2017/2018 Preschool Registration Form
Children 3-5 years old

Child's Name_________________________________ Age______

Parent/Guardian's Name (please print) ______________________________________

Address____

Phone_______________ Email_________________________________

YMCA Member: (circle one) yes/no Expiration date: ____________

Private Pay: _____ CCIS Participant: _____ **(Please provide approval letter)**

Date Child will start Preschool: ______________

Registration Fee $25.00

Care Times	Member Rate	Community Member
___ Tuesday/Thursday AM	___$100	___$120
___ Tuesday/Thursday PM	___$100	___$120
___ Monday/Wednesday/Friday AM	___$130	___$150
___ Monday/Wednesday PM	___$100	___$120

*Must have Youth or Family Membership to qualify for YMCA Member program fee discount
*10% sibling discount for second and third child's fee
*Financial assistance available

I, _________________ agree to pay the Bloomsburg YMCA $_______ per week for my child's Preschool service.
Please Note: You will pay for the days you sign up for, not days actually attended. Cancellation of care must be received in writing TWO WEEKS in advance of removal date.

Parent/Guardian Signature: ____________________________ Date: _______

Director Signature: ____________________________ Date: __________

Due at Registration:
Week 1 Fee $_____
Registration fee: _______
TOTAL: _______

Parents,

In order to resolve confusion at the front desk, we will need to be provided with a credit card or bank draft on file to be charged weekly. The charge will be scheduled in advance at registration and occur every Friday. This is needed to enroll your child/children into our Preschool program. We apologize for any inconvenience this may cause, but it will help us to better serve you.

If you have any questions or concerns, please feel free to contact us.

Sincerely,

YMCA Administration

570-784-0188

Parent Signature: _________________________ Date: _________

Director Signature: ________________________ Date: _________

CONDUCT POLICY

It is the intent of the Bloomsburg Area YMCA that each child enjoys the activities planned by understanding that he/she is responsible for his/her actions. With prior knowledge of our basic rules of safety and good conduct, each child is made aware of how to exercise self-discipline, and that the YMCA is here to help children and to know that we want him/her to succeed. As in any group activity, the inappropriate behavior of a few children can spoil the experience for the entire group. Therefore, the following conduct policies apply directly to each child and will be used in determining his/her eligibility to continue as a participant in the YMCA Preschool Program. In accordance with the severity of the infraction and the number of times the infraction occurs, a child may (A) be suspended or (B) be terminated from the program for:

1. Repeatedly using foul language and/or being rude and discourteous to staff and/or peers.
2. Defacing YMCA property.
3. Bringing or using illegal substances: alcohol, drugs, weapons (as deemed by staff of the YMCA) or unsafe personal sports equipment.
4. Stealing or defacing the property of others.
5. Refusing to remain with his/her group, intentionally and repeatedly leaving his/her group activity.
6. Inappropriate physical contact: repeated hitting, biting, other physical altercations.
7. Intentionally or repeatedly going to unauthorized areas of the facility or leaving the premises without permission will result in the following actions: a search of the premises will be conducted; if the child is not found, the police and parent/guardian will be notified and the child will not be allowed to return to Preschool. No refund will be given.

In the event that a child has proven that he/she is unwilling to follow these policies, the parent/guardian will be notified and must meet with the Director of Youth Development & Family Engagement in order to discuss the situation. The Director will consider a possible suspension or termination. NO REFUNDS will be given. It is our daily desire that every child enjoys his/her YMCA experience. It is for this reason that we have initiated polices we feel are fair, easily complied with and are of benefit to everyone involved.

Parent signature: ___________________________________ Date: ______________

Permission Agreements

Please read and initial the following permission statements indicating your agreement.

MOVIES

_____ My child has permission to **view G and PG rated** movies at Bloomsburg Area YMCA. I understand that under no circumstances will a movie rated other than G or PG be shown during YMCA Preschool Program.

PHOTOGRAPHS

_____ I authorize the reproduction and use, for promotional purposes, of any **photographic images** taken of me and/or my child by the YMCA of Bloomsburg, Pennsylvania. I understand that I will not receive any compensation, money or otherwise, for the professional use of said photographic images.

_______I authorize the reproduction and use, for promotional purposes, of any **photographic images** take of me and/or my child by the YMCA of Bloomsburg, Pennsylvania on Facebook and other social media. I understand that I will not receive any compensation, money or otherwise, for the professional use of said photographic images.

I understand, accept, and agree with the above statements. As proof of my understanding, acceptance and agreement, I have signed below.

Print Parent/Guardian Name: ___________________________________

Parent/Guardian Signature _____________________________________**Date:** __________

We build strong kids, strong families, and strong communities.

Dear Parents,

Please make sure your child's physician completes this form in its entirety, especially all screenings, signatures and dates. **This health assessment needs to be complete and returned within 30 days of enrollment in the Preschool program. If we do not receive the health assessment by that date, then your child will be suspended from the program until the assessment is received.**

Thank You,
Ashley Miccio
Director of Youth Development & Family Engagement

Dear Health Care Provider,

This child is currently enrolled in our child care facility which is licensed and inspected by the Pennsylvania Bureau of Child Day Care Services. State regulations require enrolled children to have age appropriate health appraisals, including immunizations and health screenings according to the recommendations of the American Academy of Pediatrics.

Please help us to maintain compliance with these health regulations by completing the attached form according to AAP standards. Please be sure to sign and date the form as required by state regulations. Should you have any questions, please call the PA Chapter of AAP at 800-24-ECELS.

Thank you for your cooperation.

This note must remain attached to this health assessment.

Child Health Assessment

Parents & Child Care Providers 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:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at <www.aap.org> or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): ☐ NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

Parents may write immunization dates, health professionals should verify and complete all data.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
		(Birth to Age 2)	(Beginning at age 3)
________IN/CM % ILE ________	_______LB/KG % ILE ________	________IN/CM % ILE ________	______________ / ______________

PHYSICAL EXAMINATION	☑ = NORMAL	If ABNORMAL - COMMENTS
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTa/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (attach additional sheets if necessary)

☐ NONE

NEXT APPOINTMENT - MONTH/YEAR:

Medical care Provider:		Signature of Physician or CPNP:	
Address:			
	Phone:	License Number:	Date Form Signed:

SPECIAL NEEDS FORM

Child's name___________________________ Nickname______________________

Does your child qualify to receive Special Education Services? __yes __no

List any specific disabilities allergies or special health conditions of your child. ___________

____

____

Does your child have heart trouble? ____yes ______no

If yes, please explain: ____

____

Does your child have seizures? ____yes _____no

If yes, please state type, frequency, and procedure(s) to follow during and immediately following the seizure.____

____

Please describe your child's behavior prior to and after a seizure. _______________________

____

Does your child use any special equipment? ___yes ___no

___ Wheelchair ___Braces ___Crutches ___Canes

___Walker ___Hearing Aid ___Glasses ___Pacemaker

Do you have any instructions? ____

____

Does your child need any special assistance? ___yes ____no

If yes, please explain. ____

____

Does your child have any communication difficulties? ___yes ___no

If yes, please explain including extent of difficulties and any methods used to compensate for difficulties (e.g. sign language, speech board, lip reading). ____________________________

____

If your child is deaf, does he/she require an interpreter? ___yes ___no

INDIVIDUALIZED EDUCATION PLANS (IEP) & INDIVIDUALIZED FAMILY SERVICE PLANS (IFSP) INFORMATION SHEET

Because of the diverse set of needs of the children in our program, it is important to gather as much information about the best ways to educate each child. IEP's and IFSP's are created by service providers working with children with special needs and include this information. The Keystone STARS Performance Standards therefore require each early learning provider to request copies of IEP's and IFSP's for the children in their care. Because of the importance of the IEP/IFSP to a child's learning, the program should have a copy before the child begins to attend, if possible.

The information found on an IEP/IFSP is protected by privacy lays including the Health Insurance Portability and Accountability Act (HIPAA).

Parent Sign-off Sheet

Child's Name: ____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

☐ I am providing a copy of my child's IEP or IFSP.

☐ I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child.

Signature: ____________________________ **Date:** _________________

Printed Name: ____________________________

PARENT COPY

We build strong kids, strong families, and strong communities.

To the Parent(s)/Guardian(s):

This letter is to assure you of our concern for the safety and welfare of children attending Bloomsburg Area YMCA Preschool. The YMCA Emergency Plan provides for appropriate response to all types of emergencies. Depending on the circumstance of the emergency, we will use one of the following protective actions:

- *Immediate evacuation:* Students are evacuated to a safe area on the grounds of the facility in the event of a fire, etc.
- *In-place sheltering:* Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the building is the best immediate response.
- *Evacuation:* Total evacuation of the facility may become necessary if there is a danger in the area. In this case, children will be taken to a relocation facility at Bloomsburg Area YMCA.
- *Modified Operation:* May include cancellation/postponement or rescheduling of normal activities. These actions are normally taken in case of building problems (such as utility disruptions) that make it unsafe for children.

Please listen to to the following radio stations for announcements relating to any of the emergency actions listed above:

WFFY 106.5 FM **WKAB 103.5 FM** **WHLM 930 AM**

We ask that you not call during the emergency. This will keep the main telephone line free to make emergency calls and relay information. The form designating persons to pick up your child is included with this letter for you to complete and have returned to the YMCA with your registration. This form will be used every time your child is released. Please ensure that only those persons you list on the form attempt to pick up your child. We specifically urge you **NOT** to attempt to make different arrangements during an emergency. This will only create additional confusion and divert staff from their assigned emergency duties.

In order to assure the safety of your children and our staff, I ask your understanding and cooperation. Should you have additional questions regarding our emergency operating procedures contact the Child Care Director at 570-784-0188.

Sincerely,
Ashley Miccio
Director of Youth Development &
Family Engagement

Bloomsburg Area YMCA, 30 East 7th Street, Bloomsburg, PA 17815-2728
Phone: (570) 784-0188 / Fax: (570) 784-4303
A United Way Agency

PARENT COPY

We build strong kids, strong families, and strong communities.

SUBJECT: Nondiscrimination in Services

TO: Parents/Members

FROM: Ashley Miccio, Director of Youth Development & Family Engagement

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

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 provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

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

Bloomsburg Area YMCA
30 East 7th Street
Bloomsburg, PA 17815
(570)784-0188

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health & Welfare Building
PO Box 2675
Harrisburg, PA 17105

PA Human Relations Commission
Harrisburg Regional Office
333 Market Street, 8th Floor
Harrisburg, PA 17101

U.S. Dept. of Health & Human Services
Office for Civil Rights
Suite 372, Public Ledger Bldg.
150 South Independence Mall West
Philadelphia, PA 19106-9111

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	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME 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 ____________

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ORIGINAL

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