FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LAKOTA FAMILY YMCA

REGISTRATION FORM for Before and After School
2020-2021

1. Student Information (please print legibly or type)

PROGRAM START DATE: ___/____/____

***STUDENTS FIRST NAME:_____ *STUDENTS LAST NAME: _____**

***STUDENT ADDRESS:_____**

***CITY:_____ ZIP CODE:_____**

***DATE OF BIRTH_____/_____/_____ GENDER** (circle one): Male Female

*** GRADE FOR 2020/2021 SCHOOL YEAR** (circle one)
K-AM K-Full Day 1st 2nd 3rd 4th 5th 6th

*** PROGRAM DESIRED** (circle one): _____

AM ONLY PM ONLY BOTH AM/PM

*** SCHOOL ATTENDING** (check one):

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

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

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

PARENT/GUARDIAN 1:

NAME:_____
RELATIONSHIP TO CHILD:_____
ADDRESS:_____
CITY:_____ ZIP CODE:_____
***PRIMARY NUMBER:_____**
SECONDARY NUMBER:_____
OTHER NUMBER:_____
***EMAIL :_____**

PARENT/GUARDIAN 2:

NAME:_____
RELATIONSHIP TO CHILD:_____
ADDRESS:_____
CITY:_____ ZIP CODE:_____
***PRIMARY NUMBER:_____**
SECONDARY NUMBER:_____
OTHER NUMBER:_____
***EMAIL:_____**

Office Use ONLY: GIVE COPY TO PARTICPANT

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

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LAKOTA FAMILY YMCA

BILLING FORM for Before and After School Child Care
2020-2021

STUDENTS NAME:_____

3. 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) or Last 4_____ **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) or Last 4_____ **EXP DATE:**_____
STREET NUMBER:_____ **ZIP CODE:**_____ **% OF CHARGES TO THIS CARD (E, 100%, or**

- **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:**_____
    _____

4. 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: $57	PM ONLY: $74	BOTH AM & PM: $91
Non-Member Rates:	AM ONLY: $71	PM ONLY: $89	BOTH AM & PM: $118.50

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:(parents name)_____ Date: / / 2020

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			Relationship to Child
Home Address			Home Telephone Number
City			State / Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Telephone Number		Parent's Work/School Name	
Parent's Work/School Address			City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) 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			Relationship to Child
Home Address			Home Telephone Number
City			State / Zip
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Telephone Number		Parent's Work/School Name	
Parent's Work/School Address			City

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) 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 within one hour of the center/home, 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	

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

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 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care 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, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a 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 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

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

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

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 the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

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.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

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		**OR**	Program or Home Name	
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 and 5101:2-13-15. 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

Child's Name	Date of Birth

Special Health Conditions

Symptoms to watch for and emergency action to be taken if the following symptoms occur

Activities/foods/environmental conditions to avoid, if applicable

Medical procedures to be followed and expected benefit of treatment, if applicable

Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")*
If yes, what medications?

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?
☐ Yes ☐ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?
☐ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

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

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage

To be administered at the following times	For the following period of time

☐ I understand that my child must receive one dose of medication before arriving at the program (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.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

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

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.

Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

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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 the activities at the center.

- I hereby grant permission for my child to be included in pictures, media print, electronic media and evaluations connected with any of the child care programs.

- I hereby grant permission for my child to 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 School Age 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.

Child's Name_____

Signature of
Mother/Legal Guardian_____

Signature of
Father/Legal Guardian_____

Date_____

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LAKOTA FAMILY YMCA

CHILD CARE PERMISSION TO PICK UP FORM

I give my 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 16 years of age or older. They may also be asked for identification when picking up your child.

NAME	RELATIONSHIP TO CHILD	PHONE #

Parent/Guardian Signature_____

Date_____

Please Note:

- Please let us know if there is a custody issue
- Please let us know right away if there are changes to the above list
- Please let us know if there is someone who may not pick up your child

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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 this service 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.

- 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 your account if we do not receive payment by Monday at 8:00am the week you will attend. Your child(ren) will not be permitted to use our services until the account is paid in full.

Child's Name_____

Signature of
Mother/Legal Guardian_____

Signature of
Father/Legal Guardian_____

Date_____