FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
**FOR SOCIAL RESPONSIBILITY**

Dear Pocono Family YMCA Family, Parents, & Our Beloved Community Members,

To everyone in our Pocono Family YMCA family, we are thinking of you in these uncertain times. We wanted to reach out and let you know we are here for you. We are grateful to stay connected through technology. We are announcing that we are opening up our School Age Child Care program to our community. Our program will run Monday-Friday 7am-5pm until further notice.

If your child is not currently enrolled in our program, to register for our Temporary Coronavirus School Closure Childcare Program, here is the list of what is needed:

Completed Registration Packet which includes:

___Emergency Contact w/ signatures at bottom for parental consent.
___Agreement form
___Signed consent forms
___Child Health Questionnaire
___Child Health Report (Physical)
___Immunization Record

Once the registration packet is completed, the packet must be submitted to the front desk where registrants will be placed on a waiting list. Due to the high demand, incomplete packets will be bypassed. Once a position becomes available, the first person on the list will be contacted. **Submitting a registration packet does not guarantee you a place in the Temporary exempt day program. Also, please note that once the schools reopen, the registration is discontinued.** However, we would encourage the family to become part of the YMCA community in the future.

**Cost for care is $150 for each week. $135 for children who have siblings in our program. Regular families pay the regular rate plus the $15 a day. If families are going through a hardship, they can contact Nicole at 570-421-2525 ext 112 and we will discuss things on a case by case basis.**

Additionally, if younger siblings need temporary care, please contact us, as we might be able to accommodate you.

**If you have any further questions, please do not hesitate to reach out. Please remember that this is an ever evolving situation and can change at any time. As always, we are here for you and your family.**

Thank you for your continued support,

Your Pocono Family YMCA Team

# 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 |
| ADDRESS | |
| MOTHER'S NAME/LEGAL GUARDIAN | BIRTHDATE / TELEPHONE NUMBER |
| ADDRESS | |
| BUSINESS NAME | BUSINESS TELEPHONE NUMBER |
| ADDRESS | |
| FATHER'S NAME/LEGAL GUARDIAN | BIRTHDATE / TELEPHONE NUMBER |
| ADDRESS | |
| BUSINESS NAME | BUSINESS TELEPHONE NUMBER |
| ADDRESS | |
| EMERGENCY CONTACT PERSON(S) | NAME / TELEPHONE NUMBER WHEN CHILD IS IN CARE |
| | |
| PERSON(S) TO WHOM CHILD MAY BE RELEASED | NAME / ADDRESS / TELEPHONE NUMBER WHEN CHILD IS IN CARE |
| | |
| NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER | TELEPHONE NUMBER |
| ADDRESS | |
| SPECIAL DISABILITIES (IF ANY) | ALLERGIES (INCLUDING MEDICATION 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 IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT**

| | |
|---|---|
| OBTAINING EMERGENCY MEDICAL CARE | ADMIN. OF MINOR FIRST - AID PROCEDURES |
| WALKS AND TRIPS | SWIMMING |
| TRANSPORTATION BY THE FACILITY | WADING |

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

# AGREEMENT

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

| NAME OF CHILD | | |
|---|---|---|
| FEE AMOUNT<br>$ | PER-DAY-WEEK | DAY PAYMENT TO BE MADE |

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

| CHILD'S ARRIVAL TIME | CHILD'S DEPARTURE TIME. | PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED |
|---|---|---|
| LATE FEE<br>$ | PER MIN-HR | |

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

| DATE OF CHILD'S ADMISSION |
|---|
| DATE OF WITHDRAWAL |

**PERIODIC REVIEW**

SIGNATURE-PARENT OR GUARDIAN 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:

ADDRESS:

PHONE:

SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT

TITLE:

LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Rev. 8/2/19

# Credit Card & Bank Draft Authorization

## Authorization Agreement
## Child Care LCC & SACC

I hereby give the Pocono Family YMCA permission to charge my credit card for any overdue/program/membership monies on my account to keep my account in good standing.
_____ (Initials)

The YMCA Board of Directors may, at its discretion, adjust the monthly rate applicable to my membership category. I understand that I will receive at least **two weeks notice** prior to any such change in membership/program dues.
_____ (Initials)

Should any deduction not be honored by my financial institution for any reason, I realize that I am responsible for payment, **plus a service charge of $30.00**. This is in addition to any service charge that my financial institution may charge to my account. I understand that it is my responsibility to notify the YMCA in writing should I change my financial institution or account at any time.
_____ (Initials)

I understand that if I wish to terminate my membership/program fees or change my membership/enrollment in any way, I must give **30 days written notice**. I understand that I must turn in all membership cards upon termination and that I will receive temporary cards for the balance of the time that I have paid. Membership cards remain the property of the YMCA and MUST be surrendered upon request.
_____ (Initials)

This authorization to deduct funds to remain in effect until the YMCA has received a **30-day written notification** from me indicating my desire to cancel my membership or withdraw from the program.

**Member Signature** _____ **Date** _____

I hereby authorize the Pocono Family YMCA to initiate electronic fund entries by:

☐ Bank Draft ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Bank Draft Acct No._____ Routing No. _____

C.C. Account No. _____ Expiration Date: _____

**Membership Draft** will be on the 5th / 14th / 28th (please circle preference): _____(Initials)

**SACC payments** are Due on Friday prior to the register weeks: _____(Initials)

**LCC payments** are Due on Friday prior to the register weeks: _____(Initials)

**Summer Camp payments** Due on Friday prior to the register weeks: _____(Initials)

**Office Staff Only**

Program: _____ Monthly Fees: _____

Monthly Assistance: _____ Staff Initials: _____ Date: _____

Parent/ Guardian Releases: (Responsible party must initial each item below)

_____ I, the undersigned, hereby enroll my child in the Pocono Family YMCA Program at 809 Main St. Stroudsburg, PA. I understand the YMCA must have current names and addresses of anyone authorized to pick up my children.

_____ I understand that the YMCA assumes responsibility for my child's wellbeing during the hours of care and will make every effort to contact the parent should any type of emergency arise. I understand that if I cannot be reached that individuals authorized on the emergency pickup will be contacted. Those individuals are authorized to assist in an emergency.

_____ In the event I cannot be reached, I authorized the YMCA staff to act for me according to his/her best judgment in any emergency requiring medical or surgical care. I authorize the physician selected to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child named above. I expect to be notified immediately. I further understand I am responsible for the cost of all medical care.

_____ I have provided and agree to update and keep complete, the child/ Infant information sheet and health questionnaire, to update the staff with any pertinent information which may assist the YMCA in caring for my child including but not limited to: allergies, previous or existing illness or condition, skin sensitivity, diet requirements, long term medications, disability or limiting conditions, or emotional, developmental or behavioral difficulties.

**Photo Consent**

The YMCA uses photographs in "promotional material" (such as, but not limited to, newsletters, social media, advertising, news releases, etc.) throughout the year. By consenting below, you allow any photographs or likeness of your child to be used in such "promotional material."

_____I give consent that any photographs or likeness of my child may be used in promotional materials. I understand that I will not be informed or reimbursed for such photographs.

**Health Insurance**

_____ As a condition of enrollment, The YMCA requires children to be continually covered by health insurance. Coverage information must be provided on the enrollment application and updated as changes occur.

**Change of Contact Information**

_____ I agree to inform the YMCA in writing of any changes in address, work telephone, emergency numbers, etc., for myself and any emergency contacts listed on the enrollment application.

**Does your child have any known hearing difficulties?** Yes No

If yes, please explain: _____

Has your child received services for hearing loss? Yes No

If yes, by whom? When? _____

What was the date of the last screening? _____ Conducted by? _____

Does your child have any **dietary needs** we should be aware of? Yes No

If yes, please explain: _____

Has your child ever had an **eating or appetite problem?** Yes No

If yes, please explain: _____

Does your child tend to get a lot of **ear infections?** Yes No

Does your child take **medication** regularly? Yes No

If yes, what is the medication and how often is it taken? _____

Has your child been hospitalized or seen in an emergency department? _____

_____

It is expected that the child named on this form be immunized according to the PA Code schedule for immunizations. If the child is not yet fully immunized, please describe why and when the immunizations will be completed. (Children who have not yet reached school age should be immunized according to their age. Please respond only to immunizations that should have been completed to date.)

**My child is fully immunized.** Yes No

If not, reason immunizations have not been completed: Health Concerns

Religious Beliefs

Other: _____

Does your child have any other **"Special Health Needs"** that we should be aware of? Yes No

If yes, please complete the "Individual Health Care Plan for Child with Special Health Care Needs".

In accordance with HIPPA laws, your permission is required for the Pocono Family YMCA staff to have access to health information about your child. By signing this form, you understand that the YMCA Administrative Staff and staff working with your child will have access to the information disclosed on this form and other pertinent information required to meet the daily needs of your child.

Parent/Guardian Signature: _____ Date: _____

# CHILD HEALTH QUESTIONNAIRE

Child's name: _____ DOB: _____ Date of Form: _____

Does your child have any known allergies to any of the following?

a. Food (milk, peanuts, eggs etc.) _____
b. Medicine _____
c. Animals _____
d. Bee/ wasp sting _____
e. Grass, Pollen, dust _____

What is the plan in place to respond if exposure to allergens should occur? _____

_____

_____

Does your child have Asthma? If yes, please also complete an Asthma Control Plan obtained from the Director.

What causes the attack? _____

What is done to treat an attack? _____

What can be done to prevent an attack? _____

What activities have to be limited, if any? _____

What medicine is given, if any? _____

**The YMCA requires that the following routine screening are done annually. Normally, your child's Health Care Provider will conduct these assessments.**

Does your child have any known speech / language difficulties? Yes No

If yes, please explain: _____

Has your child received speech / language services? Yes No

If yes, by whom? When? _____

What was the date of the last screening? _____ Conducted by? _____

**Does your child any known vision difficulties?** Yes No

If yes, please explain: _____

Has your child received services for impaired vision? Yes No

If yes, please explain: _____

What was the date of the last screening? _____ conducted by? _____

Does your child wear glasses or contacts? ____ Glasses _____ contacts