INDIAN VALLEY FAMILY YMCA

A branch of NORTH PENN YMCA

Serving the Indian Valley and Perkiomen Valley Communities

HUGS Day Care Registration Form

As a State licensed facility, your child's placement is dependent on availability

Child's Full Name:_____ **Date of Birth:** _____ **Male/Female:** _____

Street Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone #: _____ **Alternate Phone #:** _____ **Email:** _____

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 so, please attach a copy

Registration Fee: $30.00 (non-refundable)

Membership to the North Penn YMCA is required Is your child a member? ☐ Yes ☐ No ($50.00 program membership fee must be attached.) Type of membership _____ Name Membership is under _____

Hours of Operation: 6:30 AM – 6:00PM ***State regulations limit childcare to 10 hours per day.**

Schedule (Any future changes in schedule must be made in writing and approved by the HUGS Day Care Director)

Days	Monday	Tuesday	Wednesday	Thursday	Friday
3	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐
5	☐	☐	☐	☐	☐

Rates: Payments are due in ADVANCE, each Friday by 12:00 noon before the next week of care.

Number of Days	Infant Room	Toddler Room	Two-year-old Class	Three-year-old Class **	Pre-K Class **
3	$203.00	$196.00	$192.00	$186.00	$181.00
4	$265.00	$260.00	$253.00	$248.00	$243.00
5	$286.00	$279.00	$274.00	$268.00	$263.00

** Includes swimming lessons

Is a parent a staff member? ☐ Yes ☐ No (if Yes, Please be sure to complete the Child Care Addendum and have your supervisor sign –off)

Is there a sibling attending other child care sites in the North Penn YMCA? ☐ Yes ☐ No

Are you applying for North Penn YMCA Financial Assistance? ☐ Yes ☐ No

Financial Assistance is available to working parents only. All applicants are required to apply for ELRC benefits.

Does child receive assistance through the county (ELCR) ☐ Yes ☐ No

Please provide Case Manager: _____ Phone:_____

Parent authorizes the YMCA to take and use photographs and/or videos of the child for use in future YMCA promotional materials. ☐ Yes ☐ No Signature:_____

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	**EMAIL ADDRESS**
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	

EMERGENCY CONTACT PERSON(S) OTHER THAN PARENT: Please list the following items: Name / Address / Home Phone, Cell Phone, Work Phone
1)
2)

PERSON(S) TO WHOM CHILD MAY BE RELEASED OTHER THAN PARENT: 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**
PHYSCIAN'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)**

PARENT SIGNATURE REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

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** _____

2021-2022 CIVIL RIGHTS COMPLIANCE
PARENT AWARENESS

In accordance with applicable Federal and State civil right laws and regulatory requirements, you and your children, as a client of this facility have the right:

- to be provided services at this facility and to be referred for services at other facilities without regard to your race, color, religious creed, disability, ancestry, national origin, age, or sex

- to file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, disability, ancestry, national origin, age, or sex

Complaints of discrimination may be filed with any of the following:

Provider's Name:
Address:

Indian Valley Family YMCA
890 Maple Ave
Harleysville PA 19438

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health & Welfare Building
P.O. BOX 2675
Harrisburg, PA 17105-2675

Pennsylvania Human Relations Commission
110 North 8th Street
Suite 501
Philadelphia, PA 19107

U.S. Department of Health & Human Services
Office of Civil Rights
Suite 372, Public Ledger Building
150 South Independence Mall West
Philadelphia, PA 19106-9111

Commonwealth of Pennsylvania
DPW / Bureau of Equal Opportunity
Southeast Regional Office
Suite 5034, 801 Market Street
Philadelphia, PA 19107

_____ _____

Operator's Signature Date

_____ _____

Parent / Guardian Signature Date

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:

☐ 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:

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):
☐ 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.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ 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.
☐ 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?
☐ YES ☐ 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 WWW.AAP.ORG)

☐ YES ☐ 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:

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

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK Week	DAY PAYMENT TO BE MADE Friday before noon

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

Care between the hours of 6:30 AM -6:00 PM

Monday through Friday

Snacks and meals are provided by the parents

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $ 10	PER MIN-HR per 10 mins.	

Extra services to be provided at an additional fee if applicable

N/A

I, the parent/guardian;

☑ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☑ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN DATE