



ATTLEBORO NORTON YMCA · AFTER SCHOOL PROGRAM Registration Form

Student Name: _____ Gender: ___ Male ___ Female
 Street: _____
 City / Town: _____ State: _____ Zip: _____
 Home Phone: _____ Birth Date: _____ Age: _____
 School: _____ Grade: _____

Which days will your child attend the after school program each week?

- MON TUE WED THU FRI

PARENT & EMERGENCY CONTACT INFORMATION (All of the information below is required for Authorized Pickup verification.)

Parent 1 Name _____ Date of Birth _____ Authorized to Pick Up? ___ Yes ___ No
 Address _____ City _____ State _____ Zip _____
 Email _____ Cell Phone _____
 Relationship to Child _____

Parent 2 Name _____ Date of Birth _____ Authorized to Pick Up? ___ Yes ___ No
 Address _____ City _____ State _____ Zip _____
 Email _____ Cell Phone _____
 Relationship to Child _____

Emergency Contact Name _____ Date of Birth _____ Authorized to Pick Up? ___ Yes ___ No
 Address _____ City _____ State _____ Zip _____
 Email _____ Cell Phone _____
 Relationship to Child _____

Additional Pick-Ups (optional) Name _____ Date of Birth _____
 Address _____ City _____ State _____ Zip _____
 Email _____ Cell Phone _____
 Relationship to Child _____

Additional Pick-Ups (optional) Name _____ Date of Birth _____
 Address _____ City _____ State _____ Zip _____
 Email _____ Cell Phone _____
 Relationship to Child _____

YOUR CHILD'S HEALTH HISTORY: (Check – giving approximate dates)

Frequent Ear Infections _____	Hay Fever _____	Chicken Pox _____
Heart Defect/Disease _____	Ivy Poisoning, etc. _____	Measles _____
Convulsion _____	Insect Sting Allergy _____	German Measles _____
Diabetes _____	Penicillin Allergy _____	Mumps _____
Bleeding/Clotting _____	Other drug Allergies _____	Asthma _____

Food Allergies – Please list allergies, child’s reactions, and any related prescriptions or treatments:

Operations or serious injuries (dates): _____

Chronic or recurring illness: _____

Other diseases or details of above: _____

Name of dentist/orthodontist: _____ Phone: _____

Name of physician: _____ Phone: _____

Insurance carrier: _____ Policy/Group #: _____

Any specific activities to be restricted? _____

Will your child require any medications while in the program?

(If yes, we will send you an Individual Health Care forms that must be returned prior to your child’s first day in the program.)

Yes No

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

(If yes, a copy is required by the state to be on file for the program. This information will be shared with the director and teacher only.)

Yes No

REGISTRATION FEE: \$50 per child

Please note that the registration fee is non-refundable.

How would you like to pay your registration fee?

Check included Charge my account below

Credit Card

Card Number: _____ Exp Date: _____

Bank Account

Routing Number: _____ Account Number: _____

Parent/Guardian Signature: _____ Date: _____

Transportation Plan and Authorization

AFTER CARE TRANSPORTATION PLAN

My child will ARRIVE at YMCA via

School Bus

Other _____

My child will DEPART YMCA

at an approximate time of _____ via

Parent Pick Up

Supervised Walk

Public/Private Van

Contract/Van

Private Transportation Arranged by Parent

Other _____

Parent/Guardian Signature: _____ Date: _____

AGREEMENTS & WAIVERS

Health Policies Agreement: I agree to all health policies as outlined in the Attleboro Norton YMCA's Child Develop Centers Family Handbook, including (but not limited) to the wearing of face coverings when required. I also agree to communicate any symptoms of or potential exposure to COVID-19. I understand that if I fail to comply with any of the Health Policies, my child's enrollment in the program may be terminated.

COVID-19 Risk Waiver: COVID-19 is an extremely contagious virus that spreads easily through person-to-person contact. While I understand that the Y will take all precautions to mitigate the spread, I also know that participating in this program could increase my child's and my family's risk of contracting COVID-19. I assume all risk and responsibilities arising from participation, and do myself, my heirs and personal representatives hereby hold harmless, indemnify, release and forever discharge the Attleboro Norton YMCA, its officers, agents, and employees from and against any and all claims, demands and actions or causes of action on account of physical injury or death which may occur.

First Aid & Medical Consent Waiver: I authorize staff at the Attleboro Norton YMCA who are certified in Basic First Aid and CPR to administer first aid and emergency care when appropriate and as needed. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the staff at the Attleboro Norton YMCA to transport my child to _____ hospital (or the nearest hospital) and to secure any necessary medical treatment for my child.

Parent/Guardian Signature: _____ Date: _____

FINANCIAL AGREEMENT

I understand that my child must be an Attleboro Norton YMCA member to be enrolled in the Before and/or After School Program.

_____ My child is a current member. _____ Please sign up my child for a youth membership.

After School Weekly Rates:

5 days per week: \$115
4 days per week: \$96
3 days per week: \$72
2 days per week: \$50
1 day per week: \$25

I would like to have my child's weekly fee drafted the Friday prior to each week they're enrolled in the following way:

___ Use my billing method on file

___ Credit Card Number: _____ Exp Date: _____

___ Bank Routing Number: _____ Account Number: _____

Weekly Payments Agreement: Payment is due every week. Payments for each week of program must be made in advance by the Friday before the start of that week. Payments will be scheduled to be paid automatically through EFT or Credit Card. Any other payment type must be approved by the Childcare Billing Office and be paid in advance. No discounts will be made for missed days, unexpected school closures, or holidays. **Any payments that are unable to process due to insufficient funds will incur a \$30 fee.** Missed payments may result in disenrollment from the program. Please contact us before your payment is due if you are facing challenges in making your payments on time. Families enrolled will receive two vacation week vouchers annually to use if they do not plan on attending school for a given week. Vouchers must be presented two full weeks before the desired cancellation.

Withdrawal Notice: A **two week written notice** is required for withdrawal from the program. The Director reserves the right to terminate a child's enrollment for reasons including, but not limited to, behavioral issues, non-payment, or inability of the child to adjust to the program.

Late Pick Up Fees: Parents/Guardians must pick up their children by the end of the program day at 6:00 pm. If you know you are going to be late please call and let us know so we may reassure your child that you are okay. A late fee of \$10 for the first ten minutes and \$5 for each five-minute interval afterward, per child will be assessed for anyone picking up their children after closing hours. Payments are due the following business day.

I have read the above financial policy and understand I am responsible for making payments on time. I understand that there are no discounts for missed days, unexpected school closures/snow days, or holidays. I understand that if payments are not made weekly before the week of service I am in jeopardy of losing my childcare services.

Parent/Guardian Signature: _____ Date: _____

Permission to Photograph and/or Videotape

I give permission for my child to be photographed and or videotaped during the hours he/she attends the program for non-profit purposes and for use in the YMCA's marketing materials.

Parent/Guardian Signature

Date

Swim

I give permission for my child to participate and recreational swim at the YMCA.

Parent/Guardian Signature

Date



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Child's Name: _____ DOB: _____

ATTLEBORO YMCA CHILD PROTECTION GUIDELINES

The Attleboro YMCA wants to ensure a safe, positive environment that promotes growth and well-being of all children. The purpose of this document is to outline our policies in regards to staff hiring, our expectations of parents, and measures we have implemented to prevent child abuse.

YMCA Employee Training & Policies

- All prospective employees and program volunteers are background checked through the EEC website and at least two references are checked.
- All staff and volunteers will participate in an orientation program that reviews our Child Protection Policies.
- Attleboro YMCA staff are mandated reporters. If they suspect a child has been abused, they will immediately notify their supervisor and complete a written report. This report will immediately be reviewed by their supervisor Director. A decision will then be made to report the incident to law authorities and the Department of Children & Family Services.
- In the event a reported child abuse incident involves an employee or volunteer, the Director will suspend the employee or volunteer. Reinstatement will occur only after all allegations have been cleared to the satisfaction of the Director and the investigating agency(ies).
- Staff will never be alone with a child in a place where they cannot be observed.
- **Staff are not allow to babysit for children they meet at the Y or through Y programs. They are not allowed to transport children in their personal vehicles.**

Parents' Rights & Responsibilities

- If a parent/guardian has any concerns about their child's safety or suspects any form of abuse, they should immediately notify the Director.
- Parents should understand that staff are mandated reporters and are required by law to report any suspected cases of child abuse.
- Parents should pick up their children on time and notify the Y if they are running late. If there is no communication from a parent and emergency contacts cannot be reached at the end of the program time, the Y will contact the local police and DCF after one hour.
- If a person arrives to pick up a child and appears to be under the influence of drugs or alcohol, the staff may contact the police.
- If there are any changes in custody or who is allowed to pick up a child, parents should notify the Director.

I have read the policies above and understand the staff policies set in place to keep my child safe. I understand my responsibilities as a parent in the effort to prevent child abuse and to protect all children in Y childcare and programs.

Parent/Guardian Signature

Date

This form is only required if your child requires medications while at the program or has any of the conditions listed below.

MEDICATION & HEALTH CARE PLAN FORMS

If your child will require any medication during the program day or has any on-going medical conditions, such as asthma, allergies, or diabetes, please fill out the following forms as necessary.

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms _____

Topical Non-Prescription (**applied to open wound/ broken skin**) _____

My child has previously taken this medication _____

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

Child's Health Care Practitioner Signature _____ **Date** _____

I, _____, (parent or guardian) gives permission
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date** _____
For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only**)

This form is only required if your child requires medications while at the program or has any ongoing medical conditions.

Child's Photo

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply....

Plan was created by:

- Parent
- Doctor or Licensed Practitioner
- Program's Health Care Consultant
- Older school age child (9+ yrs. of age)
- Other: _____

Plan is maintained by:

- Director
- Assistant Director
- Child's Educator
- Other: _____

Name of child:	Date:
Any change to the child's Health Care Plan? YES (indicate changes below) NO (updated physician/parental signatures required)	
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
Name of educators that received training addressing the medical condition:	
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):	

Name of Licensed Health Care Practitioner (please print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Parental/Guardian consent: _____ Date: _____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO

Parent signature: _____ Date: _____

Administrator's signature: _____ Date: _____

This form is only required if your child has food allergies.

Food Allergy Action Plan

Student's Name: _____ D.O.B: _____ Teacher: _____

Place
Child's
Picture
Here

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:

- | | | |
|--|---------------------------------|--|
| ▪ If a food allergen has been ingested, but <i>no symptoms</i> : | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Skin Hives, itchy rash, swelling of the face or extremities | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Gut Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Throat † Tightening of throat, hoarseness, hacking cough | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Lung † Shortness of breath, repetitive coughing, wheezing | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Heart † Thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ Other † _____ | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ▪ If reaction is progressing (several of the above areas affected), give | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

Give Checked Medication**:

To be
determined
by physician
authorizing
treatment

The severity of symptoms can quickly change. † Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____) . State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)
a. _____	1.) _____ 2.) _____
b. _____	1.) _____ 2.) _____
c. _____	1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ (Required) Date _____

This form is only required if your child has asthma.



Asthma Action Plan

General Information:

■ Name _____
■ Emergency contact _____ Phone numbers _____
■ Physician/Health Care Provider _____ Phone numbers _____
■ Physician Signature _____ Date _____

Severity Classification	Triggers	Exercise
<input type="radio"/> Mild Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Pre-medication (how much and when) _____ 2. Exercise modifications _____

Green Zone: Doing Well Peak Flow Meter Personal Best = _____

Symptoms	Control Medications												
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work and play <input type="checkbox"/> Sleeps all night	<table border="1"><thead><tr><th>Medicine</th><th>How Much to Take</th><th>When To Take It</th></tr></thead><tbody><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr></tbody></table>	Medicine	How Much to Take	When To Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____
Medicine	How Much to Take	When To Take It											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											
Peak Flow Meter More than 80% of personal best or _____													

Yellow Zone: Getting Worse Contact Physician if using quick relief more than 2 times per week.

Symptoms	Continue control medicines and add:												
<input type="checkbox"/> Some problems breathing <input type="checkbox"/> Cough, wheeze or chest tight <input type="checkbox"/> Problems working or playing <input type="checkbox"/> Wake at night	<table border="1"><thead><tr><th>Medicine</th><th>How Much to Take</th><th>When To Take It</th></tr></thead><tbody><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr></tbody></table>	Medicine	How Much to Take	When To Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____	_____											
_____	_____	_____											
_____	_____	_____											
Peak Flow Meter Between 50 to 80% of personal best or _____ to _____	<table border="1"><thead><tr><th>IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN</th><th>IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN</th></tr></thead><tbody><tr><td><input type="radio"/> Take quick-relief medication every 4 hours for 1 to 2 days <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Contact your physician for follow-up care</td><td><input type="radio"/> Take quick-relief treatment again <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Call your physician/Health Care Provider within _____ hours of modifying your medication routine</td></tr></tbody></table>	IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN	IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN	<input type="radio"/> Take quick-relief medication every 4 hours for 1 to 2 days <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Contact your physician for follow-up care	<input type="radio"/> Take quick-relief treatment again <input type="radio"/> Change your long-term control medicines by _____ <input type="radio"/> Call your physician/Health Care Provider within _____ hours of modifying your medication routine								
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Red Zone: Medical Alert Ambulance/Emergency Phone Number: _____

Symptoms	Continue control medicines and add:												
<input type="checkbox"/> Lots of problems breathing <input type="checkbox"/> Cannot work or play <input type="checkbox"/> Getting worse instead of better <input type="checkbox"/> Medicine is not helping	<table border="1"><thead><tr><th>Medicine</th><th>How Much to Take</th><th>When To Take It</th></tr></thead><tbody><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr></tbody></table>	Medicine	How Much to Take	When To Take It	_____	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____	_____											
_____	_____	_____											
_____	_____	_____											
Peak Flow Meter Between 0 to 50% of personal best or _____ to _____	<table border="1"><thead><tr><th>Go to the hospital or call for an ambulance if</th><th>Call an ambulance immediately if the following danger signs are present</th></tr></thead><tbody><tr><td><input type="radio"/> Still in the red zone after 15 minutes <input type="radio"/> If you have not been able to reach your physician/health care provider for help <input type="radio"/> _____</td><td><input type="radio"/> Trouble walking/talking due to shortness of breath <input type="radio"/> Lips or fingernails are blue</td></tr></tbody></table>	Go to the hospital or call for an ambulance if	Call an ambulance immediately if the following danger signs are present	<input type="radio"/> Still in the red zone after 15 minutes <input type="radio"/> If you have not been able to reach your physician/health care provider for help <input type="radio"/> _____	<input type="radio"/> Trouble walking/talking due to shortness of breath <input type="radio"/> Lips or fingernails are blue								
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