



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LEARN GROW THRIVE

YMCA AFTER SCHOOL CARE 2017-18 St. John the Baptist Catholic School

At the Y we believe all kids deserve the opportunity to discover who they are and what they can achieve. In our afterschool program youth are cultivating the values, skills, and relationships that lead to positive behaviors, better health, and education achievement.

Program Hours

After school care: End of school day to 5:30 p.m.

Program Fees

\$53.00 per week/per child

Financial Assistance

YMCA Financial Assistance is available for qualified applicants.

For more information contact:

Ann Conroy @ 449-8464, ann_conroy@fwymca.org
Stacy Gilbert @ 449-8266, stacy_gilbert@fwymca.org
YMCA web site: www.fwymca.org



YMCA Child Care Services Branch
1117 S. Clinton Street
Fort Wayne, IN 46802
(P) 260-449-8464 (F) 260-449-4776

YMCA School-Age Childcare

2017-2018 School Year Checklist

Please use this checklist to help guide you through the registration process. Do not turn in your child's registration packet until you have done the following:

Registration Form

- _____ Complete with at least two Authorized Pick Up/Emergency Contacts
- _____ Sign and date

Health Form

- _____ Complete all questions that pertain to your child

Immunization Form

- _____ Shot dates filled in **OR** shot dates attached
- _____ YMCA Immunization Form signed and dated by a doctor or nurse

Registration Policy & Release of Liability Form

- _____ Print child's name; parent/guardian name
- _____ Sign and date

Payment Contract

- _____ Choose a payment option, sign and date
The preferred method of payment is automatic draft

Completed packets must be turned into the Child Care Office at 1117 S. Clinton Street. Office hours are 8 am-4 pm Monday-Friday. We also have a 24/7 drop-box for your convenience.

All registrations must be approved by office staff before your child can start the program. Incomplete forms/packets will not be accepted.

Please remember the registration cut-off date is August 11, 2017 by noon if you are planning for your child to start the first day of school.



REGISTRATION FORM

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CHILD'S INFORMATION

This form must be returned in order to register your child. Please inform us of any changes in information as they occur.

Name: _____
(first) (middle) (last)

Birthdate: ____/____/____ Grade: _____ Gender: ☐ male ☐ female Race: _____

Address: _____ City: _____ Zip: _____

School attending: _____ Site attending: _____

Check all that apply:

☐ Before Care ☐ After Care ☐ A.M. Pre-K ☐ P.M. Pre-K ☐ 2 hour delays ☐ Closings/cancellations

Date child will begin attending program: _____ Days of week child will attend: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____ Birthdate: ____/____/____

Relation to child: _____ Email: _____

Address: _____ City: _____ Zip: _____

Place of employment: _____ Work phone: _____

Home phone: _____ Cell phone: _____

Parent/Guardian Name: _____ Birthdate: ____/____/____

Relation to child: _____ Email: _____

Address: _____ City: _____ Zip: _____

Place of employment: _____ Work phone: _____

Home phone: _____ Cell phone: _____

Parent's Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Mother remarried ☐ Father remarried

Please state custody arrangements and provide court documentation.

AUTHORIZED PICK UP/ EMERGENCY CONTACTS (Must be 18 years or older)

I hereby give my consent for the following individuals to pick up my child from the YMCA childcare program. I understand that the YMCA of Greater Fort Wayne and the Child Care Services Branch are not responsible for my child once they have been signed out of the childcare program.

In an emergency situation, the YMCA will always try to contact the parent(s)/guardian(s) first. In case the parent(s)/guardian(s) cannot be reached, we will contact the following emergency contacts. Please list at least two emergency contacts in order of preference for contact.

Authorized Pick Up: ☐ Mother ☐ Father ☐ Guardian(s)

Individuals other than parent(s) or guardian(s):

Name: _____

Relation to child: _____

Hm #: _____

Cell #: _____

Wk #: _____

☐ Authorized Pick Up

☐ Emergency Contact

Name: _____

Relation to child: _____

Hm #: _____

Cell #: _____

Wk#: _____

☐ Authorized Pick Up

☐ Emergency Contact

Name: _____

Relation to child: _____

Hm #: _____

Cell #: _____

Wk #: _____

☐ Authorized Pick Up

☐ Emergency Contact

Name: _____

Relation to child: _____

Hm #: _____

Cell #: _____

Wk#: _____

☐ Authorized Pick Up

☐ Emergency Contact

For office use only:

_____ Approved to begin program

Staff signature

Date



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF GREATER FORT WAYNE HEALTH FORM

CHILD'S INFORMATION

This form must be returned in order to register your child.
Please inform us of any changes in information as they occur.

Name: _____
(first) (middle) (last)

School attending: _____ Site attending: _____

HEALTH INFORMATION

Please indicate if your child has any of the following:

<input type="checkbox"/> ADHD <input type="checkbox"/> Hyperactive <input type="checkbox"/> Inattentive	<input type="checkbox"/> Communication Differences	<input type="checkbox"/> Epilepsy/Seizure Disorder	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Mobility Impairment
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Dietary Needs	<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Psychological Needs

IMPORTANT: Please notify YMCA Childcare if your child is exposed to any communicable diseases.

If your child has a 504 Individualized Health Plan (IHP) or an Individualized Educational Plan (IEP) may we have a copy of the goals to reference? YES NO

Other special needs or restrictions (dietary, health, physical, psychological, or educational) for staff awareness:

Allergies

Please indicate if your child has a reaction to any of the following:

<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Lactose (dairy)	<input type="checkbox"/> Nuts type _____	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Poison Ivy or Oak
--	--	--	-------------------------------------	--

Please list any other allergies (food, medication, environmental), the reaction, and treatment: _____

Please list any medical conditions or needs that your child has: _____

Operations or serious injuries (please list dates): _____

Chronic or recurring illness: _____

Is your child taking any medication? YES NO Name of Medication: _____

Hearing and Vision

Check the responses that best describes your child's hearing and vision

Which best describes your child's hearing?	<input type="checkbox"/> Normal	<input type="checkbox"/> Mild/Moderate Loss	
	<input type="checkbox"/> Severe/Profound Loss	<input type="checkbox"/> Sensitivity to Loud Noise	
Which describes your child's vision?	<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Fully Sighted	<input type="checkbox"/> Moderate to Severe Impairment
	<input type="checkbox"/> Wears contact lenses	<input type="checkbox"/> Sensitivity to light	<input type="checkbox"/> Blind

Does your child use a hearing aid or other device to communicate? _____

Socialization			
Number Accordingly: 0-Never 1-Sometimes 2-Often			
___ Interacts with others	___ Prefers independent play	___ Prefers quiet play	___ Cooperates with others
___ Initiates conversation	___ Prefers playing with peers	___ Prefers active play	___ Ease of transition between activities

How can we assist your child in socializing with others? _____

Behaviors Staff Should Be Aware of		
Number Frequency: 0-Never 1-Daily 2-Weekly 3-Monthly		
___ Touches Others Without Permission	___ Harms Others (hitting, biting, kicking)	___ Screaming
___ Negative Verbal Outbursts to Self	___ Harms Property ___ Self-harming	___ Defiant
___ Negative Verbal Outbursts to Others	___ Flight Risk (runs away from the group without warning)	___ Bullies Others

How does your child express frustration or anger? _____

Is your child afraid of anything in particular? _____

What sensory issues (stimulation) is your child sensitive to? _____

Is there anything that may consistently upset or trigger negative behaviors from your child? What is the behavior?

Are there any major changes in the last six months (births, deaths, divorce, moves) or special situation that might impact your child's behavior? _____

What techniques work to calm your child? _____

Are there any positive reinforcements or motivators that work well for your child? _____

Are there any other behavior/emotional concerns or solutions staff should be aware of so we can help your child succeed in the program? _____

Any specific activities to be encouraged? _____

Restricted? _____

How can we best serve your child's needs? _____

Family Physician: _____ Phone: _____

Medical Insurance Carrier: _____ Policy # _____

TO BE COMPLETED BY A HEALTH CARE PROVIDER

Immunization Record

This form must be completed prior to your child's first day of attendance.

This form must be updated annually by a health care provider.

Child's full name _____ Birthdate ____/____/____

Parent/Guardian name _____ Phone _____

Childcare site attending: _____

Hep A					
Hep B					
DtaP/DTP/Td					
Hib					
MMR					
IPV					
Varicella					
PCV/Prevanar					

Date of last Tetanus shot: _____

Child has documented history of Chicken Pox? _____ No _____ Yes If yes, age _____

Parent Comments: (Please indicate religious objections, if any.) _____

Health Care Provider Comments: (Please list immunizations excluded for medical purposes.)

Please check the appropriate response:

___ Child has received age-appropriate immunizations.

___ Child is currently in the process of receiving age-appropriate immunizations.

Signed _____ Date _____
Health Care Provider's Signature (Required)

Printed Name and Title _____



YMCA Child Care Services Branch Registration Policy and Release of Liability Agreement

I understand that my child cannot attend YMCA childcare programs until all required forms are turned in to the YMCA Child Care Services Branch and you have been contacted stating your child may begin the program.

- My child has permission to participate in the YMCA childcare activities. Basic first aid and emergency treatment are authorized.
- I recognize and acknowledge that there are certain risks of physical injury and agree to assume full risk of injuries, damages or loss which said participant may sustain as a result of participating in any and all activities connected with or associated with such program.
- I authorize the YMCA to arrange emergency transportation for my child should it be deemed necessary by the YMCA staff.
- I certify that the health history provided is correct to the best of my knowledge and the child herein described has permission to engage in all prescribed activities except as noted.
- I hereby give permission to the physician selected by the director to order x-rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my child.
- I give the YMCA permission, without limitation or obligation, to use photography, video or audio recordings of my child participating in YMCA programs for the promotion or interpretation of the YMCA.
- I hereby give my consent for the individuals I listed in the registration process to pick up my child from the YMCA childcare program. I understand that the YMCA of Greater Ft. Wayne and childcare programs are not responsible for my child once they have been signed out of the childcare program.
- I acknowledge that I have received, read, and understand the policies, including the discipline policies, and procedures outlined in the Parent Handbook. I am in agreement with the conditions outlined and will abide by the same. I understand that policies may have changed from previous years. *Please be sure to read thoroughly as there are important policies, guidelines, and information in the handbook.

Child's name: _____ Date: _____
Please Print

Parent/Guardian name: _____
Please Print

Parent/Guardian signature: _____



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Payment Contract St. John 2017-2018

Child's Name: _____ Parent/Guardian Name: _____

Automatic draft is our preferred method of payment. However, other options are available to you. Please choose your payment method.

☐ I will be paying by automatic draft. Please read and initial:

_____ I give authority to the YMCA of Greater Ft. Wayne to draw on the account listed below for my childcare payments.

_____ I understand my account will be drafted on Monday for weekly fees.

_____ Changes to account information, including credit card expiration date, must be received by the YMCA no later than the Monday prior to payment date when the changes need to be effective.

_____ I authorize my bank to honor preauthorized EFT or credit card charges against my account. I understand that if my draft is returned for any reason I will be charged a \$15.00 processing fee.

_____ I understand that this account will be drafted for childcare fees unless request for cancellation of draft is provided to the YMCA Child Care Services Branch.

Credit Card / Bank Information

___ VISA ___ MasterCard ___ American Express ___ Discover ___ EFT Bank Draft

Credit Card or Bank Account Number

9 Digit Routing Number (Bank Draft Only)

Person on Bank Account/Card (Please Print)

Card Expiration Date (Credit Card Only)

☐ I am unable to pay by automatic draft. I will be paying by:

___ Check* ___ Money Order ___ Cash ___ Automatic Bill Pay ___ Online
*Returned checks will be charged a \$15.00 NSF fee.

Signature

Date



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

St. John Weekly Pro-rates

When school is closed due to a scheduled day off or a weather cancellation, weekly fees will be adjusted using the following scale.

AFTER SCHOOL CARE

Four days of school: \$42.50
Three days of school: \$31.50
Two days of school: \$21.00
One day of school: \$10.50