

## **Before and After School Child Care 2021/2020 Paperwork Checklist**

- ☐ Registration
  - Make sure to indicate AM, PM, or Both
  - Make sure Billing/Payment Information are filled out
- ☐ Health Enrollment 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 [Heather.Branham@LakotaYMCA.com](mailto:Heather.Branham@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](mailto:Lindsay.Miller@LakotaYMCA.com)

Email Heather Branham, Billing Coordinator with any Billing questions at [Heather.Branham@LakotaYMCA.com](mailto:Heather.Branham@LakotaYMCA.com)



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FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# LAKOTA FAMILY YMCA

## REGISTRATION FORM for Before and After School 2021-2022

### 1. Student Information (please print legibly or type)

PROGRAM START DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

STUDENTS FIRST NAME: \_\_\_\_\_ STUDENTS LAST NAME: \_\_\_\_\_

STUDENT ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER (check one) Male Female

GRADE FOR 2021/2022 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 ATTENDING (check one)

\_\_\_ Adena

\_\_\_ Cherokee

\_\_\_ Creekside

\_\_\_ Endeavor

\_\_\_ Freedom

\_\_\_ Heritage

\_\_\_ Hopewell

\_\_\_ Independence

\_\_\_ Liberty

\_\_\_ Shawnee

\_\_\_ Union

\_\_\_ Van Gorden

\_\_\_ Woodland

\_\_\_ Wyandot

\_\_\_ 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 PARTICIPANT

Staff Member Receiving: \_\_\_\_\_ Date Received: \_\_\_\_\_ Time Received: \_\_\_\_\_

\*Indicates mandatory field

# LAKOTA FAMILY YMCA

## **BILLING FORM** for Before and After School Child Care 2021-2022

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 (circle one):      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%): \_\_\_\_\_  
 SIGNATURE: \_\_\_\_\_

Card 2 (circle one):      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%): \_\_\_\_\_  
 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.*

### 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: \$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: (parents name) \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / 2021

Parent/Guardian Signature: \_\_\_\_\_

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. <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which number(s) 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				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. <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which number(s) 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?					
<b>Emergency Contacts:</b> Parents <b>cannot be listed</b> 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 <b>if you cannot be reached</b> . 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 <b>or medical personnel</b> 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? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> 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:	
<input type="checkbox"/> I agree with the program's schedule	<input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

#### Emergency Transportation Authorization

Give <u>Permission</u> to Transport	<b>OR</b>	<u>Do Not Give Permission</u> to Transport
Program or Home Name		Program or Home Name
<b>has permission</b> 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.	<b>Do not sign both</b>	<b>does not have permission</b> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete JFS 01217 "Request for Administration of Medication")</i> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Training Instructions <i>(Trainer must be a parent or certified professional)</i>			
Signature of Trainer			Date
Signature of trained providers, substitutes or child care staff members who have been made aware of the condition. <i>(There must always be a trained caregiver present when the child is present)</i>			
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
<i>(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)</i>			
Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

<b>Box 1</b>	The following section must always be completed by the parent/guardian.		
Check all that apply and complete all of the information.			
<input type="checkbox"/> Prescription Medication		<input type="checkbox"/> Nonprescription Medication	<input type="checkbox"/> Food Supplement
<input type="checkbox"/> Topical Product or Lotion		<input type="checkbox"/> Refrigeration Required	<input type="checkbox"/> 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	
<input type="checkbox"/> 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
<b>Box 2</b>	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.







# 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 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 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 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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_