FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

VALLEY SHORE YMCA

2018-2019 SCHOOL AGE PROGRAM REGISTRATION FORM

CHILD'S FIRST NAME _____LAST NAME_____ Gender_____

MAILING ADDRESS _____

TOWN_____ZIP_____

DATE OF BIRTH _____ AGE _____ GRADE (entering) _____

Child resides with _____ START DATE _____

MONTHLY FEES **DROP IN ONLY ___BEFORE SCHOOL ___AFTER SCHOOL**

Please register my child: ___Mon ___Tue ___Wed ___Thur ___ Fri at _____
School Name

AM SESSION: Joel, Daisy, Essex and Goodwin Schools only
□5 days $168.00 □4 days $135.00 □3 days $101.00 □2 days $67.00 □1 day $34.00

PM CARE: Chester, Daisy, Deep River, Essex, Goodwin, Joel, Old Saybrook Middle School
□ 5 days $262.00 □ 4 days $210.00 □ 3 days $157.00 □ 2 days $105.00 □ 1 day $52.00

PM CARE: Abraham Pierson School
□ 5 days $281.00 □ 4 days $225.00 □ 3 days $168.00 □ 2 days $112.00 □ 1 day $56.00

In case of emergency, which parent/guardian listed below should we contact first:_____

PARENT/GUARDIAN #1 _____
Relationship to Child _____
Home Address _____
City/State/Zip _____
Place of Employment_____
Work Address_____

Info will be sent via email

Email Address_____ _
Home Phone #_____
Cell Phone#_____
Work phone #_____

PARENT/GUARDIAN #2 _____
Relationship to Child_____
Home Address _____
City/State/Zip_____
Place of Employment_____
Work Address_____

Email Address_____
Home Phone #_____
Cell Phone #_____
Work phone #_____

Enclosed is the $25 Registration Fee**,** which is **NON-REFUNDABLE. No Membership is needed**

I understand the financial requirements, payment obligations and deadlines as outlined in the school aged child care handbook.

Parent/Guardian Signature _____ **Date** _____

Pick-Up Form and Emergency Information

Child's Name_____

PLEASE NOTE THE STATE OF CONNECTICUT REQUIRES THAT YOU LIST AT LEAST ONE EMERGENCY CONTACT IN ADDITION TO PARENT/GUARDIAN.

In order to ensure the well-being of all our participants and our ability to help you with picking up your child, please include every person that could assume the custody of your child for any unforeseen circumstances. The YMCA will require photo I.D. to release any child to an authorized pick up person listed on this form. Only these names listed below will be allowed to pick up your child. I authorize the YMCA to release my child to the custody of the following people other than me:

Name:_____Relationship:_____ Phone:_____

Name:_____Relationship_____Phone:_____

Name:_____Relationship_____Phone:_____

Name:_____Relationship_____Phone:_____

Please use additional Pick Up Form if more names are needed.

The YMCA is required to permit either parent to pick up the child unless the YMCA is furnished with a court order to the contrary. Please list below any persons not authorized to pick-up this child and attach the original copy of the court order

NAME_____ RELATIONSHIP_____

Authorization For Medical Attention:

I give permission for the YMCA Certified First-Aid staff to treat my child, if needed. I authorize the child care staff to consent to emergency treatment (under advice of a Connecticut licensed physician) for my child when the need for such treatment is immediate and when efforts to contact me are unsuccessful. My child will be transported to the nearest emergency facility. I understand that any expenses incurred, through transportation and the treatment of my child, are my responsibility.

Name of Physician _____ Address/Phone_____

Insurance Company_____ Policy Number_____

Policy Holder _____Relationship to Child_____

List all medications and medical conditions affecting your child. Must complete medication administration form, individual care plan and supply site with appropriate medication prior to starting the program).
Health form must be attached to complete registration.

Please Print Parent/Guardian Name_____

Parent/Guardian's Signature_____Date_____

Payment Authorization Form

Child's First Name:_____ Last:_____

The School Age Child Care Program is a tuition based program. The yearly cost per child for the program is based on the calendar days in the school year and divided into 10 equal monthly payments. Monthly payments remain the same regardless of weather related closings, absenteeism, and holidays. All families are required to use auto-bill payment for program tuition. Automatic payments will be drafted on the 1st of each month prior to services rendered. A $25 Late Payment fee will be assessed if credit card or EFT returns are not cleared within 10 days of original transaction. Failure to pay this fee will result in your child's dismissal from the program.

MONTHLY FEES: **DROP IN ONLY ___BEFORE SCHOOL ___AFTER SCHOOL**

Please register my child

BEFORE SCHOOL: Daisy, Essex, Goodwin and Joel Schools only

☐5 days $168.00 ☐4 days $135.00 ☐3 days $101.00 ☐2 days $67.00 ☐1 day $34.00

AFTER SCHOOL ELEMENTARY: Chester, Daisy, Deep River, Essex, Goodwin, OSMS, Joel School

☐ 5 days $262.00 ☐ 4 days $210.00 ☐ 3 days $157.00 ☐ 2 days $105.00 ☐ 1 day $52.00

After School: Abraham Pierson School

☐ 5 days $281.00 ☐ 4 days $225.00 ☐ 3 days $168.00 ☐ 2 days $112.00 ☐ 1 day $56.00

I, _____Hereby authorize the Valley Shore YMCA to charge the account listed below on the 1st of each month as payment for child care services being rendered.

I authorized my bank to honor pre-authorized Electronic Funds Transfers or credit card charges against my account for child care payments indicated below. When the bank honors the EFT or credit card by charging my account, such transfer shall constitute notice of payment due and my receipt for the payment. Should any preauthorized EFT or credit card not be honored by said bank when receive by them, then it is understood that the payment is to be made by me in the amount of said payment**.** It is further understood that if such payment is not honored by the bank or credit card institution, then the YMCA, at its discretion, may resubmit the amount due for payment on a future date. . A $25 Late Payment fee will be assessed if credit card or EFT returns are not cleared within 10 days of original transaction. Failure to pay this fee will result in your child's dismissal from the program.

❑ I choose to utilize the EFT option for payment (direct debit from my ❑Checking **OR** ❑ Savings Acct.)

Bank Name: _____ Name on Account: _____

Routing/Transit Number: _____ Account Number: _____

❑ I choose to utilize the Credit Card option for payment (direct charge to credit card)

Credit Card: ❑Visa ❑ Master ❑ Discover ❑ Amex Card Holders Name:_____

Number: _____ Expiration date: _____

Authorized Signature:_____ Date:_____

VALLEY SHORE YMCA
School Age Child Care Behavior Contract

CHARACTER CODE FOR CHILDREN AND PARENTS

I will show respect by treating other children and adults the way I would want to be treated.
I will be honest, will always tell the truth, and will be a friend that others can trust.
I will demonstrate caring by helping others and treating them kindly.
I will take responsibility for my own behavior and accept the consequences for my actions.

CHILDREN'S RIGHTS

Have a safe, calm, clean and orderly environment.
Make mistakes without being ridiculed by others.
Seek help from adults who are there to help.
Be treated with dignity and respect by everyone.

CHILDREN AND PARENTS RESPONSIBILITY

Expectations:

Avoid fights or verbal abuse of other children.
Be fair and accepting of others eager to join any activity.
Work and play safely.
Use appropriate, acceptable language.
Be kind, considerate, helpful, and respectful toward others.
Share equipment and materials fairly and use them properly.
Respect property, especially things that do not belong to me.
Cooperate with others and with adults who are here to help.
Speak out when witnessing unfairness or offensive language or behavior of other.
Be a good sport whether you win or lose.
Be truthful with everyone.

CONSEQUENCES

- Letter of discipline for talking back, destroying property, bullying children, disrupting the program, refusing to obey. Parent will be required to sign these reports acknowledging that they have read the report. After three reports child and parent may be required to meet with the Program Director.
- Letter of Discipline and immediately suspended for a minimum of one day for hitting, kicking, biting, spitting, scratching, swearing, making degrading or racial remarks, or leaving the group. Parents may be required to meet with the Program Director before the child can return to the program.
- SACC services may also be terminated if the parent is physically or verbally abusive to a staff member. It is our desire that every child enjoys his/her experience in the program.
- I understand the Student Behavior Contract.
- I will be honest about my actions and feelings. When I am frustrated or believe that I am being mistreated, I will talk with my head teacher and I will not act out in an inappropriate way.
- I will act in a caring and respectful manner to others. I will not talk back, use obscene or threatening language, or speak in an unkind manner about others. I will follow directions and listen attentively while participating in activities.
- I will take responsibility for my own behavior, not blaming others for the choices I make. If I destroy something as a result of my inappropriate behavior or actions I will replace it.
- I understand that my participation in the School-Age Child Care program may be limited or discontinued if I do not follow this contract.

VALLEY SHORE YMCA

Parent Statement of Understanding

- The following information is important for the safety of your child. Please read the information and sign below. Please keep and refer to your copy of the YMCA Child Care Parent Handbook which outlines our program policies and procedures. Your signature indicates that you have received, read, and understand the Parent Handbook.
- I understand that the YMCA staff and volunteers are not allowed to baby-sit or transport children at any time outside of the YMCA program. Immediate disciplinary action will be taken by the YMCA towards staff and volunteers if a violation is discovered.
- I understand that I am not to leave my child at the 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. A court order is required to restrict a legal parent/guardian from pick-up. Any person authorized to pick up my child must either be listed with the YMCA or other arrangements must be made by calling the YMCA Child Care office (Ext. 118) to inform them of a change.
- Do not release my child to any of the following individuals_____, if any of these individuals are biological parents, a court order is required to not release.
- 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 the position where they have to make this judgment call.
- I understand that the YMCA is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities of investigation.

Behavior Modification Techniques:

Here at the YMCA, we believe in the concept of "Positive Discipline". Through generous praise, encouragement and positive reinforcement, the motivation for most misbehavior can be eliminated. However, some discipline situations may arise. The teachers will discuss the situation with the child and any other children involved. If this does not work, the teachers will try to redirect the negative behavior. If the behavior persists, the teachers will then allow the child some time away from the activity.

The following techniques are used to help modify children behaviors:

- Changing the setting
- Giving choices
- Encouragement
- Reinforcing positive behavior
- Giving reasons
- Setting limits
- Giving consequences
- Warnings

If redirection of the child and the time out is ineffective and serious behavioral problems continue to disrupt the program, the parent will be called to pick-up their child early. The YMCA also reserves the right to remove or suspend a child without tuition reimbursement if the parents, Director of School Age Program, Head Teacher cannot mutually get the child to behave in an appropriate manner.

I affirm that I have been presented with, understand and agree to comply with the Behavioral Modification Techniques outlined above and in the Parent Handbook. I have discussed this policy with my child and the policy is understood by family as a whole.

Parent/Guardian Signature_____Date_____

Child's Name_____

The Valley-Shore YMCA

School Aged Child Care Authorizations and Acknowledgements

Child's First Name_____ Last Name _____

I understand there are risks associated with activities and programs in which my child is a participant. I hold the YMCA, its employees, representatives, agents, and assigns from any and all claims whatsoever against said parties resulting from or caused by my child's participation.
_____Initials
I acknowledge that I have received a copy of the YMCA Parent Handbook which covers the following information, general policies, accounting policies, days program is closed and complaint procedure. I understand that if I have any questions in regards to the content of this handbook it is my responsibility to notify the YMCA at the earliest convenience.
_____Initials
I hereby give permission for my child to participate in all activities that are part of the program.
_____Initials
I understand that neither the YMCA nor any of its paid or volunteer workers can be held responsible in the events of an accident. I understand that all precautions will be taken to ensure the safety and health of my child.
_____Initials
I also grant permission for photographs taken of my child while at school aged child care to be used for publicity and promotional purposes.
_____Initials
I acknowledge that the school district is not responsible for incidents/accidents that occur during before or after school hours.
_____Initials
I understand that if I am receiving Care 4 Kids, my contract for child care and all associated fees is on file with the YMCA. If for any reason Care 4 Kids fails to pay, I, as a client of the YMCA, will be held responsible for the full child care tuition. By initialing, I agree with these terms.
_____Initials
I understand that the Valley Shore YMCA, site location are not responsible for personal property lost, damaged, or stolen while members and/or participants are using the facilities, on the premises, or involved in programs.
_____Initials
I understand that my monthly payment is due on the 1st of the month for the upcoming month and that a $25 late fee will be charged if my payment is not received on time. Furthermore, I understand that if payment is not received by the 15th of the month, my child will not be allowed to attend the program until my balance is paid in full.
_____Initials
I acknowledge that I have read and understand the Discipline Policy in the Parent Handbook.
By initialing, I agree with these terms.
_____Initials
I have read and understand the YMCA Behavior Modification Policy and Procedure. (Policy has been discussed)
By initialing, I agree with these terms.
_____Initials

We believe that *every* child in our care is a unique individual with special needs. Help us to provide the best care for your child by providing us as much information as possible.

Does your child receive special accommodation during the school day (social, behavioral, medicine)?
No____ Yes_____

Please explain if there are certain situations that may cause your child difficulty.

How can we best work with your child in these situations?

_____ _____
Parent/Guardian Signature **Date**

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
	❑ Hispanic/Latino	❑ Asian/Pacific Islander
		❑ Other
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 4/2012

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required for 7th grade entry	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

* **Verification of disease:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nation-wide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number