_____ **School Year**

_____ **Site/School**

_____ **YMCA Branch**

BEFORE/AFTER SCHOOL PROGRAM REGISTRATION / FEE AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181 (c); 3280.123 & 181 (C); 3290.123 & 181 (c)

Child's Name: _____ DOB:___ / ___ /___ Gender: M / F Gr: _____ (current)

Address: _____ City: _____ Zip: _____

Home: _____ Cell:_____ E-Mail:_____

Legal Guardian 1: _____

Home: _____ Cell:_____ E-Mail:_____

Legal Guardian 2: _____

Home: _____ Cell:_____ E-Mail:_____

Please list your child's primary language: ☐ English ☐ Other: _____

Does/will this applicant have any siblings enrolled in a PFVY Childcare program(s)? ☐ Yes ☐ No

Persons to whom child may be released:

1. _____ 3. _____

2. _____ 4. _____

Start Date: _____ **Child's Typical Arrival Time _____** **Child's Typical Departure Time _____**

Services provided as part of child care fee: Care • Snack – PM • Transition meetings • Special presentations • Observation / assessment with optional family conference

YMCA Membership Options – If you are currently a Health Partners or Keystone Health member, your YMCA membership may be covered by your health insurance carrier.

I am a current Health Partners or Keystone Health insurance member. ☐ Yes ☐ No

Financial Assistance: We believe that everyone in our community should have the opportunity to experience YMCA programs and services. The Y Financial Assistance program is available for anyone with a demonstrated financial need. See your Child Care Director for details.

Afterschool Childcare Program Options – Please select one of the following options on page 2. You are registering for 9 ½ months of care and the plan that you choose will be your arrangement for the school year.

Fees - All fees are based on a monthly schedule and are due the first day of the month. Late payments will be assessed a $25.00 late fee. Prices listed may be subject to revision. **Please note that a late fee of $15 for each part of 15 minutes past closing time will be assessed.**

Payments - There will be 9 equal monthly payments and 1 half month payment (due at registration) which is considered to be June's payment.

Your registration is not complete, and your child is unable to start in the program until you receive confirmation from the Afterschool office and a welcome meeting is scheduled.

Program Options Phoenixville Area School District	Monthly Tuition Fee		
AM Program – Provides daily before school care, including delayed openings.	__ $150 (5 day) __ $116 (4 day)	__ $95 (3 day) __ $65 (2 day)	__ $40 (1 day) __ $50 (drop-in)
PM Program – Provides daily after school care, including early dismissals.	__ $295 (5 day) __ $260 (4 day)	__ $210 (3 day) __ $150 (2 day)	__ $80 (1 day) __ $50 (drop-in)
AM/PM Program – Provides daily before and after school care, including delayed openings and early dismissals.	__ $395 (5 day) __ $345 (4 day)	__ $300 (3 day) __ $200 (2 day)	__ $105 (1 day) __ $50 (drop-in)
Y DAYS / Holiday Care – Provides daily care during school closures at the YMCA branch including early dismissals, school holidays and snow days.	**First Child Fee** ___ $50 / drop-in ___ $90 / month	**Sibling Fee** ___ $45 / drop-in ___ $81 / month	
Y Financial Assistance or CCIS Co-Pay Please ensure completed forms are received by the child care office to ensure correct tuition.	My Co-Pay is: $_____		

*__Deposits are non-refundable and non-transferable.__ This deposit will be used as your June 2019 payment. This payment is due at the time of registration. Early registration is highly encouraged to ensure you receive programming.

- ☐ I, the guardian, have read and understand the payment procedures and policies.
- ☐ I understand that my child will not be allowed to attend the program if payment has not been received by the YMCA prior to my child attending care.
- ☐ I understand that my child will be evaluated periodically and the results will be shared with me.
- ☐ I have received complete written program information at the time of enrollment either electronically or hardcopy at time of enrollment. {3270.121; 3280.121; 3290.121}
- ☐ I agree to update the emergency contact/parent consent form, child health form and fee agreement form whenever changes occur or every six months. {3270.124; 3290.124}
- ☐ I understand my tuition will be automatically deducted and additional fees will be billed for the additional days my child is in care.

Legal Guardian Signature:_____ Date: _____

Legal Guardian Signature (6 months):_____ Date: _____

Operator Signature: _____ Date: _____

GETTING TO KNOW YOU
AFTER SCHOOL PROGRAM

We can work more effectively with your child throughout the school year if we know as much about him/her as possible. Please help us get to know your child better by completing this form and submitting with your registration packet.

Child's Name: _____

Well-liked nickname: _____ Grade / Age (*as of start date*): _____

Are there any areas of your child's life that you hope to see developed at the YMCA?_____

_____

Does your child have special interests that we might incorporate into the program such as games, hobbies, sports, etc.? _____

_____

Please list any information about your family's composition that may help us in supporting your child:

_____

_____

Does your child require any modifications in YMCA policies, practices, procedures or auxiliary aids and services in order to allow your child to fully participate in our programs? ☐ Yes ☐ No

If yes, please explain: _____

_____

(*Our ADA Compliance Officer will follow up with you to discuss any requests.)*

Does your child require the services of therapeutic support staff (TSS) while at the YMCA? ☐ Yes ☐ No (*If yes, please schedule an appointment with the Program Director prior to starting the program to review the YMCA TSS policy*.)

If your child has an IEP, would you like to provide a copy to the Program Director? ☐ Yes ☐ No (*Provision of the IEP is up to the discretion of legal guardian*.)

Would you like your child to work on homework in our program? ☐ Yes ☐ No

If yes, please describe your child's best work environment such as quiet space, small group, music, etc.

_____

What are the homework area(s) where your child excels and/or finds most challenging? _____

_____

What are your expectations of the YMCA After School Enrichment program? _____

_____

Please list any additional information that will help us better serve your child while in our care such as personality, disposition, social skills, and forms of behavior modification used at home, etc. Feel free to make an appointment with the Program Director to discuss. _____

_____

Will you consider joining our family committee and/or volunteering? ☐ Yes ☐ No

Do you have any special interests or talents you wish to share? _____

Legal Guardian Signature: _____ Date: _____

Office Use only: Meeting Date: _____ Attendees: _____

AUTHORIZATION FOR EMERGENCY HOSPITAL / MEDICAL TREATMENT

In case of an emergency due to illness or accident, when it is thought advisable to have immediate medical attention for my child, I hereby authorize the Philadelphia Freedom Valley YMCA Child Care program to send my child to the nearest hospital.

I agree to meet the teacher at the hospital as soon as possible after being notified.

I understand that I must bear all expenses involved, including those incurred to transport my child to the hospital.

In the event of a minor injury,

☐ I authorize the Philadelphia Freedom Valley YMCA Child Care program to administer minor First Aid to my child.

☐ I do not authorize the Philadelphia Freedom Valley YMCA Child Care program to administer minor First Aid to my child.

Name of child: _____

Relationship to child: _____

Legal Guardian Signature: _____

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:

☐ 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)

☐ YES ☐ 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.

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.

Emergency Contact/Parental Consent Form

55 PA Code Chapters 3270.124 (a) (b); 3270.181 & 182; 3280.124 (a) (b); 3280.181 & 182; 3290.124 (a) (b); 3290.181 & 182

Child's Name	Birthdate
Home Address	Email Address
Legal Guardian 1 Name	Home Phone
Home Address	Cell Phone
Business Name	Business Phone
Legal Guardian 2 Name	Home Phone
Home Address	Cell Phone
Business Name	Business Phone
Emergency Contact Person (s) - Name	**Phone number when child is in care**
1).	
2).	
Person(s) to whom child may be released – Name/Address	**Phone number when child is in care**
Name: Address:	Phone Number
Name: Address:	Phone Number
Name of Child's Physician/Medical Care Provider	Phone Number
Address	
Special Disabilities (if any)	Allergies (including medicine 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'S SIGNATURE REQUIRED FOR EACH ITEM BELOW TO INDICATE	**PARENTAL CONSENT**
Obtaining Emergency Medical Care	Administration of Minor First Aid Procedures
Transportation by the Facility	Swimming
Wading	Walking Trips

Signature of Legal Guardian **Date**

Signature of Legal Guardian (6 month review) **Date**

NON-DISCRIMINATION IN SERVICE

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, and national origin including English Limited Proficiency (ELP), age or gender.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provisions of aids, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individuals, clients, patient, student (and/or their guardian) who believes they have been discriminated against may file a complaint of discrimination with:

Philadelphia Freedom Valley YMCA
For a list of locations, please visit philaymca.org.

U.S. Department of Health and Human Services
Suite 372, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-9111

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Southeastern Regional Office
801 Market Street
Philadelphia, PA 19107

Department of Human Services
Bureau of Equal Opportunity
Room 223 Health & Welfare Building
P.O. Box 2675
Harrisburg, PA 17105

PA Human Relations Commission
Philadelphia Regional Office
110 North 8th Street
Suite 501
Philadelphia, PA 19107

Legal Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

PHOTO AND VIDEO/AUDIO RECORDING RELEASE

I am 18 years of age or older and, if not, my Legal Guardian has also signed below.

For my participation in activities to be conducted by the Philadelphia Freedom Valley YMCA, I hereby give my permission and consent, now and for all time, to YMCA and collaborating third parties to make, reproduce, edit, broadcast or rebroadcast any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities, for publication, display, sale or exhibition thereof in promotions, advertising, education and legitimate business uses without any compensation to, and/or claim, by me. I may, or may not be, identified in such reproductions; however, I shall not be stated by name to have endorsed any particular commercial products or commercial services.

I further agree to the following:

- Any video film, footage, sound track recordings, and photo reproductions of me and/or my narrative account of my experience during said activities, I authorize, according to this Release, shall belong to YMCA and collaborating third parties. Therefore, they will have full right of disposition of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities;
- Any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities will not be subject to any obligation of confidentiality and may be shared with and used by YMCA and collaborating third parties;
- YMCA and collaborating third parties collaborating shall not be liable for any use or disclosure to a third party of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience; and
- YMCA and collaborating third parties shall exclusively own all known or later existing rights to worldwide and shall be entitled to the unrestricted use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience for any purpose without compensation to me.

I agree that my consent and this release are irrevocable. I hereby release and discharge YMCA and collaborating third parties from any and all claims in connection with the uses and reproductions, any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience as described herein.

Signature: _____ Date: _____

Printed Name: _____ Age: _____

Address: _____

_____

For persons under 18 years old, please complete below:

I am the Legal Guardian of _____.
(Child's name)

For the consideration contained herein, I hereby consent to the foregoing on behalf of my minor child.

Signature of Legal Guardian: _____

Philadelphia Freedom Valley YMCA
P 215-963-3700
philaymca.org