River Valley Regional

Jersey Shore Branch

After School Program

Two locations

Jersey Shore Elementary (Before and After school)

Salladasburg Elementary (After school)

Time:

Before school starts at 6am

After school runs 2pm-6pm. daily

Fees:

$75.00 Before and After

$60.00 After School

After School Daily Activities include:

Homework Help

Nutritious Snacks.

Outside Play

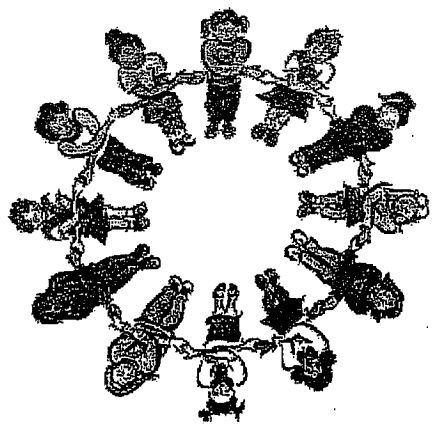
Gross Motor Games

Crafts

Science activities

Table activities

One-on-One Interaction



Keystone Stars Accredited

Lori Lohman
School Age Director
loril@lockhavenymca.org
570-748-6727 ext. 107

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

APPLICANT INFORMATION

Applicant Date:	Enrollment Date:	Termination Date:
1st Parent/Guardian	Date of Birth:	Relationship to Child:
Address:		Email Address:
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Place of Employment/School:		
2nd Parent/Guardian:	Date of Birth:	Relationship to Child:
Address:		Email Address:
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Place of Employment/School:		

FAMILY INFORMATION

Children in Family (please PRINT below)

Name:	Sex	Birthdate	Use	Site or Classroom
Name:				
Name:				
Name:				
Name:				

Total family size:	CACFP Code:		Funding Code:	

Parent Signature_____ **Date** _____

YMCA Signature _____ **Date** _____

EMERGENCY CONTACT PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

CHILD'S NAME	BIRTH DATE
ADDRESS	
MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)
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)

PARENTS 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

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Jersey Shore YMCA School Age Care School Year 2020-2021

(Please check one) ____**Jersey Shore** _____**Salladasburg**

_____

Child(ren)'s Name

II. I agree to pay the established fee(s) as indicated below:

SCHOOL AGE CARE – Begins the week of August 24, 2020. Includes **only** the scheduled school year closures: holiday vacations, early dismissals, in-service days, and snow days. **Will not include closures due to Covid-19.**

____ $60.00 After School Care **____$75.00 Before and After School Care**

____ I receive CCIS funding and I am obligated to pay $_____weekly.

COVID-19 PLAN (Must check one) IF SCHOOL CLOSES DUE TO THE PANDEMIC.....

____ I will need full time care. **_____ I will not return until school resumes normally.**

Full-time care will be at the Jersey Shore YMCA until we can return to the school. The following rates will occur.

Full-time rate-$100.00

Note: If school closes in the middle of the week you will be required to pay the $100.00 if you move to Full-time care. If they do not attend full time care you will still be required to pay the weekly fee.

_____Please check if you want AUTOMATIC PAYMENTS to continue.

III. Initial on the lines below indicating you have read and agree to the following statements:

____ I understand the normal weekly fee is due and payable by Friday of the week prior to receiving care. Other arrangements may be made with the child care director.

____ I understand that I am responsible for paying the weekly fee regardless of absences, emergency closings, or agency observed holidays.

____ I understand that there are **NO** vacation days included with this agreement.

____ I understand that services may be terminated for lack of payment and I will still be responsible for my balance owed.

____ I understand that the YMCA charges an insufficient funds/returned check fee plus expenses charged by the bank.

____ I understand that this contract may be terminated by myself with a two weeks' notice or by the child care provider. The child care provider may immediately terminate without giving any notice if the parent guardian fails to make timely payments or does not follow the YMCA Code of Conduct.

____ I understand that my account may be turned over to Keystone Credit Collections if I fail to make timely payments. **this may affect your credit rating**

Signature_____ **Date**_____

YMCA Bank Draft Authorization Form - EFT

Name of Account Holder: _____ Effective Date: _____

Joint Account Holder, if applicable: _____ Phone #: _____

Street Address: _____

City, State, Zip Code: _____

_____ New Authorization _____ Checking Account

_____ Alter current account information _____ Savings Account

Bank _____ Branch _____

City _____ State _____ Zip _____

Bank Routing Number _____ Bank Account Number _____

_____ Credit Card account (please choose): _____ Mastercard _____ Discover _____ Visa

Credit Card Account Number: _____

Expiration Month and Year: _____ Security Code from back of card: _____

To Lock Haven Area YMCA (hereinafter referred to as Y), I have given my authority to the above-named bank/credit card company to honor pre-authorized drafts drawn by the Y on my account for childcare payments. It is understood that the Y's transmission of pre-authorization drafts to the company as payments become due shall constitute valid notice of such payment due on said childcare. When bank/credit card company honors the draft by charging my account, such draft shall constitute my receipt of payment. Should any pre-authorized draft not be honored by said bank/credit card company when received, it is understood that payment is to be made by me within 15 days in the amount of said payment plus a $50 service fee applied by the Y.

Please initial on the lines below indicating that you have read and agree to the following statements:

_____ **Bank Draft/EFT Membership/Charitable Contribution/Childcare Payment Agreement**

I understand that Bank Draft/EFT is a continuous plan. I understand the payment will remain in effect until I initiate its termination. I further understand that all account information changes must be given to the YMCA with 30 days written notice in advance of the date I want the change to occur.

The Lock Haven YMCA Board of Directors may, at their discretion, adjust the monthly rate applicable to my category of membership/childcare at any time. I understand that I will receive at least thirty (30)-days' notice prior to any such changes.

The Y service charge is in addition to any service fee my bank may take. I understand that the draft may be resubmitted to my bank at the next available Y draft date to collect for that draft payment.

A check must be presented if you are signing up and your payments will be drawn on your checking account.

I agree that, for childcare and/or other non-membership services using EFT charges, fees will be drawn based on posted and agreed upon fees; these fees will be debited to the account chosen above on _____.

_____ **Bank Draft/EFT Cancellation Policy**

After the first 30 days of Bank Draft/EFT, you may appear in person to cancel the remainder of your Bank Draft/EFT agreement at any time by providing the Y with 30-days advance written notice of the day you want to cancel.

Printed Name(s): _____

Signature(s): _____ Today's Date: _____

Office Use Only:

Program Type: _____

Start Date: _____ Amount to be Deducted: _____ Staff Initials: _____

Notes: _____

_____

Lock Haven Area YMCA, 145 East Water Street, Lock Haven, PA 17745 (570) 748-6727

Jersey Shore Area YMCA Emergency Plan

Dear Parents/Guardians,

This letter is to assure you of our concern for the safety and welfare of the children attending the programs at Jersey Shore and Salladasburg after School Programs. Our Emergency Plan provides for response to all types of emergencies.

Depending on the circumstance of the emergency, we will use one of the following protective actions:

- **Immediate Evacuation** where children are evacuated to a safe area on the grounds of the facility
- **In Place Sheltering** for sudden occurrences of weather or hazardous materials related incidents
- **Total Evacuation** of facility if there is danger in the area; Children will be taken to Jersey Shore YMCA.
- **Modified Operations** may include cancellation, postponement or rescheduling of normal activities. This action is normally taken as the result of inclement winter weather or building maintaining issues.
- **In case of unplanned snow cancellations** all the children from Jersey Shore and Salladasburg will be transported to the Jersey Shore YMCA for pickup.

Please check our Facebook page for announcements related to an emergency situation. We ask that you **Do Not Call** during an emergency as staff will be making emergency calls and relaying information.

Please do NOT attempt to make different arrangements in the event of an emergency. This will cause additional confusion and divert staff from assigned emergency duties.

Thank you in advance for your cooperation. Should you have any questions regarding our emergency procedures, please contact Lori Lohman @ 570-398-2150.

I acknowledge that I have received and read the Emergency Plan Procedure.

Name (s) of children enrolled in program

Parent/Guardian Signature_____ Date_____

CHILD CARE STAFF HEALTH ASSESSMENT

(55 Pa. Code §§3270.151, 3280.151 and 3290.151)

NAME OF PERSON EXAMINED (Please print)	REASON FOR EXAMINATION
	☐ Initial employment in child care ☐ Biennial re-examination

THIS SECTION TO BE COMPLETED BY EMPLOYER

This physical examination is for the purpose of employment in a child care facility. The types of activities this individual will be doing are as follows (please check all that apply):

☐ Lifting, carrying children
☐ Close interaction with children
☐ Food preparation
☐ Desk work
☐ Driver of vehicle(s)
☐ Facility maintenance
☐ Other – describe below:

THIS SECTION TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT OR CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP)

1. DID YOU CONDUCT A PHYSICAL EXAMINATION? ☐ **YES** ☐ **NO**

The physical examination should include a functional assessment of vision and hearing and a systems review looking for conditions that might affect performance or predispose this individual to occupational injury relating to the type of activities required by the job (see type of job listed above.) Conditionals also include frequent hand washing, the stress of caring for groups of children, ability to actively supervise children, and exposure to the common infections of childhood. Please take note that substance abuse should be considered in determining suitability to provide child care.

2. DID THIS INDIVIDUAL HAVE ANY COMMUNICABLE DISEASES? ☐ **YES** ☐ **NO**

If yes, attach separate sheet(s) to describe the conditions and the risk it might pose to others exposed to this individual.

3. BASED ON YOUR FINDINGS FOR #1 AND #2 ABOVE AND OTHER INFORMATION GATHERED DURING YOUR EXAMINATION, IS THIS INDIVIDUAL SUITABLE TO PROVIDE CHILD CARE? ☐ **YES** ☐ **NO**

IF YOU ANSWERED "NO" TO QUESTION #3, please list any information regarding this individual's medical condition or other information gathered during your examination that might threaten the health of children or prohibit the individual from providing safe and adequate care to children. Please attach separate pages as needed.

DATE	SIGNATURE	TITLE
TELEPHONE NO.	PRINTED NAME	
ADDRESS		

TESTING FOR TUBERCULOSIS BY THE INTRACUTANEOUS MANTOUX OR INTERFERONGAMMA RELEASE ASSAY BLOOD TEST METHOD

Please note: The child care facility regulations require tuberculosis testing by Mantoux method or the interferongamma release assay (IGRA) blood test at initial employment in a child care setting. Subsequent testing is not required unless directed by a physician, physician's assistant, CRNP, the Department of Health or a local health department.

MANTOUX TEST DATE:	**RESULTS:** ☐ **POSITIVE** ☐ **NEGATIVE**
IF SKIN TEST IS POSITIVE:	**REPORT OF CHEST X-RAY** (Please attach an official radiology report)
	DOES THIS INDIVIDUAL NEED CHEMOPROHPHYLAXIS? ☐ **YES** ☐ **NO**

Please note: For the purposes of meeting the child care facility regulations, a person with a positive tuberculin skin test or blood test and a negative x-ray is not required to have further tuberculosis testing or x-rays, unless the person is exposed to an active case of tuberculosis or the person develops a productive cough which does not respond to medical treatment within 14 days.