



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY



**GATEWAY SUMMER
ENROLLMENT PACKET
FOR 2025
5 Day Only**

DATES: CHECK OFF ONE WEEK OR CHECK OFF THE ENTIRE 5 WEEKS.

____ July 7-July 11

____ July 14-July 18

____ July 21- July 25

____ July 28-August 1

____ August 4-August 8

BEFORE YOUR CHILD MAY ATTEND, YOU NEED TO

*Complete and return this packet to the Reception Desk with \$25.00 deposit per week

***Preschool Age children must have a current physical & immunization record attached in order to process**

***Receive a parent handbook**

***Attach current IEP/504 (if applicable)**

***Complete Individual Health Care Plan (if applicable)**

YMCA of Greater Westfield
67 Court Street
Westfield, MA 01085
(413) 568-8631 fax (413) 572-3995
www.westfieldymca.org

Minor Participant Waiver, Release, Indemnification of All Claims & Covenant Not to Sue

PLEASE READ CAREFULLY. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND IS LEGALLY BINDING. BY SIGNING THIS AGREEMENT YOU ARE RELEASING THE YMCA OF GREATER WESTFIELD, INC. FROM ALL LIABILITY AND FOREVER GIVING UP ANY CLAIMS THEREFOR

Assumption of Risk

I, in my legal capacity as parent/guardian of the minor named below ("Minor"), acknowledge and agree that any use of The YMCA of Greater Westfield's facilities, services, equipment and premises ("Facilities") and any participation in The YMCA of Greater Westfield's programs and activities ("Programs") comes with inherent risks including, but in no way limited to: (1) moderate and severe personal injury, (2) property damage, (3) disability, (4) death, and (5) sickness or disease. I voluntarily, for myself and Minor, accept and assume full responsibility for these risks as well as any and all other risks of the use of Facilities and participation in Programs. I agree that I have full knowledge of the nature and extent of all such risks and am not relying on all such risks being described in this document.

Waiver, Release, Indemnification & Covenant Not to Sue

In consideration of Minor's use of Facilities and participation in Programs I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor that The YMCA of Greater Westfield, Inc., its officers, directors, agents, employees, volunteers, insurers and representatives ("Releasees") will not be liable for any personal injury, property damage, disability, death, sickness or disease incurred by Minor, however occurring including, but not limited to, the negligence of Releasees. I understand that Minor and I will be solely responsible for any loss or damage, including personal injury, property damage, disability, death, sickness or disease sustained from the use of Facilities and participation in Programs.

I further agree, in my legal capacity as the parent/guardian of Minor, on behalf of Minor, myself, and any and all legal successors and proxies, to release and **HEREBY DO RELEASE, WAIVE AND COVENANT NOT TO SUE** Releasees from any causes of action, claims, suits, liabilities or demands of any nature whatsoever including, but in no way limited to, claims of negligence, which Minor, myself, and any and all legal successors and proxies may have, now or in the future, against Releasees on account of personal injury, property damage, disability, death, sickness, disease or accident of any kind, arising out of or in any way related to the use of Facilities or participation in Programs, whether that participation is supervised or unsupervised, however the injury or damage occurs, including, but not limited to, the negligence of Releasees.

In further consideration of the use of Facilities and participation in Programs, I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor to **INDEMNIFY AND HOLD HARMLESS** Releasees from any and all causes of action, claims, demands, losses, suits, liabilities or costs of any nature whatsoever, including claims of negligence, arising out of or in any way related to the use of Facilities and participation in Programs.

Minor Name (Print Clearly) _____

Date: _____

Parent/Guardian Signature: _____

Parent/Guardian Name (Print Clearly) _____

GATEWAY SUMMER Y'S KIDS ENROLLMENT APPLICATION 2025

APPLICANT INFORMATION			
CHILDS NAME:		DATE OF BIRTH:	
AGE AT ENROLLMENT		GENDER IDENTITY:	
DATE OF ENROLLMENT:		START DATE:	
STREET ADDRESS:		CITY, STATE, ZIP:	
WHO DOES THE CHILD LIVE WITH:			
PARENT/GUARDIAN INFORMATION			
PARENT/GUARDIAN #1		PARENT/GUARDIAN #2	
RELATIONSHIP TO CHILD		RELATIONSHIP TO CHILD	
DATE OF BIRTH		DATE OF BIRTH	
STREET ADDRESS		STREET ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
HOME PHONE		HOME PHONE	
CELL PHONE		CELL PHONE	
EMAIL		EMAIL	
EMPLOYER		EMPLOYER	
STREET ADDRESS		STREET ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
EMPLOYER PHONE		EMPLOYER PHONE	
HOURS AT WORK		HOURS AT WORK	

School Age Only: Current School _____ Grade _____

I certify that documentation of physical examination and immunization in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements are on file. **Parent/Guardian Initials** _____

Required Documents for Registration:

1. Current custody agreements, court orders and/or restraining orders pertaining to your child
2. Current IEP, IFSP, or 504 Plan

I authorize _____ to sign and/or review all child care documents in my absence.

EMERGENCY CONSENT FORM

Child's Name: _____ Date of Birth: _____ Gender Identity: _____

I authorize staff members in the child care program who are trained in the basics of First Aid/CPR to give my child First Aid/CPR when appropriate. 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 program to transport my child to the nearest medical care facility and/or to _____ and to secure medical treatment for my child.

Child's Physician Name: _____ Phone: _____

Address _____ City _____ State _____
Zip _____

List Allergies/ Special Concerns:

HEALTH INSURANCE INFORMATION			
Insurance Company		Policy Number	
Insured Individual		Relationship to Child	

EMERGENCY CONTACT AND PICK-UP INFORMATION

Parent / Guardian #1		Parent / Guardian #2	
Relationship		Relationship	
Home Address		Home Address	
City, State, Zip		City, State, Zip	
Home Phone		Home Phone	
Cell Phone		Cell Phone	
Do you give permission for your child to	Yes / No	Do you give permission for your child to	Yes / No
Authorized Person #1		Authorized person #2	
Relationship		Relationship	
Home Address		Home Address	
City, State, Zip		City, State, Zip	
Home Phone		Home Phone	
Cell Phone		Cell Phone	
Do you give permission for your child to	Yes / No	Do you give permission for your child to	Yes / No

Parent/Guardian Signature

Date

TRANSPORTATION PLAN & AUTHORIZATION PLEASE CHECK OFF IN BOX BELOW

Child's Name: _____

Please let us know how your child will arrive and leave the program	Parent Drop Off	Parent Pick up	HUB Stop
ARRIVE To The Summer Program			
LEAVE The			

The following is **MANDATORY**. Please initial

☐ I understand that a late fee will be charged to me for late pick-ups and I am responsible to pay in full all fees for child

The following is **OPTIONAL**. Please initial those you choose. I give permission for:

☐ my child to attend all walks within walking distance of the center. Field trips will have prior permission forms

☐ the Y to use my child's picture in Y publicity and media promotions

☐ the Y to use my child's picture inside the facility and/or school

☐ my child to participate in a supervised Y swim program as offered

☐ the Y to communicate with my child's school for any information relevant to the success of my child in both school and the Y program

☐ I give the Y permission to obtain my child's IEP or 504 from their school to be part of the file

Parent/Guardian Signature

Date

ENROLLMENT

Rates	
Financial Assistance available	
Cost: is \$200. per week	
Hours 7AM-6PM	
Please circle the extended program needed	
Program	Weekly
Week 1 7/7-7/11	\$200.
Week 2 7/14-7/18	\$200
Week 3 7/21-7/25	\$200
Week 4 7/28-8/1	\$200
Week 5 8/4-8/8	\$200

Weeks	5 Day a week only
X off your selection for weeks	
Week 1 (7/7- 7/11)	
Week 2 (7/14 - 7/18)	
Week 3 (7/21 - 7/25)	
Week 4 (7/28-8/1)	
Week 5 (8/4-8/8)	

PAYMENT OPTIONS

EFT DRAFT AUTHORIZATION

Checking Account Information

Name of Bank	
Account Holder	
Routing #	
Account #	

Credit / Debit Card Information

Name on Card	
Card Type	☐ Visa ☐ Master Card ☐ American Express ☐ Discover ☐ Other
Card Number	
Expiration Date	

EFT Draft Agreement

Should an EFT draft be declined by my bank or other financial institution, I understand that I am still responsible for that payment plus the Y will apply a \$25.00 service charge.

I understand that I am responsible to inform the Y within 3 days of any account change with updated information.

 Authorized Signature

 Date



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For Preschool Parents Only:

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION Regulations for licensed child care facilities require this information to be on file to address the needs of children while in care. CHILD'S NAME: _____ DATE OF BIRTH: _____

Please provide information for Infants and Toddlers (marked *) as appropriate to the age of your child. DEVELOPMENTAL HISTORY Age began sitting: _____ crawling: _____ walking: _____ talking: _____ *Does your child pull up? _____ *Crawl? _____ *Walk with support? _____ Any speech difficulties? _____

Special words to describe needs _____

Language spoken at home _____

*Any history of colic? _____

*Does your child use pacifier or suck thumb? _____ *When? _____

*Does your child have a fussy time? _____

*When? _____

*How do you handle this time? _____

HEALTH Any known complications at birth? _____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, disabilities: _____

Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: _____

Regular medications: _____

EATING HABITS Special characteristics or difficulties: _____

*If infant is on a special formula, describe its preparation in detail: _____

_____ Favorite foods: _____

_____ Foods refused: _____

Page 2 of 3



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* Is your child fed held in lap? _____ High chair? _____ *
Does your child eat with spoon? _____ Fork? _____ Hands? _____

TOILET HABITS

*Are disposable or cloth diapers used? _____ *Is there a frequent occurrence of diaper rash? _____ *Do you use: oil: _____ powder: _____ lotion: _____ other: _____ *Are bowel movements regular? _____ How many per day? _____ *Is there a problem with diarrhea? _____ Constipation? _____ *Has toilet training been attempted? _____
*Please describe any particular procedure to be used for your child at the center: _____

*What is used at home? Pottychair? _____ Special child seat? _____ Regular seat? *How does your child indicate bathroom needs (include special words): _____
Is your child ever reluctant to use the bathroom? _____

Does your child have accidents? _____

SLEEPING HABITS *Does your child sleep in a crib? _____ Bed? _____ Does your child become tired or nap during the day (include when and how long)? _____

Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver. When does your child go to bed at night? _____ and get up in the morning? _____
Describe any special characteristics or needs (stuffed animal, story, mood on waking etc) _____

SOCIAL RELATIONSHIPS How would you describe your child?

Previous experience with other children/day care: _____

Reaction to strangers: _____
Able to play alone? _____
Favorite toys and activities: _____

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Fears (the dark, animals,
etc.): _____

How do you comfort your child

What is the method of behavior management/discipline at home?

What would you like your child to gain from this childcare experience?

DAILY SCHEDULE Please describe your child's schedule on a typical day. For infants, please include
awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc.

Is there anything else we should know about your child?



The Commonwealth of Massachusetts Department of Early Education and Care

POLICY	
Individualized Health Care Plans	Applicability: All Licensed and Funded Child Care Programs
Effective Date: October 29, 2010 Updated: June 30, 2022	

BACKGROUND

Comprehensive, individualized child care begins with planning and preparation, especially for children with chronic health care needs. It is critical for programs to have a plan that clearly describes what needs to be done, when, and by whom to respond to the child's actual and potential health care needs. Good planning is informed by the child's parents and health care provider, and often includes training and consultation for program staff.

POLICY STATEMENT

The licensee must maintain as part of a child's record, an up-to-date individualized health care plan for care for each child with a chronic medical condition which has been diagnosed by a licensed health care practitioner. This plan is used to outline the child's medical needs and how they should be handled by the program.

An individualized health care plan must include the following:

- The child's name, age, and assigned classroom, if applicable.
- A description of the child's medical condition and its symptoms.
- Instructions for any medical treatment that may be necessary while the child is in care, including the name of the staff person who will be administering the child's treatment while the child attends the program, and identification of any potential side effects of the treatment.
 - Program administrators should use the child's individualized health care plan to identify what specific training and supervision must be available for educators administering the child's treatment plan.
- Explanation of the potential consequences to the child's health if the treatment is not administered.
- Name and contact information of the child's licensed health care practitioner

A program may provide the EEC Individual Health Care Plan form (attached below) to the family to have their child's physician complete or a program may accept equivalent physician's forms (i.e. asthma action plans, diabetes action plans, IEP *with* medical content) as long as those forms contain the same information that would be provided on the EEC form.

A current copy of the individualized health care plan must be maintained in the child's file. It is recommended that a copy of the plan also be in the child's classroom, on field trips, and with the child outdoors, along with any rescue medication, if applicable.

There must be one person trained in the implementation of a child's individualized health care plan whenever the child is in the care of the program¹.

Individualized health care plans must be kept confidential and should be shared only with those program staff who might need to deal with an emergency involving the child.

Individualized health care plans shall be valid for one year, unless withdrawn sooner, and must be renewed annually and following any change to the child's condition for administration of medication and/or treatment to continue.

Please note: Programs must maintain current copies of all required parental consents for medication administration and emergency medical treatment, as required by 606 CMR 7.04(7)(a)4 and 606 CMR 7.11(1) and (2). See also Compliance Requirements for Center-Based Funded Programs 8.13(2)(a)4 and 8.03(3)(b-c). Copies of any applicable written consent forms from the child's parent(s) must be stored with the child's individualized health care plan.

EEC *strongly* recommends that, upon enrollment and re-enrollment, the program talks to parents about their child's individual health care needs.

When is an individualized health care plan required?

A licensee must have an individualized health care plan for any child who has been diagnosed with a chronic medical condition, including but not limited to a condition that may require an emergency response or ongoing, long-term administration of health care procedures. Examples of common conditions that require an individualized health care plan include, but are not limited to:

- asthma
- epilepsy
- diabetes
- serious allergies
- anaphylaxis
- physical disabilities
- ADD/ADHD

For additional guidance and resources, please visit <https://www.mass.gov/lists/health-and-safety-in-childcare-resources-for-child-care-health-consultants>

AUTHORITY

606 CMR 7.11(3)(a)(c): Individual Health Care Plans. *The licensee must maintain as part of a child's record, an individual health care plan for each child with a chronic medical condition, which has been diagnosed by a licensed health care practitioner. The plan must describe the chronic condition, its symptoms, any medical treatment that may be necessary while the child is in care, the potential side effects of that treatment, and the potential consequences to the child's health if the treatment is not administered.*

See also ***Compliance Requirements for Center-Based Funded Programs 8.13(2)(a)8(d).***

¹ All staff who administer medication of any kind must be trained in medication administration, as required by 7.11(1)(b)2.

EEC Individual Health Care Plan Form

Name of child:	Date of Birth:
Name of chronic health care condition:	
Description of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Who has been trained and will be administering this treatment while the child is at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)	

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

Parental/Guardian Signature: _____ Date: _____

Program Administrator Signature: _____ Date: _____

For Older Children ONLY (9+ years of age)

In accordance with 606 CMR 7.11(3)(b-c) and 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's Signature: _____ Date: _____

Program Administrator's Signature: _____ Date: _____