



Harleysville YMCA Early Childhood Center

A branch of the North Penn YMCA

311 Alumni Avenue Harleysville, PA 19438 Phone: 215-256-0767

2023-2024 HARLEYSVILLE YMCA PRESCHOOL REGISTRATION

CHILD'S NAME _____ DATE OF BIRTH _____ GENDER M / F (CIRCLE ONE)
 ADDRESS _____ CITY _____ ZIP CODE _____
 PARENT'S NAME _____ EMAIL _____
 HOME PHONE _____ CELL PHONE _____

Please follow the schedule below to ensure your child is enrolled in the proper class :

OLDER TODDLERS - Age 2+ as of Sept. 1, 2023

***PRE-K 3** - Age 3+ as of Sept 1, 2023

***PRE-K 4** - Age 4+ as of Sept. 1, 2023

M/W OLDER TODDLERS	_____	\$215.00 Mo.	9:15- 11:30 AM
T/TH OLDER TODDLERS	_____	\$215.00 Mo.	9:15- 11:30 AM
T/TH Pre-K 3 (a.m. only)	_____	\$215.00 Mo.	8:45 - 11:15 AM
M/W/F Pre-K 3 (a.m. only)	_____	\$245.00 Mo.	8:45 - 11:15 AM
M/W/F Pre-K 3 (a.m. & p.m.)	_____	\$425.00 Mo.	8:45 - 2:00 PM
5 Days Pre-K 3 (a.m. & p.m.)	_____	\$600.00 Mo.	8:45 - 2:00 PM
M/W/F Pre-K 4 (a.m. only)	_____	\$245.00 Mo.	9:00 - 11:45 AM
M/W/F Pre-K 4 (a.m. & p.m.)	_____	\$425.00 Mo.	9:00 - 2:15 PM
T/TH Pre-K 4 (a.m. & p.m.)	_____	\$285.00 Mo.	9:00 - 2:15 PM
5 DAYS Pre-K 4 (a.m.& p.m.)	_____	\$600.00 Mo.	9:00 - 2:15 PM

* Must be potty-trained

** Full Day hours may be available (Ages 3-5) . Please call for pricing and availability **

REGISTRATION FEE: Youth Program Membership Included. \$80.00 non-refundable **DUE NOW.**

LATE REGISTRATION FEE: Additional \$20 if registering after August 1, 2023.

CHECKS PAYABLE TO: North Penn YMCA

Parent authorizes the YMCA to take and use photographs and/or videos of the applicant for use in future YMCA promotional materials. Yes No

Is your child a member of the North Penn YMCA Yes No

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

Is a parent a staff member? Yes No

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

Please provide Case Manager: _____ Phone: _____

Does your child have Custody or IEP Documents? If yes , please provide a copy Yes No

Office use

Start Date	Emergency Contact	Date of Physical	Agreement	Civil Rights
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**Parent Payment Agreement
YMCA CHILD CARE PROGRAMS
2023-2024**

CHILD'S NAME: _____

PRE- SCHOOL FEE

<input type="checkbox"/>	M/W OLDER TODDLERS	\$215.00 Mo.	9:15AM - 11:30AM	EXTENDED HOURS FEE: <hr/> DAYS ATTENDING: <hr/> HOURS ATTENDING: <hr/>
<input type="checkbox"/>	T/TH OLDER TODDLERS	\$215.00 Mo.	9:15AM - 11:30AM	
<input type="checkbox"/>	T/TH PRE-K 3 a.m. only	\$215.00 Mo.	8:45AM - 11:15AM	
<input type="checkbox"/>	M/W/F PRE-K 3 a.m. only	\$245.00 Mo.	8:45AM - 11:15AM	
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<input type="checkbox"/>	M/W/F PRE-K 4 a.m.& p.m.	\$425.00 Mo.	9:00AM - 2:15 PM	
<input type="checkbox"/>	T/TH PRE-K 4 a.m.& p.m.	\$285.00 Mo.	9:00AM - 2:15 PM	
<input type="checkbox"/>	5 Days PRE-K 4 a.m.& p.m.	\$600.00 Mo.	9:00AM - 2:15 PM	

PERSONS OTHER THAN PARENTS AUTHORIZED TO PICK UP CHILD :

I the parent/guardian agree to these terms & conditions:

MONTHLY PAYMENTS – Payments are due the 1st of each month. Set up automatic payments through our office, pay online, or send checks payable to NORTH PENN YMCA to 311 Alumni Ave Harleysville, PA 19438.

If payment is not received by the 15th of the month, a \$15.00 late charge will be automatically added to your balance.

Your child may be dismissed from our program on the last day of the month if payment is not received.

The YMCA reserves the right to adjust their fees at any time. Parents will receive a 30-day notification of any changes.

No refunds for days missed due to illness, vacation, weather conditions or holidays (including Winter Break), or failure to attend a scheduled day. All children are expected on registered days.

LATE FEE – Your child must be picked up at the assigned end time for his/her program or there will be an extra charge of \$15.00 per 15 minutes per child. Your promptness and consideration are appreciated.

WITHDRAWAL – Withdrawal from our program requires a 30-day notification in writing or one month's tuition will be charged. If you re-enroll your child during the same school year, there is a **\$30.00 re-registration fee**.

FINANCIAL ASSISTANCE - Applications are available at the Indian Valley YMCA or on our website at <https://www.northpennymca.org/?s=financial+assistance>. All financial assistance applications & required documents must be turned in with your child's registration information.

CHILD HEALTH APPRAISAL FORMS- All children must have a current health appraisal (from an exam within the past 12 months) on file at the YMCA within 30 days of their initial admission date. Health Appraisals must be updated annually through age 6 and biennially thereafter.

EMERGENCY CONTACT/PARENTAL CONSENT FORM Parent/ Guardian agrees to update the information on the Emergency/ Parental Consent form whenever changes occur or every 6 months at a minimum.

MEDICAL CARE - If required, medical care will be paid by parent/ guardian.

RELEASE -Parent grants permission for the child to participate in all planned activities. Parent holds harmless the staff and North Penn YMCA from all liability for any injury which may occur to my child during or resulting from participating in the program. The YMCA is not responsible for lost, stolen or damaged personal articles.

Diane Manus

02/06/2023

Signature- Administrator, Director, Caregiver

Date

Signature, Parent or Guardian

Date

Signature, Parent or Guardian

6 month review Date



North Penn YMCA APPLICATION FOR MEMBERSHIP

Date: _____

Staff Initial: _____

Our mission is to make the community we serve a better place to live. Through our programs and activities, we strive to enrich and strengthen families; provide wholesome supervised recreation; offer positive learning, leadership and character development opportunities; and promote wellness for all people regardless of ability to pay.

MEMBERSHIP TYPE

Choose Membership Type: Full Member Program Member

Choose Membership Category: Youth Young Adult Adult Single Parent Family Family 65 Plus

PRIMARY MEMBER

First Name	MI	Last Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> other
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Home Address	Apt	City	State	Zip
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Home:	Cell:	Email
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Ethnicity Caucasian/White African American/Black Hispanic/Latino Asian American Native American/Pacific Islander Other

Have you been a YMCA Member before? Yes No Are you interested in Volunteering? Yes No

Emergency Contact First Name	MI	Last Name	Phone Number	Relation to Emergency Contact
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Employer Name	Business Address	Business Phone:
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SECONDARY ADULT

First Name	MI	Last Name	Relation to Primary Member
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Phone	Email	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> other
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DEPENDENTS

First Name	MI	Last Name	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> other
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				<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> other
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				<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> other
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				<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> other
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Please check the box that represents your approximate annual household income:

- Below \$10,000
- \$10,000-\$20,000
- \$20,001-\$30,000
- \$30,001-\$40,000
- \$40,001-\$50,000
- \$50,001-\$100,000
- Over \$100,000

I want to help underprivileged youth and families in my community participate in Y programs. I authorize the Y to add the following amount to my monthly bank draft to support the YMCA Annual Campaign.

- \$5/month
- \$10/month
- \$15/month
- \$_____ One time gift
- Decline

Authorized Signature



WAIVER AND RELEASE:

I (we) hereby hold the NORTH PENN YMCA, its executive directors, employees, volunteers, and members (collectively, the "YMCA"), harmless and free from any liability for any actions, incidents or occurrences, including but not limited to its or their own negligence; (2) that I (we) hereby waive, release, and forever discharge any and all rights and/or claims for damages that I may have or that may hereafter accrue to me/us arising from my/our use of or connected with my/our participation in any of the activities of the NORTH PENN YMCA, its facilities, equipment, or program activities within the facilities; (3) that I (we) do hereby agree to indemnify the YMCA for any and all claims for damages that may be asserted against the YMCA, by any person or entity, related to or arising from my/our use of or connected with my/our participation in any of the activities of the NORTH PENN YMCA, its facilities, equipment, or program activities within the facilities; (4) that I (we) hereby grant permission for myself and my family for video or photographs taken by YMCA to be used for NORTH PENN YMCA publicity and advertising purposes; and (5) that I (we) hereby grant permission for the YMCA to use my email address as a means of contact.

By participating in the YMCA Nationwide Membership Program, I (we) agree to release the National Council of YMCAs of the United States of America, and its independent and autonomous member associations in the United States and Puerto Rico, from claims of negligence for bodily injury or death in connection with the use of YMCA facilities, and from any liability for other claims, including loss of property, to the fullest extent of the law,

The YMCA conducts regular sex offender screenings on all staff, volunteers, members, participants, and guests. If a sex offender match occurs, the YMCA reserves the right to cancel membership, end program participation, and remove visitation access.

I (we) agree to abide by all of the policies and procedures outlined in the NORTH PENN YMCA Member Handbook, and any other policies and procedures of the YMCA as may be adopted.

I, (and if applicable, on behalf of all members of my family that are part of this membership,) agree to this Waiver and Release agreement and have read and understand the Member Code of Conduct. I agree to advise all members of my family that are part of this membership as to the terms of this Waiver and Release agreement and the Member Code of Conduct.

Print Name

Signature of applicant

Date

Staff Initials

Date

NOTES:



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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:

- Admissions, the provisions of services and referrals shall be made without regard to your race, color, religious creed, disability, ancestry, national origin, age, or sex.
- Program Services shall be made accessible to eligible persons with disabilities whenever feasible. This includes equipment redesign or auxiliary aides and/or alternate services.

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

Provider's Name & Address:

Harleysville YMCA
Early Childhood Center
311 Alumni Ave
Harleysville, PA 19438

Commonwealth of PA
Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
P.O. BOX 2675
Harrisburg, PA 17105

Pennsylvania Human Relations
Commission
Philadelphia Regional Office
110 N. 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
Department of Human Services
Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, Pa. 19107

Diane Manus

02/07/2023

Operator's Signature

Date

Parent / Guardian Signature

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, *Jaka 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	
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)	
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 _____

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:		

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) <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.						
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (subjective until age 3)		HEARING (subjective until age 4)		LEAD	
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.