ATTLEBORO NORTON YMCA • BEFORE & 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 BEFORE school program?

☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI

How many days per week will your child attend the AFTER school program?

☐ 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: $25 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

BEFORE CARE TRANSPORTATION PLAN (Leave blank if not applicable.)

My child will ARRIVE at YMCA

at an approximate time of _______ via

___Parent Drop Off

___Supervised Walk

___Public/Private Van

___Contract/Van

___Private Transportation Arranged by Parent

___Other ______________________

My child will DEPART from YMCA via

___School Bus

___Other ______________________

AFTER CARE TRANSPORTATION PLAN (Leave blank if not applicable.)

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.

Before School Weekly Rates:

5 days per week: $65
4 days per week: $60
3 days per week: $45
2 days per week: $32
1 day per week: $16

After School Weekly Rates:

5 days per week: $110
4 days per week: $92
3 days per week: $69
2 days per week: $48
1 day per week: $24

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.** 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:__________________

ALLERGY TO: ____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

Place Child's Picture Here

◆ STEP 1: TREATMENT ◆

Symptoms:		Give Checked Medication**:	
▪ If a food allergen has been ingested, but *no symptoms*:		☐ EpiPen	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine
▪ Throat †	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine
▪ Other †	______________________________	☐ EpiPen	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine

**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____ Date______________
(Required)

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
❍ Mild Intermittent ❍ Moderate Persistent ❍ Mild Persistent ❍ Severe Persistent	❍ Colds ❍ Smoke ❍ Weather ❍ Exercise ❍ Dust ❍ Air pollution ❍ Animals ❍ Food ❍ Other ______________	1. Pre-medication (how much and when) ______________ ______________ 2. Exercise modifications ______________ ______________

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Peak Flow Meter

More than 80% of personal best or ________

Control Medications

Medicine	How Much to Take	When To Take It

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50 to 80% of personal best or

________ to ________

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- ❍ Take quick-relief medication every 4 hours for 1 to 2 days
- ❍ Change your long-term control medicines by ______________
- ❍ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- ❍ Take quick-relief treatment again
- ❍ Change your long-term control medicines by ______________
- ❍ Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Between 0 to 50% of personal best or

_______ to ________

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Go to the hospital or call for an ambulance if

- ❍ Still in the red zone after 15 minutes
- ❍ If you have not been able to reach your physician/health care provider for help
- ❍ ______________

Call an ambulance immediately if the following danger signs are present

- ❍ Trouble walking/talking due to shortness of breath
- ❍ Lips or fingernails are blue