FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CIVIL RIGHTS COMPLIANCE
PARENT AWARENESS

In accordance with applicable Federal and State Civil Rights laws and regulatory requirements, you as a resident of this agency, have the right:

> to be provided services at this agency and to be referred for services of other agencies without regard to your race, color, religious creed, disability, ancestry, national origin, age or sex.
>
> to file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, disability, ancestry, national origin, age or sex.

Complaints of discrimination may be filed with any of the following:

Executive Director
Boyertown Area YMCA
All State Licensed
Child Care Programs
301 West Spring Street
Boyertown, PA 19512

Department of Public Welfare
Bureau of Equal Opportunity
Room 223, Health and Welfare Bldg.
PO Box 2675
Harrisburg, PA 17105-2675
Tel. 717-787-9695
Fax 717-772-4366

U.S. Department of Health
And Human Services
Office for Civil Rights- Suite 372
Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-9111
Tel. 215-861-4441
1-800-368-1019

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

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

Rev2/10

____
Parent/Guardian Signature Date

____
Staff Signature Date

Boyertown Area YMCA
301 West Spring Street, Boyertown, PA 19512-1027
P 610 369 9622 F 610 369 1012 www.boyertownymca.org

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Emergency Operations Plan
CHILD PICK-UP AUTHORIZATION
Camp Program______________

I, ______________________________, authorize the Boyertown Area YMCA Child Care Programs to release my child(ren) to the person(s) designated. This is in agreement with the Boyertown Area YMCA Emergency Operations Plan.

Student's Name	Designated Custodian(s) Name & Relationship
__________________	____________________________________
__________________	____________________________________
__________________	____________________________________
__________________	____________________________________

____
Your signature Relationship Date

____
Print Name

____
Address

____
Address

____
Home Phone Work Phone Cell Phone

____
Email address while child is in care

NOTE: Parents and guardians should designate themselves as designated custodians. Friends, neighbors, and other relatives may also be designated.

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RELEASE FORM

I, the undersigned, authorize the Boyertown Area YMCA to utilize videotape or photograph materials of my child, _______________________, for the purpose of promotional materials for the Boyertown Area YMCA programs and services.

Signature ____

(If under 18-signature of parent or guardian)

Date ______________________

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PARENT STATEMENT OF UNDERSTANDING

The following information is important for the safety and protection of your child. Please read the information, sign this form and return it to the appropriate Program Director.

I understand that the YCMA discourages staff and volunteers from babysitting, fraternizing, dating, and transporting children at any time outside the YMCA programs. Violation of this may cause disciplinary action or possible termination of the staff or volunteer involved.

I understand that I am not to leave my child at the YMCA or program site unless a YMCA staff or volunteer is there to receive and supervise my child.

I understand that my child will not be allowed to leave the program with an unauthorized person. Any person authorized to pick up my child must either be on file with the YMCA or other arrangements must be made by calling he appropriate YMCA staff to inform the of a change.

I understand that should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police. Please do not put staff in a position where they have to make this judgment call.

I understand that state law mandates the YMCA, to report any suspected cases of child abuse or neglected to the appropriate authorities for investigation.

I have received a copy of the YMCA childcare/camp Handbook/Parent Policies and Procedures.

__________________________________ ____________________

__________________________________ ____________________

Parent/Guardian Signature Date

I have read and understand the statements above and the YMCA Parent Policies and Procedures.

__________________________________ ____________________

__________________________________ ____________________

Parent/Guardian Signature Date

Copy of Statement Filed with Child's Records.

FOR YOUTH DEVELOPMENT
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Dear Parents,

As part of The Boyertown Area YMCA's continuing effort to "Go Green," effective immediately, the Child Care Accounting Department will no longer be issuing tuition receipts on a weekly basis. If you need to receive tuition receipts for a childcare reimbursement plan, please complete the bottom portion of this form and place it in the childcare payment box.

We will continue to provide a year end statement for tax purposes if requested.
Thank you for your cooperation and please feel free to contact any of us with questions.

Sincerely,

Karrie Showalter
Child Care Director
610-369-9622

Alicia Dinnell
Assistant Sports Director
610-754-7010

Tracy Pyne
Assistant Camp Director
610-369-9622

Danielle DeForge
Gilbertsville Center Childcare Director
610-367-9622

Amy Templin
William S. Hollenbach Center Childcare Director
610-754-7010

REQUEST FOR CHILDCARE TUITION RECEIPTS

Name of Child: ____

Center/Site: ____

Parent's Name: ____

Email Address ____

Phone number where you can be reached: _____________________

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:

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

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:

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 ____________

AGREEMENT

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

NAME OF CHILD

Days enrolled: M T W TH F

FEE AMOUNT	PER-DAY-WEEK	DAY PAYMENT TO BE MADE
$		Friday before care

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

A Child Services Report will be provided to the parent every 6 months to discuss the child's growth and development. A non-refundable and non-transferable deposit is required for the first week's tuition. Part-time campers are not permitted to change enrolled days; however, you may add an additional day occasionally based on availability for an additional day fee.

GRFA % Subsidy Co pay Additional Child Rate

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $ 10.00	PER MIN-HR Every 15 min. past 6:05 pm	

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