

Child Name: _____



BEFORE AND AFTER SCHOOL ENRICHMENT ENROLLMENT PACKET

Welcome to Before and After School Enrichment!

We are so excited to have you as part of our YMCA family. Our staff is planning some amazing and extraordinary school-year activities for your child to experience, while also providing homework help!

This completed BASE Enrollment Packet must be submitted in its entirety to attend BASE. Without this completed step, we are not allowed to accept your child into care. Please complete this packet within 14 days of registration, with the exception of the health report which may be received at a later date, to ensure your enrollment is finalized.

Once completed, paperwork should be sent to the Youth Development Business Office via email to **base@ymcapgh.org**, fax to **412 774 2537**, or mail to:

**YMCA of Greater Pittsburgh
Youth Development Business Office
7140 Bennett St.
Pittsburgh, PA 15208.**

For the security of your child's personal information, we request that you do not drop paperwork off at your branches.

The enrollment packet may be typed but signature boxes do require physical signatures. Due to state regulations, electronic signatures cannot be accepted. All lines on the Emergency Contact/Parent Consent form must be completed or the packet will be returned for corrections. If a particular line does not apply, please ensure it is marked N/A. "Same as above" or "Same" cannot be used on the forms. All information, including duplicate information, must be filled in per state regulations.

Our Business Managers are available Monday through Friday, from 7:00 AM to 4:30 PM to assist you with any questions. Please call us at 412 573 4166 for assistance.

We look forward to sharing the school year with you and your child!

Access this form electronically!
Visit **pittsburghymca.org**

For a better us.

EMERGENCY CONTACT FORM

Every field in this form is mandatory.
If a field does not apply to your child, you must mark (NA).

Child Name: _____

School Attending: _____

Site Attending: _____

CHILD'S NAME		BIRTHDATE	GENDER	ETHNICITY	GRADE IN FALL
STREET ADDRESS		CITY		STATE	ZIP
PARENTAL/LEGAL GUARDIAN-PRIMARY		BIRTHDATE	GENDER	ETHNICITY	
STREET ADDRESS		CITY		STATE	ZIP
CELL PHONE	HOME PHONE	EMAIL ADDRESS			
EMPLOYER			WORK PHONE		
EMPLOYER'S STREET ADDRESS		CITY		STATE	ZIP
PARENTAL/LEGAL GUARDIAN-SECONDARY		BIRTHDATE	GENDER	ETHNICITY	
STREET ADDRESS		CITY		STATE	ZIP
CELL PHONE	HOME PHONE	EMAIL ADDRESS			
EMPLOYER			WORK PHONE		
EMPLOYER'S STREET ADDRESS		CITY		STATE	ZIP
EMERGENCY CONTACT PERSON 1		TELEPHONE NUMBER WHEN CHILD IS IN CARE			
EMERGENCY CONTACT PERSON 2		TELEPHONE NUMBER WHEN CHILD IS IN CARE			
EMERGENCY CONTACT PERSON 3		TELEPHONE NUMBER WHEN CHILD IS IN CARE			
PERSON(S) WHOM CHILD MAY BE RELEASED (OTHER THAN PARENT OR GUARDIAN ABOVE)			TELEPHONE NUMBER WHEN CHILD IS IN CARE		
STREET ADDRESS		CITY		STATE	ZIP
PERSON(S) WHOM CHILD MAY BE RELEASED (OTHER THAN PARENT OR GUARDIAN ABOVE)			TELEPHONE NUMBER WHEN CHILD IS IN CARE		
STREET ADDRESS		CITY		STATE	ZIP
PERSON(S) WHOM CHILD MAY BE RELEASED (OTHER THAN PARENT OR GUARDIAN ABOVE)			TELEPHONE NUMBER WHEN CHILD IS IN CARE		
STREET ADDRESS		CITY		STATE	ZIP
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER			PHONE		
STREET ADDRESS		CITY		STATE	ZIP
SPECIAL DISABILITIES, IF ANY		ALLERGIES INCLUDING MEDICAL REACTION		MEDICAL OR DIETARY INFORMATION	
NECESSARY IN AN EMERGENCY SITUATION		MEDICAL, SPECIAL CONDITION MEDICATIONS ADMINISTERED DURING CARE			
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD REQUIRED MEDICATION LOG					
HEALTH INSURANCE OR MEDICAL ASSISTANCE BENEFITS (CHILD)		POLICY NUMBER (REQUIRED)			
PARENT SIGNATURE IS REQUIRED FOR EACH OF THE (6) ITEMS BELOW TO INDICATE PARENTAL CONSENT.					
1. OBTAINING EMERGENCY MEDICAL CARE (SIGNATURE REQUIRED)			4. ADMIN OF MINOR FIRST - AID PROCEDURES (SIGNATURE REQUIRED)		
2. WALKS AND TRIPS (SIGNATURE REQUIRED)			5. SWIMMING (SIGNATURE REQUIRED)		
3. TRANSPORTATION BY THE FACILITY (SIGNATURE REQUIRED)			6. WADING (SIGNATURE REQUIRED)		

SIGNATURE OF PARENT OR GUARDIAN

DATE

6 MONTH REVIEW - SIGNATURE OF PARENT OR GUARDIAN

DATE



Child Name: _____

School Attending: _____

Site Attending: _____

2020 BEFORE AND AFTER SCHOOL ENRICHMENT AGREEMENT

Child's Arrival Time: _____ a.m.

Departure Time: _____ p.m.

BASE PAYMENT SCHEDULE 2020

Check days child will attend:	Please enter in the monthly dollar amount.	Important Payment Information
Before School Care: 4 - 5 Days OM OT OW OTH OF 1 - 3 Days OM OT OW OTH OF Kindergarten Wrap: 4 - 5 Days OM OT OW OTH OF	\$ _____ \$ _____ \$ _____	YMCA membership is required for all children. Credit/debit card or bank draft information to be used for automatic payment is required. Fees will be automatically drafted on due dates. A \$10 return fee will be applied to all returned payments. Payments received more than 5 days late will be subject to a \$25 late payment fee. Late Pick Up Fee per child is \$15 for 1-15 minutes, \$30 for 16-30 minutes and so on. Fees are charged for each child picked up after the close of the program day. Open and close times vary by location. <input type="radio"/> CYF <input type="radio"/> ELRC <input type="radio"/> YMCA Financial Assistance ELRC Co-Pay \$ _____ Caseworker _____ Additional fees (based on location) may be required based on activities. Services provided as part of Before & After School Enrichment tuition include case, snack and/or dinner (dependent upon program registered), homework support, and activities. Extra Services are provided at an additional fee if applicable: Field trips, which would require an additional fee, may be offered throughout the school Year. Advance notice is provided and parents/students may opt-out of attending.
After School Care: 4 - 5 Days OM OT OW OTH OF 1 - 3 Days OM OT OW OTH OF	\$ _____ \$ _____	
Annual one-time fees: Registration	\$ _____	

YMCA Financial Assistance is based on total household income. Families unable to qualify for tuition subsidy through the typical third party systems may apply for YMCA Financial Assistance by first applying for ELRC. Once the family has received a ELRC denial or waitlist letter, the letter, along with the household's most recent tax return, may be submitted for YMCA Financial Assistance consideration.

Person(s), other than the parents/guardians, to whom the child may be released to:

- 1.
- 2.
- 3.

PARENT ACKNOWLEDGEMENT

I, the Parent/Guardian have read and provided any and all information requested about my child.

- I agree to update emergency contact/parent consent information whenever changes occur and every 6 months (3270.124; 3280.124; 3290.124).
- I received complete, written program information at the time of enrollment (3270.121; 3280.121; 3290.121).
- I understand that membership fees are non-refundable and non-transferrable.
- I understand that cancellations must be received in writing 2 weeks prior to a scheduled change to avoid payment.

SIGNATURE OF STAFF

DATE OF ADMISSION

DATE OF WITHDRAW

SIGNATURE OF PARENT OR GUARDIAN

DATE

6 MONTH REVIEW - SIGNATURE OF PARENT OR GUARDIAN

DATE

CHILD HEALTH REPORT

Child Name: _____

CHILD NAME		PARENT GUARDIAN	
DATE OF BIRTH	HOME PHONE	ADDRESS	
FACILITY NAME			
FACILITY PHONE	COUNTY	WORK PHONE	
<input type="radio"/> I authorize the camper care staff and my child's health professional to communicate directly if needed to clarify information on this form about my camper.			
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

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) <input type="radio"/> YES <input type="radio"/> 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.						
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">VISION (Subjective until age 3)</td> <td></td> </tr> <tr> <td>HEARING (Subjective until age 4)</td> <td></td> </tr> <tr> <td>LEAD</td> <td></td> </tr> </table>	VISION (Subjective until age 3)		HEARING (Subjective until age 4)		LEAD	
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
	LICENSE NUMBER
	DATE FOR SIGNED
	PHONE



Child Name: _____

YMCA of Greater Pittsburgh Authorization Agreement for Automatic Payment

The YMCA of Greater Pittsburgh requires all child care and day camp tuition to be paid via bank draft, credit card draft, or debit card. Payments for standard tuition plans are deducted on the 1st and 15th of each month. ELRC copays are deducted on the 1st day of care each week.

Parent's Name _____	Child's Name _____
Billing Address _____	
City _____	State _____ Zip _____

Please enroll me in automatic payment via bank draft from my financial institution.

Financial institution name _____
Name as it appears on account _____
Financial institution routing number _____
Financial institution account number _____

PLEASE ATTACH VOIDED CHECK

Please enroll me in automatic payment via credit/debit card.

Visa Mastercard Discover

Name as it appears on card _____
Account number _____
Expiration date (mm/yy) _____ 3-Digit security code _____

I understand I am responsible for ensuring that the account designated above has sufficient funds on my automatic payment date to allow for the automatic deduction of my payment. Should any draft/charge not be honored by my bank for any reason, I realize that I am still responsible for that payment plus a returned payment fee of \$10.00 per transaction. This is in addition to any fee my bank may charge. I am also responsible for notifying the YMCA of any changes made to my drafting information, including credit card expirations, checking account charges, card number changes, etc.

I understand that they YMCA reserves the right to increase tuition as necessary and will notify me in writing at least 30 days prior to an increase at the address I have given, unless such increase is due to change in ELRC or other third party funding out of the YMCA's control.

I understand that it is my responsibility to bring any billing discrepancies to the YMCA's attention within 60 days after they first appear on my financial statements. After 60 days, I waive my right to dispute such discrepancies.

SIGNATURE OF PARENT OR GUARDIAN

DATE