to follow? *(include all steps to care for the child/perform the medical procedure)*

Part II: Conditions Requiring Medication or Medical Food

Completed by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant

(If no medications or medical foods are required for the condition, skip Part II).

If a non-prescription medication does not meet any of the items 1-5 below, the parent can complete Part II.

Part II must be completed by or separate instructions attached from a Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant when any of the following apply:

1. The (prescription or non-prescription) medication contains codeine or aspirin
2. Instruction is needed for the (prescription or non-prescription) medication
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the (prescription or non-prescription) medication
4. The (prescription or non-prescription) medication is to be given longer than three consecutive days within a fourteen-day period
5. The intended use differs from the manufacturer's instructions or use

Child's Name	Date of Birth	Weight *(if needed to determine dosage)*

Name of Medication/Medical Food	Name of Medication/Medical Food	Name of Medication/Medical Food
Dosage of Medication/Medical Food	Dosage of Medication/Medical Food	Dosage of Medication/Medical Food
Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration	Time of Medication/Medical Food Administration
Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date	Medication/Medical Food Expiration Date

☐ **Check here if questions A through C are included in a separate attachment that is signed/issued by Licensed Physician, Licensed Dentist, Advanced Practice Registered Nurse, or Certified Physician's Assistant**

A. What are the symptoms which require staff to administer medication or medical food?

B. What are the specific instructions for administration of medication or medical food?

C. What are the actions to be taken if symptoms do not subside?

Physician's Signature	Date of Signature

Part III: Administration of Medication or Medical Food Training Authorization

Completed by parent, trainer, administrator/provider, and/or trained child care staff member(s)

Part III must be completed

Child's Name

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure		**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided instructions for care and/or training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.	**Complete Only One Section**	*My signature indicates I have provided instructions for care and/or training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have received instructions for care and/or have been trained in performing the proced for this child. Additional printed names and signatures can be written on the back of this form or on an attached sheet.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.	Administrator/Provider Signature	Date of Signature

This 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, a new form must be completed.

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

Part IV: Documentation of Administration of Medication or Medical Food

Completed by child care staff member, family child care provider or in-home aide for the child listed on this form

All medication or medical food must be documented when administered. Document each medication or medical food on its own page. Incomplete information elevates the level of risk to children. If more than one medication or medical food is needed, make a copy of this page for each medication or medical food.

This medication or medical food is not to be administered until after the child has received the first dose or application at least once prior to the program administering a dose to avoid unexpected reactions. Emergency medications for the child are exempt from this requirement.

Child's Name	Name of medication/medical food

Date	Time	Dosage	Signature of designated person administering medication

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This form is to be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

Child's Name	Date of Birth *(if needed to determine the correct dosage)*	Weight *(if needed to determine the correct dosage)*

Box 1 The following section must always be completed by the parent/guardian.

Name of medication	Dosage	
	☐ See attached	
To be administered at the following times	For the following period of time	Medication expiration date

I understand:

1. *This form expires twelve months from the date of my signature, if box 2 has not been completed.*
2. *That my child must receive at least one dose of medication at home prior to the program administering the medication (unless the medication is used for emergencies).*

Signature of Parent/Guardian	Date

Box 2 The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant when any of the following apply:

1. The nonprescription medication contains codeine or aspirin;
2. A physician's instruction is needed for a nonprescription medication;
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication;
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen-day period;
5. The intended use differs from the manufacturer's instructions or use

Instructions

☐ See Attached

Possible side effects to watch for are

☐ See Attached

The child is under my care and should receive the above medication as written. I understand this form expires twelve months from the date of my signature.

Signature of licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant	Date of Signature

Phone Number

This form shall be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

The following section must be completed by the child care staff member, family child care provider or in-home aide for the child listed on this form. All medication must be documented when administered. Incomplete information elevates the level of risk to children.

Child's Name	Name of Medication

Date	Time	Dosage	Signature of designated person administering medication

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/guarding 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 state 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: _____