EMERGENCY CONTACT/PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270 124(a)(b). 3270 181 & 182. 3280124 (a)(b) 3280 181 & 182 3290 124 (a)(b). 3290 181 & 182

CHILD'S NAME		BIRTHDATE
ADDRESS		
MOTHER'S NAME/LEGAL GUARDIAN	E-mail address	HOME TELEPHONE NUMBER
ADDRESS		DRIVER'S LICENSE #
EMPLOYER		BUSINESS TELEPHONE NUMBER
ADDRESS		CELL PHONE NUMBER
FATHER'S NAME/LEGAL GUARDIAN	E-mail address	HOME TELEPHONE NUMBER
ADDRESS		DRIVER'S LICENSE #
EMPLOYER		BUSINESS TELEPHONE NUMBER
ADDRESS		CELL PHONE NUMBER

EMERGENCY CONTACT (OTHER THAN PARENT)	RELATIONSHIP	TELEPHONE #
PERSON(S) TO WHOM CHILD MAY BE RELEASED	COMPLETE ADDRESS	TELEPHONE #
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE #
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 FULL 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

_____ _____

FAMILY CODE WORD DATE

SIX MONTH PERIODIC REVIEW:

_____ _____

SIGNATURE DATE

AGREEMENT

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

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE **FRIDAY BY 6 P.M.**

Services to be provided as part of the weekly fee (Child Care & homework supervision.)

Fees are to be paid weekly according to your registered schedule regardless of attendance. Payment for services is due **NO LATER than FRIDAY at 6:00 P.M.** for the following week. Any payment not received by that time will prevent your child from future attendance in the program unless and until payment is made. No cash payments can be accepted at your child's site. A two-week written notice is required for termination and payment for these weeks will be required.

IN THE EVENT THAT WE ARE REQUIRED TO TAKE YOUR ACCOUNT TO A COLLECTION AGENT, YOU WILL BE FULLY RESPONSIBLE FOR ALL COLLECTION COSTS, COURT COSTS, AND ATTORNEY FEES.

The YMCA reserves the right to change tuition prices. Parents will be given no less than a 30 day notice of any changes.

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE **$1.00**	PER MIN-HR **Per Minute**	

Fees are charged ONLY for days school is in session. ALL DAY CARE is an option on some holidays/inservice days for $35.00 per child. Should any family have two checks returned, **ALL** future payments will need to be made by money order.

$20 late fee will be applied if the weekly tuition isn't received by Monday at 8am.

PROPER IDENTIFICATION (picture I.D.) is required of any person picking up your child who is not known to our staff and **no one under the age of 18** can be considered an authorized release person.

I, the parent/guardian;

- ☐ Received complete written program information at the time of enrollment (3207.121,3280.121,3290.121)
- ☐ Agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum. (3270.124, 3280.124, 3290.124)
- ☐ Understand that any change in my child's enrollment must be done by contacting the office **2 weeks prior** to the scheduled change.
- ☐ Understand that the YMCA reserves the right to terminate my child's enrollment in the program at any time, for non- payment of childcare fees.

_____ _____ _____ _____

SIGNATURE OF PERSON(S) RESPONSIBLE FOR PAYMENT | DATE | SIGNATURE-OPERATOR | DATE

DO NOT SIGN BELOW UPON ADMISSION TO PROGRAM

DATE OF CHILD'S ADMISSION	**PERIODIC REVIEW:**
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN DATE

HARRISBURG AREA YMCA
MEMBERSHIP APPLICATION

PRIMARY MEMBER

ID NUMBER _____ TYPE_____

FIRST NAME_____ M.I. _____ LAST NAME_____

ADDRESS_____ HOME PHONE_____

CITY _____ STATE_____ ZIP_____

EMPLOYED BY_____POSITION_____ WORK PHONE _____

BIRTH DATE _____ SEX : ☐ MALE ☐ FEMALE

E-MAIL ADDRESS _____

EMERGENCY CONTACT

NAME & RELATIONSHIP	PHONE NUMBER	MOBILE NUMBER

A Family Membership consists of 2 adults and any dependent children -- please complete the following.

SECONDARY MEMBER

ID NUMBER _____

FIRST NAME_____ M.I. _____ LAST NAME_____

EMPLOYED BY_____POSITION_____ WORK PHONE _____

BIRTH DATE _____ SEX : ☐ MALE ☐ FEMALE

E-MAIL ADDRESS _____

DEPENDENT FAMILY MEMBERS

ID Number	First Name	Middle Initial	Last Name (If different)	Birth Date	Sex

FINANCIAL ASSISTANCE

It is the policy of the Harrisburg Area YMCA to provide services for any person who desires to participate. This policy is designed to ensure that YMCA services are accessible to all members of the community and that no one is excluded because of an inability to pay. While participants are expected to pay their fair share of operating costs, those not able to pay the full fee may be awarded full or partial assistance based on their demonstrated ability to pay.

YMCA CHILD CARE
Background Information

Child's Name: _____Date of Birth:_____

Names and ages of other children in the family: _____

_____

Names and types of pets: _____

Methods of discipline used at home: _____

How does your child relate to new situations? _____

Does your child have any fears? _____

_____

Does your child have any known allergies: (asthma, hay fever, insect bites, food, medicines, etc.)

_____

Are there any medical problems of which we should be aware? _____

_____

Are there any special instructions regarding food or eating? _____

_____

Is there any ethnic or religious information about your child or family that you would like us to know?

_____

_____

We say prayers before snack and lunch. If you rather your child not participate please let us know:

_____

Please use the back of the paper to tell us anything else about your child that you would like us to know.

NEW ENROLLMENT
YMCA CHILD CARE CENTER

Dear Parents,

As per OCDEL's (formally known as the Department of Public Welfare) regulations, it is required that the YMCA have on file your written permission to use the following products. (Which you must provide should they need to be used.) Please sign name where applicable.

Child's Name: _____ Date: _____

Start Date: _____ Days Attending: _____

Baby wipes _____ Petroleum Jelly _____

Oral gel _____ Diaper rash ointment _____

Sun tan lotion _____ Moisturizing lotion or cream _____

Parents are urged to spend some extra time at the center on a child's first day, to help that child become adjusted to the center's environment. Parents will be responsible to provide certain supplies for their children. They are as follows:

Infants: (Please label all belongings, so that they may be returned)

- Bottles for the day (must be plastic and labeled)
- Formula
- Snacks
- A menu and schedule for feedings
- 3 changes of clothing
- 2 crib sheets
- 1 blanket
- 2 plastic bibs
- 1 package of disposable diapers
- Cream or lotion (the center must have a note from the parent stating what can be used on the baby's skin)
- Baby wipes

Toddlers: (Please label all belongings)

- Small blanket
- 2 changes of clothing
- 1 package of disposable diapers
- Cream or lotion (the center must have a note form the parent stating what can be used on the baby's skin)
- Baby wipes

Preschool/Pre-Kindergarten: (Please label all belongings)

- Small blanket
- 2 changes of clothing
- Sleep-time friend (optional)

Please understand that we have a limited supply of extra clothes at the center – If your child uses one of their extra sets of clothes, you must provide another set the next day. If your child has no clothes for us to change them into, you will be notified to provide some immediately.

HARRISBURG AREA YMCA
PICTURE/PHOTO RELEASE FORM

There are times when the YMCA takes pictures or videos of those people involved in our programs. These pictures may be used in a promotional display, a YMCA brochure or for marketing purposes. Because you have enrolled your child in a Harrisburg Area YMCA program, we would like to have permission from you before we take any pictures of your child to use for public purposes. Therefore, please complete the form below:

I do____ /do not____ give permission for my child, _____,
To be photographed or video taped by or for the Harrisburg Area YMCA or any organization we are in cooperation with for any pictures or videos which may be published or used in promotional displays, brochures or marketing events.

SIGNED: _____

DATE: _____

CAMP SITE ATTENDING: _____

Harrisburg Area YMCA
East Shore Branch

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

SUBJECT: **NONDISCRIMINATION IN SERVICE**
TO: **YMCA CHILD CARE AND SCHOOL AGE CHILD CARE PARENTS**
FROM: **EAST SHORE YMCA CHILD CARE DIRECTOR**

Admissions, the provision of services, and referrals of residents shall be made without regard to race, color, religious creed, disability, ancestry, national origin, age or sex.

Program services shall be made accessible to eligible disabled persons through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aids, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any resident/client/patient/student (and/or their guardian) who believes they have been discriminated against may file a complaint of discrimination with:

East Shore YMCA
701 North Front Street
Harrisburg, PA 17101

Pennsylvania H. R. C.
Harrisburg Regional Office
Riverfront Office Center
1101 South Front Street, 5th Floor
Harrisburg, PA 17104

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

U.S. Department of Health and Human Services
Office for Civil Rights
Suite 372, Public Ledger Bldg.
150 S. Independence Mall West
Philadelphia, PA 19106-9111

_____

PARENT SIGNATURE AND DATE

701 North Front Street | Harrisburg, PA | 17101-1093
P: 717.232.9622 | F: 717.232.9631
www.ymcaharrisburg.org

CHILD HEALTH ASSESSMENT

Parents & Child Care Providers 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:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at < www.aap.org > or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): ☐ NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

Parents may write immunization dates, health professionals should verify and complete all data.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE (BIRTH TO AGE 2)	BLOOD PRESSURE (BEGINNING AT AGE 3)
_____ IN/CM % ILE _____	_____ LB/KG % ILE _____	_____ IN/CM % ILE _____	_____ / _____

PHYSICAL EXAMINATION	✔ = NORMAL	IF ABNORMAL - COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

☐ NONE

NEXT APPOINTMENT - MONTH/YEAR:

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CPNP:	
ADDRESS:			
	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED:

04131A

CY 51 - 2/01

Tax Receipts Furnished Only Upon REQUEST

Form **W-10**
(Rev. August 1996)
Department of the Treasury
Internal Revenue Service

Dependent Care Provider's Identification and Certification

Do NOT file Form W-10 with your tax return. Instead, keep it for your records.

Part I **Dependent Care Provider's Identification** (See Instructions.)

Please print or type	Name of dependent care provider **Harrisburg Area YMCA**	**Provider's taxpayer identification number** **23-1665437**
	Address (number, street, and apt. no.) **123 Forster Street**	If the above number is a social security number, check here ▶ . . . . . ☐
	City, state, and ZIP code **Harrisburg, PA 17102**	

Certification and Signature of Dependent Care Provider.—Under penalties of perjury, I, as the dependent care provider, certify that my name, address, and taxpayer identification number shown above are correct.

Please Sign Here	**Dependent care provider's signature** John Monsted CFO	**Date** 02-01-2015

Part II **Name and Address of Person Requesting Part I Information** (See instructions.)

Name, street address, apt. no., city, state, and ZIP code of person requesting information

General Instructions

Section references are to the Internal Revenue Code.

Purpose of form.—You must get the information shown in Part I from each person or organization that provides care for your child or other dependent if:

1. You plan to claim a credit for child and dependent care expenses on Form 1040 or 1040A, or

2. You receive benefits under your employer's dependent care plan.

If either **1** or **2** above applies, you must show the correct name, address, and taxpayer identification number (TIN) of each care provider on **Form 2441,** Child and Dependent Care Expenses, or **Schedule 2,** Child and Dependent Care Expenses for Form 1040A Filers, whichever applies.

You may use Form W-10 or any of the other sources listed under **Due diligence** below to get this information from each provider.

Penalty for failure to furnish TIN.—TINs are needed to carry out the Internal Revenue laws of the United States. Section 6109(a) requires a provider of dependent care services to give to you a valid TIN, even if the provider is not required to file a return. The IRS uses the TIN to identify the provider and verify the accuracy of the provider's return as well as yours.

A care provider who does not give you his or her correct TIN is subject to a penalty of $50 for each failure unless the failure is due to reasonable cause and not willful neglect. This penalty does not apply to an organization described in section 501(c)(3). See **Tax-exempt dependent care provider** later.

If incorrect information is reported.—You will not be allowed the tax credit or the exclusion for employer-provided dependent care benefits if:

- You report an incorrect name, address, or TIN of the provider on your Form 2441 or Schedule 2, and
- You cannot establish, to the IRS upon its request, that you used due diligence in trying to get the required information.

Due diligence.—You can show due diligence by getting and keeping in your records any one of the following:

- A Form W-10 properly completed by the provider.
- A copy of the provider's social security card or driver's license that includes his or her social security number.
- A recently printed letterhead or printed invoice that shows the provider's name, address, and TIN.
- If the provider is your employer's dependent care plan, a copy of the statement provided by your employer under the plan.
- If the provider is your household employee and he or she gave you a properly completed **Form W-4,** Employee's Withholding Allowance Certificate, to have income tax withheld, a copy of that Form W-4.

If your care provider does not comply with your request for one of these items, you must still report certain information on your Form 2441 or Schedule 2, whichever applies. For details, see the Form 2441 or Schedule 2 instructions.

Specific Instructions

Part I

The individual or organization providing the care completes this part.

Enter the provider's name, address, and TIN. For individuals and sole proprietors, the TIN is a social security number (SSN). But if the provider is a nonresident or resident alien who does not have and is not eligible to get an SSN, the TIN is an IRS individual taxpayer identification number (ITIN). For other entities, it is the employer identification number. If the provider is exempt from Federal income tax as an organization described in section 501(c)(3), see **Tax-exempt dependent care provider** below.

How to get a TIN.—Providers who do not have a TIN should apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office. To apply for an ITIN, get **Form W-7,** Application for IRS Individual Taxpayer Identification Number, from the IRS. To apply for an EIN, get **Form SS-4,** Application for Employer Identification Number, from the IRS.

Note: *An ITIN is for tax use only. It does not entitle the individual to social security benefits or change his or her employment or immigration status under U.S. law.*

Tax-exempt dependent care provider.—A provider who is a tax-exempt organization described in section 501(c)(3) and exempt under section 501(a) is not required to supply its TIN. Instead, the provider must complete the name and address lines and write "tax-exempt" in the space for the TIN. Generally, an exempt 501(c)(3) organization is one organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or for the prevention of cruelty to children or animals.

Income tax reporting requirements for dependent care providers.—The individual provider must report on his or her income tax return all income received for providing care for any person. If the provider is a self-employed individual, the income is reported on Schedule C or C-EZ (Form 1040), whichever applies.

Part II

Complete this part only if you are leaving the form with the dependent care provider to return to you later.

Harrisburg Area YMCA
East Shore Branch

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

According to OCDEL licensing regulations, every child enrolled must have a complete health form on file. Forms are included in the registration packet or you can request a form from the onsite staff. **The form must include a physician's signature AND an updated immunization record.** A print out of the immunization record alone is not acceptable.

Infants and Toddlers...birth to 36 months...are required to submit an updated form every six months until the child turns 3 years old.

Preschoolers...3-5 years old...are required to submit an updated form yearly.

Yearly inspections of Pa state licensed child care programs are now unannounced. Meaning, our licensing representative may show up at the school any day and request to see any/all documentation on both the staff and children.

If you are contacted about missing paperwork for your child's file, please submit it ASAP so as to prevent your child from being suspended from the program.

If you have any questions, please contact Kelly Campbell at Kelly.campbell@ymcaharrisburg.org or 717-329-7503.