FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

IT'S THE SUMMER TO DISCOVER

Summer Day Camp Enrollment Packet

May 30 – August 11

Serving children who have completed Kindergarten through age 12.

RIVERFRONT YMCA
544 BROAD BLVD
CUYAHOGA FALLS, OH 44221
(330) 923-9622

akronymca.org

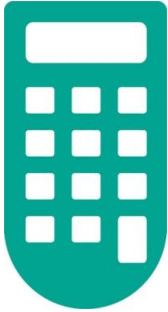
The Y strives to make programs and membership available to all. Financial assistance may be available to those who qualify.

Mission: To put Christian principles into practice through programs that build a healthy spirit, mind and body for all.

Connect with us!

PARENT INFORMATION PAGE

Tear off and keep for your records!



CAMP FEES

Registration Fee: $40.00 per child
YMCA Member: $135/ Week
Program Member: $155/week
Extended Care for Camp Y-Noah campers only:
$45/ week for Before AND After Care
$25/week for Before OR After Care

Auto draft is REQUIRED.

CAMP TIMES

Before Care: 6:30-9:00 am
Camp: 9:00 am-4:00 pm
After Care: 4:00-6:00 pm

Before and After Care are provided at no extra charge for children attending day camp. The child needs to arrive at camp by 8:45 am each day.

WHAT TO BRING

- Camp t-shirt
- Closed toe shoes (tennis shoes)
- Packed lunch
- Water bottle
- Backpack
- Swimsuit and towel

WHAT NOT TO BRING

-Open toe shoes (flip flops)
-Crocs
-Cell phones and other electronics
- Toys from home
-Valuables
-Two Piece Bathing Suits

DATES TO REMEMBER

First Day of Camp: May 30
Last Day of Camp: August 11

Open house on May 27, 2016
from 9:00 am- 11:00 am

PASSPORT PROGRAM

Register your child for 6 or more weeks of Day Camp and receive 20% off a week of Adventure Camp (Overnight) at Camp Y-Noah! To take advantage call Camp Y-Noah at 877-GOT-CAMP!

From exercise to education, from volleyball to volunteering, from preschool to preventive health, the Y doesn't just strengthen bodies- we strengthen community! The YMCA strives to make programs and memberships available to all. Financial Assistance is available to those who qualify.

WHO TO CALL: 330-923-9622

HAYLEY RAYL:
Youth Enrichment Director
hayleyr@akronymca.org
REBECCA BAKER:
Youth Enrichment Director
rebeccab@akronymca.org

Summer Day Camp 2017

Please select the weeks and/or service you need:

- ☐ Week 1: May 30-June 2
- ☐ Week 2: June 5-9
- ☐ Week 3: June 12-16
- ☐ Week 4: June 19-23
- ☐ Week 5: June 26-30
- ☐ Week 6: July 3-7 (no camp 7/4)
- ☐ Week 7: July 10-14
- ☐ Week 8: July 17-21
- ☐ Week 9: July 24-28
- ☐ Week 10: July 31-August 4
- ☐ Week11: August 7-11

☐ **For Camp Y-Noah campers only-** Extended Care, Before OR After Week(s): ______________________________

☐ **For Camp Y-Noah campers only-** Extended Care, Before AND After Week(s): ______________________________

Payment Information:

Weekly Payment Amount: ☐ $135 (YMCA Members) ☐ $155 (Non-Y Members) ☐ Other (contact director)

Please draft payment: ☐ Weekly on Fridays ☐ Other (contact director)

Account: ☐ Use account on file (ending in _____) ☐ Provide account info at registration ☐ FLEX (contact director)

Person responsible for tuition: ________________________________

Do you have Title XX? ☐ Yes ☐ No

Are you or another parent/guardian currently an employee of the YMCA? ☐ Yes ☐ No

If yes, what is his/her name? ____

Child and Family Information:

Child's Name and Nick Name ____ ☐ male ☐ female

Child's Birth date ____________________ Age ________

Street Address ____

City _______________________________ State ___________ Zip ___________

Shirt Size (please circle) YS YM YL AS AM AL AXL

Parent Name ________________________________

Primary Number ( ) ☐ C ☐ H ☐ W

Secondary Number ( ) ☐ C ☐ H ☐ W

Email _______________________________________

Birth date ___________________________________

Parent Name ________________________________

Primary Number ( ) ☐ C ☐ H ☐ W

Secondary Number ( ) ☐ C ☐ H ☐ W

Email _______________________________________

Birth date ___________________________________

Authorized Persons to Pick Up Child

Your child will only be released to a parent/guardian or persons listed in this section. Staff will require a government issued identification before releasing your child.

Name ____ Relation ________________________________

Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Name ____ Relation ______________________________

Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Name ____ Relation ______________________________

Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐ W

Name ____ Relation ______________________________

Primary Number ( ) ☐ C ☐ H ☐ W Second Number ( ) ☐ C ☐ H ☐

Please note: if there are any custody issues involved with your child, you must provide the center directors with full court papers including who has permission to pick up the child. The program may not deny a parent access to his/her child without proper documentation.

Child's name ________________________________

Photograph Consent

I give my permission for my child _____________________________________ to be photographed for the promotion of the Akron Area YMCA.

Parent/Guardian Signature ____ Date _____________________

==

Permission for Routine Walks

Weather permitting, I give permission for my child _____________________________________ to accompany his/her group on routine walks in the neighborhood of the YMCA.

Parent/Guardian Signature ____ Date _____________________

==

Permission for Routine Field Trips

I give permission for my child _______________________________________ to accompany his/her group on routine field trips throughout the week from 9:00-4:00 May 30- August 11. Transportation is provided by school busses (CF City Schools Transportation Services).

Parent/Guardian Signature ____ Date _____________________

==

Permission to Participate in Swimming Activities

I give permission for my child _______________________________________ to participate in swimming activities near water two feet or more in depth – and/or water activities planned in water two feet or more in depth. The center will be providing 1 additional adult above the required staff/child ratio.

Swim Site	Riverfront YMCA Pool
Date(s)	May 30- August 11, 2017
Departure/Arrival Times from Center	9:00 am-4:00 pm
Mode of Transportation	Pool on site
My child is a	☐ Swimmer ☐ Non Swimmer

Parent/Guardian Signature ____ Date _____________________

==

Child Drop-Off/Pick-Up Policy

When you enroll your child in any YMCA Day Camp, it is to be understood that our policy is for you to bring your child into the center each morning, sign the attendance sheet, and let one of the staff members know your child has arrived. Please note: we are not legally responsible for your child when he/she is dropped off without completing the above procedure.

I understand that state law requires me to sign my child in and out each day, as well as notify staff that my child is leaving for the day.

Parent/Guardian Signature ____ Date _____________________

Child/Family Information Form

In an effort to understand your child and to meet his/her needs, we would like you to complete the following:

Child's Name: ____

Brothers and sisters (names and ages):

____

Child lives with:

____

What is the primary language spoken in your child's home? ____

Does your child have any particular fears such as dogs, storms, etc.?

____

What are your child's special interests?

____

____

Have there been any changes or transitions in your child's life recently, such as divorce, new home, death, etc.?

____

____

Are there additional personality and behavior characteristics that would be useful to know about your child?

____

____

How do you reassure or reward your child?

____

____

How do you discipline your child?

____

____

Please list the three most important things you would like your child to work on while in our program:

____

____

What other information would be helpful for the staff caring for your child to know?

____

____

Child's name ______________________________

2017 Center Policies Agreement

Please read the policies carefully and **initial** all lines.

________ I understand there is a $40 non-refundable registration fee per child.

________ Weekly tuition is due on Fridays prior to the week of service via auto draft.

________ I understand that if my childcare payments fall one week behind I will be asked to withdraw my child until payment is made.

________ Outstanding balances of $100 or more that are past 30 days in arrears will be turned over to collections.

________ I understand that if I have any outstanding balance at any facility within the Akron Area YMCA Association I am unable to register for any programs or membership until balance is paid.

________ I understand that there will be a $10 fee assessed for any and every returned payment.

________ CANCELLATION POLICY: Notification must be given no later than one week in advance. Otherwise, I understand that I will be responsible to pay that week's tuition in-full, regardless of attendance.

________ I understand that late pick-up fees in the amount of $15 for every 15 minute increment per family will be imposed if my child(ren) is picked up after the center's designated closing time (6:00 pm).

________ I understand that staff will contact Summit/Medina County Children Services if my child remains at the center longer than one hour after closing and all attempts to reach me, the child's other parent, and authorized persons have been made, without success.

________ I understand that state licensing requires that all forms in this registration packet must be completely filled out and turned in prior to the child's admission to the program.

________ I understand that I am required to disclose all medical, physical, or behavioral issues that pertain to my child at the time of enrollment, and supplement that information on an ongoing basis as needed.

________ I have read the YMCA BASE/Day Camp Registration Packet and agree to all terms therein for my child(ren) to receive childcare. I understand that I forfeit the privilege of childcare if all policies are not followed.

FOR TITLE XX RECIPIENTS ONLY

_______ I understand that my Title XX co-pay is due every Friday via auto draft prior to care.

_______ I understand that if my Title XX authorization is not current and/or not for the correct location, I will be responsible for private pay rates.

_______ I understand that I must swipe my Title XX card daily. I understand there is a two-week back swipe period if daily swipes are missed. If I miss the back swipe period, I understand that I will be charged the difference between my co-pay and the weekly private-pay rates. I understand it is my responsibility to know for which dates and times I need to back swipe.

Parent/Guardian Signature ____ Date ___________________

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No
If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No
If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation**.**
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every __________ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every __________ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			*Do Not Give Permission* to Transport	
Program or Home Name		**OR**	Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		**Do not sign both**	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No
(check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name			Date of Birth
Special Health Conditions			
Symptoms to watch for and emergency action to be taken if the following symptoms occur			
Activities/foods/environmental conditions to avoid, if applicable			
Medical procedures to be followed and expected benefit of treatment, if applicable			
Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")* If yes, what medications?			
In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? ☐ Yes ☐ No			
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? ☐ Yes ☐ No			
Training Instructions *(Trainer must be a parent or certified professional)*			
Signature of Trainer			Date
Signature of trained providers, substitutes or child care staff members who have been made aware of the condition. *(There must always be a trained caregiver present when the child is present)*			
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
Signature	Date	I have been ☐ Informed	I have been ☐ Trained
(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)			
Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name	Phone Number		May we contact? ☐ Yes ☐ No
Name	Phone Number		May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage

To be administered at the following times	For the following period of time

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician’s instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement
Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number
Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Additional T-Shirt Order

Children need to wear their camp t-shirt to camp every day! Each child will receive one camp t-shirt as part of registering for summer day camp.

If you would like to order additional t-shirts, please fill out this form:

Child's Name: ____

Parent's Name: ____

Number of additional shirts: __________

(Each additional shirt costs $9)

Size (please circle):	YS	YM	YL	AS	AM	AL	AXL
		Youth Sizes			Adult Sizes		

Please include payment when turning in your registration packet. You will not receive the additional shirts unless payment has been made.

You will be given the t-shirts during the first week of camp.

Riverfront YMCA
544 Broad Blvd
Cuyahoga Falls, OH 44221
(330) 923-9622

akronymca.org

The Y strives to make programs and membership available to all. Financial assistance may be available to those who qualify.

Mission: To put Christian principles into practice through programs that build a healthy spirit, mind and body for all.

Connect with us!