FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Dear Parent/Guardian,

Thank you for your interest in our Summer Camp! We are excited to announce that the camp will run from **June 9th** to **August 15th**, with hours of operation from **6:30 AM to 6:00 PM**.

This year, we are simplifying our offerings by moving to a **single rate**, which now includes field trips. We will no longer offer the three-day or five-day options, and there will be no separate charges for before- and after-camp care. Instead, we are introducing a **flat fee** for the full camp experience.

Early bird registration will be available from **March 1st to April 12th**. To qualify for the early bird rate, you must be a private pay customer. Registration will require full payment for the first week of camp, as well as an additional $10 per week for each week your child will attend.

Attached is the registration packet, which must be filled out completely. Emergency contacts and approved pick-ups must include addresses. Before your child can attend camp, we also require a current health assessment and updated shot records.

Thank you for choosing our program. We look forward to an exciting summer with your child!

Sincerely,
Stacy Wallick
Director of Childcare

Bloomsburg Area YMCA
30 East 7th Street
Bloomsburg, PA 17815
570-784-0188
www.bloomsburgy.org
Serving Columbia and Montour Counties

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Serving Columbia & Montour Counties
The Bloomsburg Area YMCA

Summer Camp
Parental Consent Form

Please **initial** the items you give consent

Child's Name:_____

_____ I understand that in case of an emergency, childcare staff will make every effort to reach me, or the emergency person designated by me. In case of life-threatening accident or illness. When none of the above-mentioned people can be contacted, childcare staff has permission to secure emergency medical care for my child. The child will be taken to the emergency room if deemed necessary. I understand that if my child is injured while under childcare supervision, my family's medical insurance or medical card will be billed.

_____ I would like my child to be taken to **Geisinger Danville** or **Geisinger Bloomsburg** in case of an emergency. **(Circle your preference)**

_____ Administer medication prescription and non-prescription medication. (Must have a current written instructions from a Physician for each medication.)

_____ Administer minor First Aid (ice packs, wash scrapes/cuts, apply band aid)

_____ Photos and video taping for classroom use

_____ Photos and video taping for publicity (social media and Website)

_____ Watch G/PG rated movies/tv shows

_____ Application of: _____ sunscreen (SPF 15 or higher _____ insect repellent (W/ Deet)

_____ Transportation by the facility for field trips. Are there any instructions for special care while the child is being transported by the facility (motion sickness, seizures, ect.)?

_____

_____ Field trips away from the facility, including neighborhood walks

_____ Swimming at the pool (Kiddie Camp will use the Baby Pool)

Please **initial** swimming level: _____ Beginner _____ Intermediate _____ Advanced

Please **initial** what area of the pool your child may use:

_____ Low end only _____ Middle Pool(No Diving) _____ Entire Pool(with Diving)

Parent's Signature_____ **Date**_____

FOR YOUTH DEVELOPMENT®
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The Bloomsburg Area YMCA
Serving Columbia & Montour Counties

The Bloomsburg Area YMCA
30 East 7th St. Bloomsburg, PA 17815

Y-Care Enrollment Form

Child's Name:_____ Birthdate:_____

School Currently Attending:_____ Current Grade:_____

Parent/Guardian:_____ Phone:_____

Home Address:_____
Street City Zip

Email Address:_____

Employer:_____ Work Phone:_____

Address:_____
Street City Zip

Parent/Guardian:_____ Phone:_____

Home Address:_____
Street City

Email Address:_____

Employer:_____ Work Phone:_____

Address:_____
Street City

Emergency Contacts

Name:_____ Phone:_____

Address:_____
Street City

Name:_____ Phone:_____

Address:_____
Street City

Approved Pick-ups

Name:_____ Phone:_____

Address:_____
Street City

Name:_____ Phone:_____

Address:_____
Street City

Name:_____ Phone:_____

Address:_____
Street City

Child's Doctor:_____ Phone:_____

Doctor's Address:_____
Street City

Insurance Carrier:_____

Policy Number:_____

Chronic Conditions/Allergies:_____

_____

Medical Restrictions/Special Needs:_____

_____
Does your child have an IEP (Individualized Education Plan)

◯ Yes ◯ No

Care is needed: ◯ Monday ◯ Tuesday ◯ Wednesday ◯ Thursday ◯ Friday

Hours Care is needed:_____ to _____

Week care is needed (Mark with an **X)**:

	June 9th-13th		July 14th-18th
	June 16th-20th		July 21st-25th
	June 23rd-27th		July 28th-August 1st
	June 30th-July 4th		August 4th-8th
	July 7th-11th		August 11th-15th

Start Date:_____

Child's Special Interests:_____

_____

_____

Please provide any additional information about you child:_____

_____

_____

Schedule/Payment

Registration Fee: $25.00

◯ Member	◯ Non-Member
Early Bird (March 1st-April 12): $175	Early Bird (March 1st-April 12): $195
After Early Bird: $200	After Early Bird: $225

◯ Private Pay $_____ per week ◯ ELRC Co-Pay $_____ per week

Method of Payment ◯ Credit Card ◯ Bank Draft

Payment Schedule:

- Payments will be processed on Friday each week.

Payment Methods:

- Accepted payment methods are credit card or Bank account set up on autopay through Brightwheel.

Refund Policy:

- No refunds will be issued for absences or holidays.

Additional Fees:

- Registration Fee: $25.00 (non-refundable)
- Late Pick-up Fee:$5.00 per every 5 minutes late

Acknowledgement:

By signing below, I acknowledge that I have read, understand and agree to the terms and conditions outlined in this agreement and the parent handbook that I received.

Parent/Guardian Signature:

_____ Date:_____

Childcare Provider Signature:

_____ Date:_____

The Bloomsburg Area YMCA
30 E. 7th St.
Bloomsburg, Pa. 17815
570-784-0188

Child and Adult Care Food Program
Child Enrollment Form

Sponsor/Center Name: Bloomsburg Area YMCA
Agreement #: 311-49-138-7

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE: This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas, including signing and dating the yellow highlighted area:

FULL NAME OF FIRST CHILD (Include Birthdate/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME	☐ MONDAY									
LAST NAME	☐ TUESDAY	☐ Yes ☐ No I work multiple shifts and my child(ren) may be in care different days/hours.								☐ BREAKFAST
	☐ WEDNESDAY	Other:								☐ A.M. SNACK
BIRTHDATE	☐ THURSDAY									☐ LUNCH
	☐ FRIDAY									☐ P.M. SNACK
AGE	☐ SATURDAY	**Enrollment Date:**			**Withdrawal Date:**					☐ DINNER
	☐ SUNDAY									☐ EVENING SNACK
FULL NAME OF SECOND CHILD (Include Birthdate/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		☐ *Same Times as Above*								
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME	☐ *Same as Above*									☐ *Same Meals as Above*
	☐ MONDAY									
LAST NAME	☐ TUESDAY	☐ Yes ☐ No I work multiple shifts and my child(ren) may be in care different days/hours								☐ BREAKFAST
	☐ WEDNESDAY	Other:								☐ A.M. SNACK
BIRTHDATE	☐ THURSDAY									☐ LUNCH
	☐ FRIDAY									☐ P.M. SNACK
AGE	☐ SATURDAY	**Enrollment Date:**			**Withdrawal Date:**					☐ DINNER
	☐ SUNDAY									☐ EVENING SNACK
FULL NAME OF THIRD CHILD (Include Birthdate/Age)	**DAYS OF WEEK IN ATTENDANCE**	**TIMES CHILD NORMALLY ATTENDS DURING WEEK**								**MEALS RECEIVED**
		☐ *Same Times as Above*								
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME	☐ *Same as Above*									☐ *Same Meals as Above*
	☐ MONDAY									
LAST NAME	☐ TUESDAY	☐ Yes ☐ No I work multiple shifts and my child(ren) may be in care different days/hours.								☐ BREAKFAST
	☐ WEDNESDAY	Other:								☐ A.M. SNACK
BIRTHDATE	☐ THURSDAY									☐ LUNCH
	☐ FRIDAY									☐ P.M. SNACK
AGE	☐ SATURDAY	**Enrollment Date:**			**Withdrawal Date:**					☐ DINNER
	☐ SUNDAY									☐ EVENING SNACK

Signature: _____ _____ _____
Signature of Parent or Guardian *Date* *Best Contact (Phone) No.*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____
Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

****

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Ave SW
   Washington, DC 20250-9410
2. fax: (833) 256-1665 or (202) 690-7442
3. email: program.intake@usda.gov

This institution is an equal opportunity provider.

CACFP Meal Benefit Income Eligibility (Child Care)

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL children in day care (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Start
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 **IF YES >** Write case number here and proceed to STEP 4 (do not complete STEP 3) **CASE NUMBER:**

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The **"Sources of Income for Children"** chart will help you with the Child Income section.

The **"Sources of Income for Adults"** chart will help you with All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Children listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Household Members (Including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Household Members (First and last)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X X X

Check if no SSN ☐

STEP 4 Contact information and adult signature. This form is not valid without signature and date of adult household member

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member regularly gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults

Earnings from Work

- Salary, wages, cash bonuses
- Net income from self-employment (farm or business)

If you are in the U.S. Military:

- Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances)
- Allowances for off-base housing, food, and clothing

Public Assistance/Alimony/ Child Support

- Unemployment benefits
- Workers compensation
- Supplemental Security Income (SSI)
- Cash assistance from State or local government
- Alimony payments
- Child support payments
- Veterans benefits
- Strike benefits

Pensions/Retirement/ All other sources of income

- Social Security (including railroad retirement and black lung benefits)
- Private Pensions or disability benefits
- Income from trusts or estates
- Annuities
- Investment income
- Earned interest
- Rental income
- Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

***Only use this address if you are filing a complaint of discrimination.**

For Official CACFP Sponsor Use Only NOT VALID WITHOUT DETERMINING OFFICIAL'S SIGNATURE AND DATE

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

Total Income

How often? Weekly ○ Bi-Weekly ○ Monthly ○ 2x Month ○

Household size

Categorial Eligibility ☐

Eligibility: Free ○ Reduced ○ Denied ○

Determining Official's Signature

Date

Confirming Official's Signature (second check)

Date

Follow-up Official's Signature (For Pricing Institutions - Verification Official)

Date

Effective Date: If the Institution is using the parent/guardian signature date as the effective date, the form must have been signed by the Institution representative within the same month the parent signed the form or the immediately following month.

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.