

YWCA Programs for School Age Development Summer Camp Enrollment Packet

Child's Name: _____

Parent Name: _____

Lime Street Location

Hambright Elementary Location

-FOR OFFICE USE ONLY-

- _____ Financial Forms
- _____ Contracted Schedule Form
- _____ Emergency Contact form-MUST BE COMPLETE
- _____ Child Health Assessment
- _____ Getting to Know Your Child Form
- _____ CACFP Paperwork (Lime Street location only)

Payment Information: _____ Funded Caseworker: _____

_____ Self-Pay Record Number: ____ - _____

Checked By: _____ Sibling name for discount _____

-FOR OFFICE USE ONLY-

\$ _____ Registration

\$ 100.00 Activity Fee

\$ _____ Deposit or ELRC Co-pay

\$ _____ First Week Fee
(Only when program already started)

\$ _____ Key Cards
(Additional cards- \$15.00) Refunded upon card return

\$ _____ Total

Data entry & Health Assessment Completed

___/___/___ By: _____

Ledger/Tuition/Schedule Completed

___/___/___ By: _____

Payment Option

___ Tuition Express Automatic
(Attach form will be processed once file is entered into Pro-Care)

___ My Pro Care

(www.myprocare.com use e-mail address given to center to setup account)

Receipt Number: _____

Cash Check # _____ Money Order # _____ Credit Card # _____ TE # _____

Initials: _____

Date: _____

Start Date: _____

Site Notified: _____

Shirt Size: Youth: S YM YL YXL Adult: S M L XL 2XL

YWonderful Kids

School Age Childcare Program

Penn Manor School District/School District of Lancaster
2021-2022

Child's Full Name _____ Start Date: _____ Site: _____

Age: _____ Birthdate: _____ Gender: _____ Race: _____ Grade: _____

Address _____

Home Phone # _____

Annual Household Income: _____ \$0-\$9999 _____ \$10,000-\$14,999 _____ \$15,000-\$24,999 _____ \$25,000-\$34,999 _____ \$35,000-\$49,999

_____ \$50,000-\$74,999 _____ \$75,000-above Number of household members: _____ * Information required for YWCA funding source

Please attach an IEP or IFSP for your child if applicable. Indicate with a check mark one of the following:

- I am providing a copy of my child's IEP/IFSP
 I am not providing a copy of my child's IEP/IFSP
 This is not applicable to my child

PUBLICITY AND PHOTO CONSENT AND RELEASE

For good consideration, which I hereby acknowledge, I grant to the YWCA Lancaster ("the YWCA") and its licensees, successors and assigns (collectively called the "Licensed Parties") worldwide, absolute, and irrevocable permission to use, reproduce, print and/or publish my name, likeness, image, voice, and/or appearance ("the Material") in any media, including but not limited to photographs, video recordings, audiotapes, digital images in which I may be included intact or in part, composite or distorted in character, sound or form, without restriction as to changes or transformations in conjunction with my own or a fictitious name, or reproduction hereof. I agree that the Material may be used for any purpose consistent with the YWCA's mission, including in new releases, advertisements, publications, marketing campaigns, media coverage, videos, web sites, billboards, and any other promotional or educational materials compiled by or on behalf of the YWCA.

I understand and agree that the YWCA has and will have complete ownership of the Material, and that I will not receive any compensation for the use of the Material.

I hereby release the Licensed Parties from any and all claims out of their use of the Material as agreed to in this document, including without limitation any claims based on the right of publicity or privacy, misappropriation or misuse of image, and/or defamation, including liability by virtue of blurring, distortion, alteration, optical illusion, or use in composite form whether international or otherwise. I further hereby waive any future right to prior review of any use of the Material.

_____ Permission is granted for photo/video reproduction of my child to be used in YWCA Lancaster publications, social media, and classroom purposes.

_____ Permission is NOT granted for photo/video reproduction of my child to be used in YWCA Lancaster publications, social media, and classroom purposes

Parent/Guardian's Signature

Child's Name

Date

Please sign and date below that you have received the Penn Manor or YWCA Lancaster Child Care Parent Handbook.

Parent/Guardian's Signature

Date

Child's Name: _____

Site: _____

FINANCIAL INFORMATION

1. At the time of enrollment, a deposit/co-pay equal to the amount of one contracted week is required; in addition to the Registration and security card fees. The deposit will be credited for the last week of service assuming a two week (14 days) written notice has been given. **These fees are non-refundable.**
Please call Early Learning Resource Center at (717) 393-4004 for more information on subsidized care.
2. I understand my bill will be sent weekly via-email to the address I have provided to the YWCA Lancaster. It is my responsibility to review all correspondence sent from the YWCA Lancaster.
3. I understand that there is an annual non-refundable registration fee for all Programs, and I understand that all Program fees are based on my contracted schedule. I agree to pay in advance for each week my child is contracted. I also understand that payment is due the Thursday before the week that service is needed.
4. I understand that billing is based on the full time or part time enrollment for which I have contracted and not for actual attendance. I understand that no fees will be credited to my account if my child is ill or fails to attend.
5. I agree to pay late fees of **\$2/minute** if my child is not picked up by 5:30 pm (Lime Street Building) or 6:00 pm (Penn Manor Sites).
6. I understand that if my ELRC funding is discontinued I am responsible to pay the entire fee. Per ELRC regulations, if I reach 40 days absent from the program, I am responsible to pay the Center the daily rate for each day absent after the first 40 days.
7. I understand that failure to pay my contracted fees or an unpaid balance will result in my childcare services being interrupted until said balance is addressed. I understand that there is a **\$25 charge for all returned checks or declined payments.** Checks are to be made payable to YWCA Lancaster. I understand that it is my responsibility to keep statements, receipts or canceled checks for income tax purposes. YWCA Lancaster's Federal ID number is 23-1352609.

PROGRAM INFORMATION

8. All designated individuals understand that my child may not be left on school grounds without supervision. I understand that staff are not prepared to accept my child until 6:30 a.m. I will sign my child in each morning and out each evening.
9. I understand all forms with the exception of the health assessment must be completed prior to my child starting the program.
10. I understand that I must provide a current health assessment, along with a current vaccination record for my child within 30 days of starting the program. I understand that the YWCA Lancaster reserves the right to suspend care until said assessment is provided.
11. I understand that my child may not attend the program with any illness that threatens the health of other children. I will be asked to pick up my child from the program if he/she has a suspected contagious illness.
12. I understand that no medication is administered unless I fill out the medication log completely. Written instructions from a physician are required for medication administration. All medication must be in the original prescription bottle.
13. I understand that staff must release children to parents unless a court order indicating sole custody is provided to the Program Director. I also understand that I need to give written permission allowing staff to release my child to any individual other than the parent/guardian or those persons listed on Emergency contact form.
14. I understand that all YWCA childcare programs are state licensed programs and that all staff are mandated reporters who are required to report any evidence of suspected abuse/neglect to ChildLine.
15. I understand that I am responsible for any damages resulting from my child's actions to either YWCA Lancaster or school property. The price of any damaged items will be added to my weekly bill.
16. I waive any claim for bodily injury or property damage against any municipalities or boroughs in which YWCA Lancaster programs participate.
17. In accordance with applicable Federal and State civil rights laws and regulatory requirements, you and your child, as clients of the YWCA Lancaster, have the right:
 -To be provided services by YWCA Lancaster and to be referred for services at other facilities without regard to your race, color, sexual orientation, religious creed, disability, ancestry, national origin, age or sex.
 -Program services shall be made accessible to persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to equipment redesign, the provision of aids, and the use of alternative services delivery locations. Structural modifications shall be considered only as a last resort among available methods.
 -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:

YWCA Lancaster Attention: Cathy Lerch 110 North Lime Street Lancaster, PA 17602	PA Human Relations Comm. Harrisburg Regional Office 333 Market Street-8 th Floor Harrisburg, PA 17101	Department of Human Services Bureau of Equal Opportunity Room 223, Health & Welfare Building P.O. Box 2675 Harrisburg, PA 17105	U.S. Department of Health and Human Services Office for Civil Rights Suite 372, Public Ledger Building 150 S. Independence Mall West Philadelphia, PA 19106
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18. I will notify the YWCA Lancaster of any change on the enrollment forms and will verify by signature that all information is correct semi-annually.

Primary Parent/Guardian Signature

Date

YWCA Lancaster Signature

Date

Secondary Parent/Guardian Signature (optional)

Date

Contracted Schedule Form

Child's Name: _____

Start Date: _____

Primary Guardian Name: _____ Date of Birth: _____ Social Security # _____

Secondary Guardian Name: _____ Date of Birth: _____ Social Security # _____

Preferred email address for communication from YWCA Lancaster: _____

To provide a quality program for your child, program staff must be scheduled appropriately. YWCA staff are scheduled in relation to the number of children attending the program each day.

Schedules are established for the school year because we plan and staff for each child's contracted attendance. Parent(s)/Guardian(s) will be given the opportunity to revise the Contracted Schedule Form, if needed, up to two times per school year with a two weeks' (14 days) notice before the start of the requested change. All changes must be reviewed for space availability in the program requested and automatic approval should not be assumed. You must contact the Administrative Team at 717-869-5016 to approve any changes to your contract.

Your contracted fees do not change for days absent or if you are on vacation. If you find your child will be absent from our program you will need to contact 717-824-4363 by 9:00AM. This allows us to notify our staff and the secretaries of the respective schools in a timely manner.

If you need to terminate your care, a **two-week written notice** must be submitted to the Administrative Team prior to the last day of attendance. If two weeks' notice is not given, **you will be charged two week's tuition from the time of withdrawal.**

I understand my bill will be sent weekly via-email to the address I have provided the YWCA Lancaster. I agree to pay in advance for each week my child is contracted. I understand that payment is due the Thursday prior to the following week service.

Method of payments:

- a. **Tuition Express is the preferred method of payment** at the YWCA Lancaster. By signing up, your account will always be current and no late charge will be applied to your account. If funds are not available by Friday, you will receive a \$25 service charge for non-sufficient funds.
- b. **MyProcure**, is free online portal for you to access account information and easily pay tuition. Parents/Guardians can sign in and make credit card payments manually each week. Go to www.myprocure.com.
- c. Children who are picked up after our sites are closed at 5:30 pm for Lime Street and 6:00 pm for Eshleman, will be charged a late fee of a **\$2.00 per minute**, per child. Late pick up fees will be entered into the child/ren's account and must be paid with your next weekly fee payment.
- d. If balance is not paid in full weekly, a late payment charge of \$10 will be affixed to your account.

Persons My Child/ren Can Be Released To:

The YWCA Lancaster has permission to release my child/ren to anyone whom I have listed on the child/rens emergency contact/parental consent form.

Please check the days your child is to be contracted.

Example: If you choose a 2 day minimum, you must identify which two days (example: Monday/Tuesday).

Contracted Option	Weekly Fee	Please mark your weekly care
1-3 days	\$150.00	_____
4-5 days	\$180.00	_____
ELRC Clients will be charged daily rate for days of absence after the 40th absence, starting the 41st day of absence.		
School Age	\$36.00 Daily Rate	

Total # of days contracted _____		Total Weekly Fee: _____		Sibling name discount: _____	
School Age Students Only		Time In AM: _____	Time Out AM: _____		
_____ Monday 6:30 AM-6:00PM (HAM) 6:30AM-5:30 PM (Lime)	_____ Tuesday 6:30 AM-6:00PM (HAM) 6:30AM-5:30 PM (Lime)	_____ Wednesday 6:30 AM-6:00PM (HAM) 6:30AM-5:30 PM (Lime)	_____ Thursday 6:30 AM-6:00PM (HAM) 6:30AM-5:30 PM (Lime)	_____ Friday 6:30 AM-6:00PM (HAM) 6:30AM-5:30 PM (Lime)	

Parent/Guardian Signature _____

Date _____

Director Signature _____

Date _____

Start Date: _____
Camp Group: _____

GETTING TO KNOW YOU FORM

Basic Information

Child's Name: _____ Birthdate: _____

What time do you expect to drop off/pick up? _____

Are there any custody agreements that we should be aware of? _____

Illness or Injury Contact

If your child becomes ill, who would you prefer us to call?

Name: _____ Phone Number: _____

When do you wish to be informed on a minor injury or illness (i.e. scratch, headache, etc.?)

- Immediately by phone
- At pick up
- Other: _____

Food and Allergy Information

Food Allergies: _____

Other Allergies: _____

Favorite Foods: _____

Special Information

What are your child's strengths? _____

What skills do you most want to see your child develop? _____

What are your child's favorite activities? _____

Please provide any additional information that will be helpful to our staff, which we did not cover on this paper:

Parent/Guardian's Signature: _____ Date _____

EMERGENCY CONTACT / PARENTAL CONSENT FORM

CODE CHAPTERS 3270.124(a)(b), 3270.181 & .182, 3280 124 (a)(b), 3280.181 & .182: 3290.124 (a)(b). 33290.181

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S) NAME		TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASE	NAME	ADDRESS
		TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)		ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY		MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE		ADMINISTRATION OF MINOR FIRST AID PROCEDURES
WALKS AND TRIPS		SUNSCREEN APPLICATION
TRANSPORTATION BY THE FACILITY		WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

CHILD HEALTH ASSESSMENT

Parents may write immunization dates, health professionals should verify and complete all data. Parents & Child Care Providers fill-in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME: YWCA Lancaster		
FACILITY PHONE: (717)393-1735	COUNTY: Lancaster	WORK PHONE:

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at < www.aap.org > or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> NONE	Date of most recent well-child exam: _____
Allergies to food or medicine (describe, if any): <input type="checkbox"/> NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____ IN/CM %ILE	_____ LB/KG %ILE	_____ IN/CM %ILE	(BEGINNING AT AGE 3) _____ / _____

PHYSICAL EXAMINATION	<input checked="" type="checkbox"/> =NORMAL	IF ABNORMAL - COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHES		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTA VIRUS						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
<input type="checkbox"/> NONE		NEXT APPOINTMENT - MONTH/YEAR:	
MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CRNP:	
ADDRESS:			
	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED: