FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Most Precious Blood School
YMCA School-Age Childcare
2017-2018 School Year

Learn, Grow, Thrive

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

Program Hours & Location

After School Care: End of school day to 5:30 p.m.
Two Hour Delay Care: 7:00 a.m. to start of school day
Program Location: School basement

Program Fees

After School Care: $53 weekly per child
2 Hour Delay Care Only: $11 per day

Weekly fee includes early dismissal and 2 hour delay care at no additional charge.

Additional Information

Weather Closings: All day care is available from 6:30 a.m.-6:00 p.m. at Harris Elementary, Harrison Hill Elementary, Holland Elementary, and Washington Elementary when FWCS is closed. Cost is $26.00 per child.

Financial Assistance

YMCA Financial Assistance is available for qualified applicants.
Sibling Discount of 10% is offered to families with multiple children in the program. First child is full price with each additional child 10% off our regular rates. Sibling discount is applied only when there is not other form of financial assistance.

For more information contact:

Ann Conroy @ 449-8464, ann_conroy@fwymca.org or
Stacy Gilbert @ 449-8266, stacy_gilbert@fwymca.org
Childcare Services fax: 449-4776 YMCA web site: www.fwymca.org

YMCA ChildCare Services Branch
1117 S. Clinton Street
Fort Wayne, IN 46802

YMCA School-Age Childcare Program—Precious Blood

How To Register

- Print a registration packet (Registration Form, Health Form, Immunization Form, Payment Contract, and Parent Handbook Acknowledgement) from the YMCA website: www.fwymca.org. Complete all forms and return them to the Child Care Services Branch no later than August 4 in order for your child to start the first day of school.

- Call the YMCA Child Care Services Branch to have a registration packet sent to you via mail, email, or fax. You may call Ann @ 449-8464 or Stacy @ 449-8266. Complete all forms and return them to the Child Care Services Branch no later than August 5 in order for your child to start the first day of school.

- Come into the YMCA Child Care Services Branch offices located at 1117 S. Clinton Street to pick up a registration packet. Complete all forms and return them to the Child Care Services Branch no later than August 5 in order for your child to start the first day of school.

Please mail or drop off your completed registration packet to:

Ann Conroy
YMCA Child Care Services Branch
1117 S. Clinton St.
Ft. Wayne, IN 46802

Current Resident or:

YMCA of Greater Fort Wayne
Child Care Services Branch
1117 S. Clinton Street
Fort Wayne, IN 46802

YMCA Child Care Services Branch
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 Record:

_____ This form must be completed and signed by a Health Care Provider. Please note: Your child's registration will not be accepted without a Heath Care Provider's signature on this form.

Payment Contract:

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

Parent Handbook:

_____ Sign and date the acknowledgement.
Handbook is available at www.fwymca.org

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 will not be accepted.

Please remember the registration cut-off date is August 4, 2017 if you are planning for your child to start the first day of school.

REGISTRATION FORM

FOR YOUTH DEVELOPMENT
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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: _____	Name: _____	Name: _____
Relation to child: _____	Relation to child: _____	Relation to child: _____
Hm #: _____	Hm #: _____	Hm #: _____
Cell #: _____	Cell #: _____	Cell #: _____
Wk #: _____	Wk#: _____	Wk#: _____
☐ Authorized Pick Up	☐ Authorized Pick Up	☐ Authorized Pick Up
☐ Emergency Contact	☐ Emergency Contact	☐ Emergency Contact

PARENT/ GUARDIAN CONSENT

My child has permission to participate in 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 transport my child via emergency transportation should it be deemed necessary by the YMCA staff.

I give my permission for my child to participate in field trips during childcare program hours with the understanding that advance notice and details will be provided.

I give the YMCA permission, without limitation or obligation, to use photography, video, or audio recordings of my child participating in YMCA childcare programs for the promotion or interpretation of the YMCA.

I understand that my child cannot attend YMCA childcare programs until all required forms are turned in to the YMCA.

_____ _____

Parent / Guardian Signature **Date**

_____

Printed Name

For office use only:

_____ Approved to begin program

_____ _____

Staff signature Date

the YMCA

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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:			
__ ADHD ☐ Hyperactive ☐ Inattentive	__ Communication Differences	__ Epilepsy/Seizure Disorder	__ Learning Disability
__ Asthma	__ Diabetes	__ Hearing Impairment	__ Mobility Impairment
__ Autism Spectrum Disorder	__ Dietary Needs	__ Intellectual Disability	__ 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:				
__ Insect Stings	__ Lactose (dairy)	__ Nuts type_____	__ Penicillin	__ 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?	☐ Normal	☐ Mild/Moderate Loss	
	☐ Severe/Profound Loss	☐ Sensitivity to Loud Noise	
Which describes your child's vision?	☐ Wears glasses	☐ Fully Sighted	☐Moderate to Severe Impairment
	☐ Wears contact lenses	☐ Sensitivity to light	☐ 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 _____

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Payment Contract
Precious Blood 2017-2018

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

Address:_____
Street Address Zip Code

My child will be attending under the following contract option:

After School Care

_____ $53 per week

Weekly fee includes early dismissal and 2 hour delay care at no additional charge.

Two Hour Delay Care Only

_____ $11 per day

All day care is available from 6:30 a.m. to 6 p.m. at Harris Elementary, Harrison Hill Elementary, Holland Elementary, and Washington Elementary when FWCS is closed. Cost is $26 per child.

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 written 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.

I understand that all weekly program fees are due on Monday and all monthly program fees are due on the first of the month. Fees will not be pro-rated due to illness, personal vacation, scheduled school cancellations, weather cancellations, suspension from school, or suspension from the childcare program. Weekly contract options Include two hour delays and school cancellations at no additional charge.

_____ _____
Signature Date