

# LANSDALE AREA FAMILY YMCA

## 2021-22 School's Out Registration Form (K – 6<sup>th</sup>)

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male/Female: \_\_\_\_\_

Parent(s) Full Name(s): \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. \_\_\_\_\_ Town/Zip Code: \_\_\_\_\_

Primary Cell #: \_\_\_\_\_ Secondary cell #: \_\_\_\_\_

Primary Parent Email: \_\_\_\_\_ (please be legible)

Does your child have any special needs, medical or physical conditions of which we should be aware? Is there a custody order in place? **If yes to any of these, please contact the Childcare Director, prior to registration to discuss, so we may be sure our program is a good fit for your child.** Please explain:

**Elementary schools served:** Knapp, Gwyn Nor, North Wales, Inglewood, Walton Farm, York, Oak Park, Bridal Path

**Grade attending:** \_\_\_\_\_

**School attending:** \_\_\_\_\_

\_\_\_ A.M. Care (6:30 a.m. – 9 a.m.) \$325/mo.

\_\_\_ P.M. Care (3:30 a.m. – 6 p.m.) \$385/mo.

\_\_\_ A.M. & P.M. Care \$425/mo.

2<sup>nd</sup> child discount - \$15/month

**AM/PM** – care from 6:30 am – 6 pm (includes late starts and early dismissals)

**AM only** – care from 6:30 a.m. until school opening (includes late opening)

**PM only** – provides care from school dismissal (includes early dismissal)

**Late Starts:** our program may open 1 – 3 hours later than normal based on NPSD opening during inclement weather.

### Important Note:

Parents/guardians are asked to make arrangements to speak with the Childcare Director prior to registration if their child has any specific needs, as outlined above, to determine if our program is a good fit for the their child.

### Registration:

\$25 (non-refundable) deposit required  
\$50 YMCA Program Membership required

### Health Assessment Form:

A completed form must be on-file the day of admittance into the program. A copy of what's on-file at school is acceptable.

### General Information:

- Program costs are based on a yearly tuition divided into 9 1/2 monthly payments for your convenience.
- Refunds are not made due to missed classes, illness, vacations, or withdrawals, except under extraordinary circumstances and at the discretion of the Childhood Director.
- Payments may be made on-line, check (made payable to the North Penn YMCA), or mailed (Lansdale Area Family YMCA 608 E. Main Street, Lansdale, PA 19446).

### Pertinent Program Information

**First payment due August 2<sup>nd</sup> (this is for September).**  
All subsequent payments are due the 15<sup>th</sup> of each month thereafter, (e.g., October's payment due 9/15<sup>th</sup>).  
The final payment is for half a month (June) due May 15<sup>th</sup>, 2022.

If the August payment is not made on-time the spot reopens to the public.

No refunds for payments/deposits made once program has started.

30-day withdrawal notice required.

Parents are asked to make arrangements to meet with the Childcare Director prior to registration if their child has any special needs, as defined above, to determine if our program is a good fit for their child prior to registering.

**I, the undersigned, having read the foregoing application, understand and agree to follow the above policies.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

# LANSDALE AREA FAMILY YMCA

## 2021-22 School's Out Parent Agreement Form

Child's Name: \_\_\_\_\_ School/Grade: \_\_\_\_\_

Person's other than parent/guardian, designated by parents, to whom child may be released:

**Enrollment Fees (full-time only):**

**Hours of Operation:**

		<u>Each add'l child</u>	
___ 5-day A.M.	\$325/month	\$310/month	6:30 – 8:45 A.M.
___ 5-day P.M.	\$385/month	\$370/month	3:30 – 6:00 P.M.
___ 5-day A.M./P.M.	\$445/month	\$430/month	

I, the parent/guardian, agree to the additional terms and conditions:

- Completed Registration, Parent Agreement, and Child's Health Assessment Forms are due upon registration.
- First tuition payment due Monday, August 2<sup>nd</sup>. All subsequent payments are due by the 15<sup>th</sup> of each month. June's payment is pro-rate to a half month.
- Payments may be made as follows On-line, Check (made payable to the North Penn YMCA), or mailed (Lansdale Area Family YMCA, 608 E. Main Street, Lansdale, PA 19446).
- Any payment not made by the 15<sup>th</sup> of the month will be subject to a \$15 late fee. Payment not made by the end of the month may result in child being subject to dismissal from the program.
- Refunds will not be made for days missed to vacation, illness, weather conditions, holidays (including winter and spring breaks ), or failure to attend on a scheduled day.
- 30-day withdrawal notice required. No refunds for monies paid once program starts.
- Parent received written program information at time of enrollment
- Parent agrees to update Emergency Contact and Parent Agreement Forms whenever changes occur or every 6-months as required by DHS.
- Parent/guardian grants permission for their child to participate in all planned activities.
- Parent/guardian authorizes the YMCA to take photos and/or videos of their child for use in YMCA publications.
- Parent/guardian agrees to abide by all childcare policies and procedures as outlined in the Parent Handbook, and on the Registration and Agreement Forms. Parent/guardian agrees to abide by our Parent Code of Conduct.
- Agree to alert the North Penn YMCA of a Custody Order and will provide copy of the Order to the Childcare Director upon admittance into the program.
- Agree to pay late pick up fee - \$5/5 minute.

Operator Signature _____	Date _____	Full Parent Signature/Guardian _____	Date _____
		(due at time of enrollment)	

Six month periodic review: \_\_\_\_\_  
Full Parent Signature/Guardian
Date

**Child's Admittance Date:** \_\_\_\_\_ **Child's Withdrawal Date:** \_\_\_\_\_

# EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS §3270.124(a)(b), §3270.181 & §3270.182: §3280.124(a)(b), §3280.181 & §3280.182: §3290.124(a)(b), §3290.181 & §3290.182

**DIRECTIONS:** Please print all information. Per DPW regulations all sections must be completed; there can be No Blank areas.  
If a section does not apply to your child, please put **NONE IN THAT SPECIFIED AREA AND SIGN FULL NAME.**

**Ex: Allergies = None, John Smith.** All forms must be signed and dated in the space provided at the very bottom of form.

CHILD'S NAME		BIRTHDATE	
ADDRESS		OUTREACH SITE	
MOTHER/LEGAL GUARDIAN NAME		HOME PHONE NUMBER	
ADDRESS		CELLPHONE NUMBER	
BUSINESS NAME		WORK PHONE NUMBER	
BUSINESS ADDRESS			
FATHER/LEGAL GUARDIAN NAME		HOME PHONE NUMBER	
ADDRESS		CELLPHONE NUMBER	
BUSINESS NAME		WORK PHONE NUMBER	
BUSINESS ADDRESS			
<b>EMERGENCY CONTACT PERSON(S) OTHER THAN PARENT:</b> Please list the following items:      Name                                      Address                                      Home Phone, Cell Phone, Work Phone			
1)			
2)			
<b>PERSON(S) TO WHOM CHILD MAY BE RELEASED OTHER THAN PARENT:</b> Please list the following items:      Name                                      Address                                      Home Phone, Cell Phone, Work Phone			
1)			
2)			
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		PHONE NUMBER	
PHYSICIAN'S OFFICE ADDRESS			
SPECIAL DISABILITIES (IF ANY)		ALLERGIES (Including Medical 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)	
<b>PARENT SIGNATURE REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT</b>			
OBTAINING EMERGENCY MEDICAL CARE		ADMIN OF MINOR FIRST-AID PROCEDURES	
WALKS AND TRIPS		SWIMMING	
TRANSPORTATION BY THE FACILITY		APPLY SUNSCREEN	
ARE THERE CUSTODY PAPERS FOR THIS CHILD?	YES	NO	IF YES, COPIES MUST BE ATTACHED
IS THERE AN IEP DOCUMENT FOR THIS CHILD?	YES	NO	IF YES, COPIES MUST BE ATTACHED

SIGNATURE OF PARENT OF GUARDIAN (required at registration)

DATE

Periodic Review:

SIGNATURE OF PARENT OF GUARDIAN (to be signed at six (6) month review)

DATE

This form must be on-file day of admittance in to program. A copy of what's on-file at school is acceptable.

# 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:		

Parents may write immunization dates; health professional should verify and complete all data.

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):							
<input type="checkbox"/> 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.							
<input type="checkbox"/> NONE							
CHILD'S ALLERGIES (DESCRIBE, IF ANY):							
<input type="checkbox"/> 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.							
<input type="checkbox"/> 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?							
<input type="checkbox"/> YES <input type="checkbox"/> 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 <a href="http://www.aap.org">WWW.AAP.ORG</a> )  <input type="checkbox"/> YES <input type="checkbox"/> 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:	