School Age Child Care (SACC)
After School Care

West Rocks Middle School

Student Name: _____

Grade: _____

SACC Program Start Date: _____

Tuition for School Year 2014-2015

Please check schedule choice:

Registration Fee (due at time of registration/non-refundable): $75

5 Days per week
O PM only $240 (per month)

4 Days per week – Circle choice of days: **M T W TH F**
O PM only $215 (per month)

3 Days per week - Circle choice of days: **M T W TH F**
O PM only $190 (per month)

2 Days per week - Circle choice of days: **M T W TH F**
O PM only $130 (per month)

The registration packet checklist at the end of this packet must be complete for program registrations to be processed.

Norwalk YMCA School Age Child Care
2014-2015 Registration Form
West Rocks Middle School

Grade Entering: _____

Child's Name _____ Date of Birth_____ Sex _____

Home Address _____ ZIP_____

Mother's Name _____ Father's Name _____
Mother's Employer _____ Father's Employer _____
Employer's Address _____ Employer's Address _____
City _____ City _____
Work Phone _____ Work Phone _____
Home Phone _____ Home Phone _____
Cell Phone _____ Cell Phone _____
Email Address _____ Email Address _____
Child's Physician _____ Physician Phone _____

Do not list a parent who does not have permission to pick up the above child named.

Please list the name and telephone number of three (3) persons, other than the parents, who have permission to pick up your child and may be called in the parents' absences or in an emergency situation. THIS SECTION MUST BE COMPLETED TO ENSURE YOUR CHILD'S SAFETY. Only those names mentioned below will be permitted to pick up and transport your child. If other arrangements have been made for pick-up a note must be sent in with your child and submitted to either the Director or your child's teacher.

Name _____ Relationship _____
Day Phone_____ Home Phone _____ Cell Phone _____

Name _____ Relationship _____
Day Phone_____ Home Phone _____ Cell Phone _____

Child lives with (check one):

___Mother ___Father ___Both ___Other _____

If one parent retains sole legal custody, for the protection of the child, copy of a court order must accompany this form.

_____ Date _____
Parent Signature

_____
Parent Name Printed

Automatic Monthly Tuition Charge/Debit
Authorization Form
2014-2015

This form authorizes the Norwalk YMCA to process monthly tuition payments and is valid for the current school calendar year. The agreed tuition amount is based on the YMCA fee schedule. Tuition is collected by Electronic Funds Transfer on the sixteenth of each month PRIOR to the month of care to be received.

Parent Name: _____ Daytime Phone: _____

Home Address: _____ City: _____ State: _____ ZIP: _____

Child's Name: _____ School: _____

As a duly authorized check signer on the financial institution account identified below, I authorize the Norwalk Y to perform scheduled or periodic electronic funds transfer debits and/or credits from my account identified below for payments due or when applicable, apply electronic funds transfer credits to the same. This applies to check by phone payments as well as any other electronic payment. I understand the dollar amount can vary depending on services performed.

Furthermore, if any such electronic debit(s) should be returned by my financial institution as Non-Sufficient Funds (NSF) I authorize the Norwalk Y to collect a returned item fee of $25.00 per item by electronic debit from my account identified below.

For accounting purposes, all electronic debits will be reflected in the monthly bank statement that corresponds with the financial institution account identified below.

I understand and authorize all of the above as evidenced by my signature below:

Authorizing Signature: _____ **Date:** _____

NAME OF BANK: _____ **Branch:** _____

City: _____ **State:** _____ **Zip:** _____

9 Digit Transit/ABA Routing #: _____ **Account #** _____

Attach a blank VOIDED check

Circle type of card: **VISA** **MASTERCARD** **AM.EX.** **DISCOVER**

Card Number: _____ **Expiration Date:** _____

Attach a PHOTO COPY of the card

I give authority to bank named above to agree to provide updated information upon request. The YMCA of Norwalk needs updated information to continue to process monthly payments. By initialing below I confirm I have read and agree to the attached policies & procedure and agree to pay my monthly tuition, in full. I authorize the Y to draw this amount by the 16th of the month prior to the month of care to be received. X (initial here)_____

MONTHLY TUITION AMOUNT: $ _____

YMCA Tuition Agreement

1. YMCA tuition program is a continuous tuition plan
2. It is my complete understanding that if I wish to terminate or change my tuition plan in any way, I must give the Norwalk Y a 30 day written notice.
3. The Norwalk Y Company may, at their discretion, adjust the monthly rate applicable to my category of tuition. I understand I will receive at least 4 weeks notice prior to such change.
4. Should any tuition draft NOT be honored by my bank for any reason, I realize that I am still responsible for that payment, plus a service charge applied by the Norwalk Y.
5. In signing the YMCA Tuition Agreement I acknowledge that I understand and will abide by all the conditions stated herein.
6. As a convenience to me, I hereby authorize the Norwalk Y to pay and charge my account checks drawn on my account by and payable to the order of the *YMCA of Norwalk, Inc.* provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. The authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of my child's enrollment.

Sign here as you sign your checks: _____ Date: _____

YMCA Employee Signature: _____ Date: _____

To: The Bank named on the Authorization to honor ACH Debits or Drafts by the Norwalk Y

So that you may comply with the depositor's authorization the Norwalk Y agrees that:

1. No such checks will be drawn except upon valid subsisting authority from the depositor whose account is to be charged
2. You shall be under no obligation whatsoever to make any investigation or determination as to the authenticity or correctness of any such check or to verify the authority to pay such checks.
3. You will be indemnified and held harmless from any loss you may suffer as a consequence of your action resulting from or in litigation with the execution and issuance of any check under the Plan whether or not purporting to be received by you in the regular course of business for the purpose of payment including any cost or expenses incurred in connection therewith.
4. In the event of any such check issued under the Plan is dishonored whether with or without cause and whether intentionally or inadvertently, you will be indemnified and held harmless from any loss you may suffer even though dishonor results in forfeiture of enrollment.
5. We will defend at our own cost and expenses any action which might be brought by an depositor or any other persons because of your actions taken pursuant to the foregoing authorization or in any manner arising by a reason on your part in the foregoing plan
6. We will refund any amount erroneously paid by you on any such check issued under the Plan if claim for the erroneous payment is made by you within twelve months from the date which such erroneous payment was made.

For families receiving THIRD PARTY tuition assistance:

(Care4Kids, City of Norwalk, DSS, DCF etc.)

- For families receiving tuition assistance, should your certificate authorization come to an end, you will continue to receive childcare services however your monthly fee will be *increased* to the full YMCA posted monthly tuition amount.
    - You will be charged for your parent portion PLUS the amount previously covered by the third party, totaling 100% of the monthly tuition for services.
- The Norwalk Y is unable to extend reduced billing while redetermination is pending.
- Billing is effective on the 16th of each month. Please ensure sufficient funds are available in your account. Bank Accounts, credit cards, and debit cards are charged on the 16th of each month PRIOR to services rendered.
- Parents are responsible for handling their redetermination letters for Care4Kids and should allow sufficient time to process redetermination paperwork. Do not delay! Parents are informed of their status *before* the YMCA is informed.
- Should your Certificate lapse, and later is renewed, the Y will reverse the excess charges paid by you, once payment is received by the Y from your third-party payer.
- If you receive Care4Kids tuition assistance, and have any questions about the status of your renewal, please contact your Care4Kids Counselor.

_____

Parent's Initials

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name _____ Controlled Drug? ☐ YES ☐ NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration Start Date ____/____/____ Stop Date ____/____/____

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Signature _____

Parent/Guardian Authorization:
I request that medication be administered to my child as described and directed above and attest that I have administered at least one dose of the medication to my child without adverse effects.

Name of Day Care Program _____ Today's Date ____/____/____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: _____

Address _____ Town _____ Phone Number (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Childcare Personnel Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

Medication Administration Record (MAR)

Name of Child _____ Date of Birth ____/____/____

Pharmacy Name _____ Prescription Number _____

Medication Order _____

[illegible]	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing / Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ Authorization form is complete

☐ Medication is appropriately labeled

☐ Medication is in original container

☐ Date on label is current

Person Accepting Medication (print name)_____ Date ____/____/____

State of Connecticut

Early Childhood Health Assessment Record

To Parent or Guardian:

In order to provide the best experience, early childhood providers 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 health evaluation (Part II). State law requires complete primary immunization and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse, a physician assistant or the school medical advisor prior to entering an early childhood program in Connecticut.

Please print

Name of Child (Last, First, Middle)	Social Security Number	Birth Date	Sex

Address (Street)	Race/Ethnicity	
	❑ American Indian	❑ White, not of Hispanic origin
(Town and ZIP code)	❑ Asian	❑ Hispanic/Latino
	❑ Black, not of Hispanic origin	❑ Other

Parent/Guardian (Last, First, Middle)	Home Phone Number	Work/Cell Phone Number

Early Childhood Program	Program Phone Number

Primary Health Care Provider	Preferred Hospital	Health Insurance Company/Number* or Medicaid/Number*

* If applicable

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

Part I — To be completed by parent

***Important*: Complete Part I before your child is examined.**

Take this form with you to the health care provider's office.

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

	Yes	No	
1.	❑	❑	Do you have any concerns about your child's general health, development or behavior?
2.	❑	❑	Has your child been diagnosed with any chronic disease ❑ asthma ❑ diabetes ❑ seizure disorder ❑ other _____
3.	❑	❑	Does your child have any allergies (food, insects, medication, latex, etc.)? Please specify: _____
4.	❑	❑	Does your child take any medications (daily or occasionally)?
5.	❑	❑	Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
6.	❑	❑	Has your child had any hospitalization, operation, major illness or injury, or significant accident?
7.	❑	❑	In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?
8.	❑	❑	In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?
9.	❑	❑	Has your child had a dental examination in the last 12 months?
10.	❑	❑	Would you like to discuss anything about your child's health with the child care provider or health consultant/coordinator?

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

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian

Date

ED191 REV 6/2004 C.G.S. Section 10-16q, 10-206, 19a-79(a), 19a-87b(a); Pub. Code Section 19a-79-3a(a)(2), 19a-87b-10b(2)

To be maintained in the child's Health Record

Part II — Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

Child's Name _____ Birth Date (mm/dd/yy) _____ Date of History/Physical Exam (mm/dd/yy) _____

LENGTH/HEIGHT		WEIGHT		WT FOR HT/BMI	HEAD CIRCUMFERENCE[2]		BLOOD PRESSURE[3]
INCM	%ILE	LB/KG	%ILE	%ILE	INCM	%ILE	/

Screening/Test Results

Screening Test	Result	Date	Abnormal/Concerns
Vision[1] Test type:			
Hearing[1] Test type:			
Lead[1] Risk: Yes/No			
TB[1] Risk: Yes/No			
Urinalysis (UA)[1]			
Anemia[1] (Hgb/Hct) Risk: Yes/No			
Developmental Assessment[1] Test type:			

Has this child received dental care in the last 12 months?[1] ☐ Yes ☐ No ☐ N/A

* Chronic Disease Assessment:

Yes	No		Date of onset
☐	☐	Asthma: ☐ mild ☐ moderate ☐ severe ☐ exercise induced ☐ unclassified	
☐	☐	Diabetes: ☐ Type I ☐ Type II	
☐	☐	Anaphylaxis: ☐ med. ☐ food ☐ insect ☐ latex	
☐	☐	Seizures: Type _____	
☐	☐	Other: Please specify _____	

Minimum requirements: [1]Up to 2 years; [2]annual at 3 years; [3]annual at 4 years; [4]at enrolment; [5]9–12 months; [6]each visit through 5 years; [7]annual at 2–3 years. Federal requirements (eg. Head Start, WIC) may vary.
[8]Prior to Public School Entry: Same as above and High-Risk.

Immunization Record

Vaccine (Month/Day/Year)	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP						
DTP/Hib						
DTaP						
DT/Td						
OPV						
IPV						
MMR						
Measles						
Mumps						
Rubella						
HIB						
Hep B						
Varicella						
PCV					Pneumococcal conjugate vaccine	
Other Vaccines (Specify)						

Disease Hx of above _____ (Specify) _____ (Date mm/yy) _____ (Confirmed by)

Exemption

Religious ____ Medical: Permanent ____ Temporary ____ Date ____

Recently Date ____ Recently Date ____ Recently Date ____

This child has the following problems which may adversely affect his or her educational experience:

☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical Dysfunction ☐ Emotional/Social ☐ Behavior

☐ The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. *Specify:* _____

☐ Yes ☐ No This child has a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program.

☐ Yes ☐ No Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

☐ The child may fully participate in the program.

☐ The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

☐ I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider	MD/DO NP RN	Name (Please type or print.)	Phone number

Address: _____

☐ Yes ☐ No Is this the child's Medical Home? | Next Appointment (mm/yy): _____ | Next Immunization Appointment (mm/yy): _____