FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

New Rochelle YMCA Afterschool Program
Child Information

Child's Name_____Date of Birth:_____ Circle: M or F

Child's School:_____Grade: Bus#_____Site: Webster Or YMCA____

Home Address:_____

Mother's Name:_____Home#_____Cell#_____Work#_____

Father's Name:_____Home#_____Cell#_____Work#_____

Guardian's Name:_____Home#_____Cell#_____Work#_____

Email (parent #1)_____Email (parent #2)_____

Child Lives with: Mother___ Father___ Both___ Other_____

**For the protection of the child, a copy of the court order must accompany this form if one parent retains sole legal custody of the child.

Does your child have an Individualized Educational Plan and/or 504 Plan? ☐ Yes ☐ No

Students with disabilities are invited to participate in the program as long as we can meet the needs of the child. If the center is unable to meet the needs of the child enrolled for any reason, the center will assist the family in finding a facility that will better serve and meet the child's need.

(M - F) $325.00 per month/ Must Sign a monthly Credit/Debit Card Contract
(M - F) $100.00 per 3 Days/Week/ Must Sign a weekly Credit/Debit Card Contract
$40 per½ Day (11:30-3:00 PM) - If your child is enrolled to attend on that day.

Late fees: A grace period of 5 minutes will be allocated for your convenience. If a child is pickup up after **6:35** a charge of **$1.00 a minute** will be applied to your bill. **Habitual late pick-ups may result in suspension from the program.**

Alternate Emergency Contacts

List two additional emergency contact persons who may pick up your child. We will not release your child to anyone other than persons stated unless specified in writing before pick up. Telephone approval is not acceptable. I understand and agree that once my child is released into the custody of any of the above or below named individuals, the YMCA and its staff no longer have any responsibility for my child. We strongly recommend that you establish a secret password with your child to be used in an emergency situation. **Contact persons will be asked to show identification prior to release of the child.**

Name:_____Home#_____Cell#_____Work#_____

Address:_____City_____State____ Zip Code_____

Name:_____Home#_____Cell#_____Work#_____

Address:_____City_____State___ Zip Code_____

Parent/Guardian Signature:_____Date:_____

Monthly Credit/Debit Card Contract

I authorize the New Rochelle YMCA to keep my signature on file and to charge my credit card account on an ongoing basis for amounts I owe. **I understand that this authorization is valid for the duration of my child's enrollment and that I may cancel the authorization at any time through a 30 day written notice. (I would change this. Don't we need to plan staffing? I would state that it has to be by the 15th of the month to go into effect for the ensuing month)** I also agree to contact the merchant if there are any changes to my credit card account information.

Account will be charged on the 1st of every month that school is in session.

Cardholder Name: _____

Cardholder Address:_____City:_____State:___Zip:____

Account Number:_____Expiration Date:_____

Cardholder Signature:_____Date:_____

Monthly charges are:

- **(M - F) $325.00 per month/ Must Sign a monthly Credit/Debit Card Contract**
- (M - F) $100.00 per 3 Days/Week/ Must Sign a weekly Credit/Debit Card Contract
- **(M _ F) $40 per Half Day (11:30-3:00 PM) – If you opt for Half Day service**
- **Late fees:** A grace period of 5 minutes will be allocated for your convenience. If a child is pickup up after **6:35** a charge of **$1.00 a minute** will be applied to your bill. **Habitual late pick-ups may result in suspension from the program.**
- Payments received after the 5th of the month will be charged a $35.00 late fee

All information on this form is correct as far as I know. I understand that the YMCA reserves the right to refuse an application or terminate enrollment of any child based upon disciplinary difficulties or lack of payment.

Parent/Guardian Signature:_____Date:_____

Parent/Guardian Signature:_____Date:_____

Witness Signature:_____Date:_____

WITHDRAWAL PROCEDURES

All withdrawals must be made in writing only. Withdrawals must be sent directly to the **YMCA** located at **50 Weyman Avenue, New Rochelle, NY 10805.** Monthly enrollment fees will be charged until the director receives notification of withdrawal in writing. You are paying for your child's space in the SACC program; therefore, supervision has been planned for the entire month whether your child attends or not.

Please plan accordingly as all payments received are final. **NO REFUNDS**.

PICK UP AUTHORIZATION FORM

YMCA POLICY: Your child will not be released into the custody of any person that you have not specified below as an accepted pick-up person, *even* including other family members. Telephone approval is not acceptable. Please print below the full names of any and all persons you authorize to pick up your child (list your name first).

My Child may be picked up only by the following people:

1. _____ **Tel:**_____

2._____ **Tel:**_____

3._____ **Tel:**_____

4._____ **Tel:**_____

5._____ **Tel:**_____

6._____ **Tel:**_____

7._____ **Tel:**_____

8._____ **Tel:**_____

9._____ **Tel:**_____

10. _____ **Tel:**_____

I understand and agree that once my child is released into the custody of any of the above named individuals, the YMCA and its staff no longer have any responsibility for my child. **Contacts will be asked to provide photo identification at pick up.**

We recommend that you establish a secret password with your child to be used in an emergency situation.

Late Pick Up: A grace period of 5 minutes will be allocated for your convenience. If a child is pickup up after **6:35 PM** a charge of **$1.00 a minute** will be applied to your bill. **Habitual late pick-ups may result in suspension from the program. Please be on time!**

Parent/Guardian: _____
Signature

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed by Licensed Physician, Physician's Assistant or Nurse Practitioner

Name Of Child:	Date Of Birth:	Date of Examination:

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health.

Attach certification specifying the exempt immunization(s). ☐Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	**1st Date**	**2nd Date**	**3rd Date**	**4th Date**	**5th Date**
Polio (IPV or OPV)	**1st Date**	**2nd Date**	**3rd Date**	**4th Date**	
Haemophilus influenzae type B (Hib)	**1st Date**	**2nd Date**	**3rd Date**	**4th Date OR 1st Date (if given on or after 15 months of age)**	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	**1st Date**	**2nd Date**	**3rd Date**	**4th Date**	
Hepatitis B	**1st Date**	**2°" Date**	**3"' Date**		
Measles, Mumps and Rubella (MMR)	**1s Date**	**2°" Date**			
Varicella (also known as Chicken Pox)	1s Date	2°" Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test. If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: ____/____/____

Attach lead level statement

Lead Screening (Include All Dates and Results)

☐Venous ☐ Capillary

Most recent date of lead screening (if different from above):

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screeninQ test.

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies?	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

Phone

Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Working in collaboration with the child's parent/guardian and child's health care provider, the following health care plan was developed to meet the individual needs of:

Child's Name:	Child's date of birth:
Name of the child's health care provider:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the program staff who will provide care to this child with special health care needs:

Name	Credentials or Professional License Information*

This is a double-sided form

OCFS-LDSS-7006 (Rev. 11/2004)

OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Continued

Describe any additional training, procedures or competencies the staff identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

Signature of Authorized Program Representative:

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. *I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications or have a license that exempts them from training; and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Provider/Facility Name: Facility ID Number:

Parent/Guardian Signature:_____ Date:_____