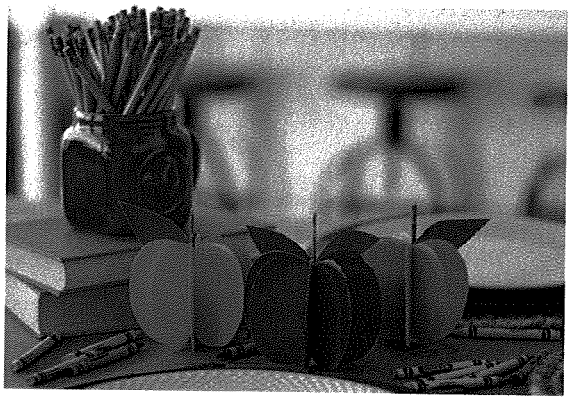
the YMCA
FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF GREATER WESTFIELD
67 COURT STREET, WESTFIELD, MA 01085
413.568.8631 | www.westfieldymca.org

REGISTRATION PACKET FOR THE 2023-2024 SCHOOL YEAR



BEFORE YOUR CHILD MAY ATTEND , YOU NEED TO:

*Complete and return this packet to the Welcome Center

***Preschool** Current physical with Immunization record including lead screening

*Payment for the first week

*Receive a parent handbook

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

PLEASE READ CARFULLY. 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)_____

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ENROLLMENT APPLICATION

APPLICANT INFORMATION			
CHILDS NAME:		DATE OF BIRTH:	
AGE AT ENROLLMENT:		Child's School	
DATE OF ENROLL-MENT:		START DATE:	
STREET ADDRESS:		CITY, STATE, ZIP	
WHO DOES THE CHILD LIVE WITH:			

PROGRAM CHOICE—please select one			
Preschool Programs	School Age Before School	School Age After School	School Age Closures Only

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:

Preschool

1. Immunizations
2. Current physical record with lead screening

All Ages

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.

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EMERGENCY CONSENT FORM

Child's Name: _____ Date of Birth: _____

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 herby 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 Chronic Conditions:

- List doctor diagnosed and documented allergies or chronic conditions such as asthma, food allergies, insect bites/ stings. **Please see Child Care Director to complete the state mandated forms for each condition.**

_____

_____

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 be released to this person?	Yes / No	Do you give permission for your child to be released to this person?	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 be released to this person?	Yes / No	Do you give permission for your child to be released to this person?	Yes / No

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TRANSPORTATION PLAN & AUTHORIZATION PLEASE CHECK OFF IN BOX BELOW

Childs Name: _____

Please let us know how your child will arrive and depart the program	Parent Drop Off	Released from School	Other	Describe
ARRIVE at Preschool Program				
LEAVE Preschool Program				
ARRIVE at the Before School Program				
ARRIVE at the Afterschool Program				
LEAVE the Afterschool Program				

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 care services provided to me by the Y. I must give the Y 2 weeks notice of my intent to withdraw my child from the program and I am

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

_____ my child to work on homework in the After School program

_____ 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

Parents enter a contract relationship with the YMCA in which both parties agree in writing. Those conditions include the child's schedule and tuition rate, acceptance of the Y's policies, and support of the program.

Waiver of Liability: I hereby give permission to the medical personnel selected by the child care director to act in the best interest of my child in the event of an emergency. Every effort will be made to contact the parent/guardian and emergency contacts. In consideration of being allowed to participate in the activities and programs of the Y and to use its facilities, equipment, in addition to any fee or charge, I do hereby waive, release, and forever discharge the Y and its officers, agents, employees, representatives, (collectively the Y), from any and all responsibilities and liability for injuries or damages to myself, including those caused by the negligent act or omission of the Y, or in any way arising out of our connected with my participation in any activity at the Y. I agree to adhere to all policies set

_____ _____

Parent/Guardian Signature **Date**

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ENROLLMENT

SCHOOL AGE (Grades K—6) Select Days:						
Before School Care						
# of Days	M	T	W	TH	F	Cost
2						$25/week
3						$32/week
5						$50/week
After School Care						
2						$40/week
3						$58/week
5						$80/week

SCHOOL CLOSURES ONLY I understand that I must fill out a separate sheet that list all the dates my child(ren) will be attending		
Currently Enrolled in Y's Kids	Dates:	$40/daily
Not Enrolled in Y's Kids	Date:	$40/daily

Preschool (Please check selection)							
# of Days / Program	M	T	W	TH	F	Cost	SELECTION
2 Day AM (2.9—3yrs/9AM-12:00PM)		x		x		$45.00 per week	
2 Day Full Day (2.9-3 yrs./ 9AM-3:00PM)		x		x		$90.00 per week	
3 Day AM (3-5 yrs./ 9-12:00PM)	x		x		x	$65.00 per week	
3 Day PM (3-5 yrs./12:15PM-3:15PM)	x		x		x	$65.00 per week	
3 Day Full Day (9AM-3PM)	x		x		x	$130.00 per week	
5 Day AM (4-5 yrs./ 9-12:00PM)	x	x	x	x	x	$90.00 per week	
5 Day PM4-5 yrs./ 12:15PM-3:15PM)	x	x	x	x	x	$90.00 per week	
5 Day Full Day (4-5 yrs./ (9AM-3PM)	x	x	x	x	x	$170.00 per week	
Pre-K (5 .yrs./9AM-3PM)	x	x	x	x	x	$170.00 per week	
Before School 2 Day (2.9-5yrs/ 7-9AM)						$22/weekly (Select days)	
Before School 3 Day (2.9-5yrs/ 7-9AM)						$28/weekly (Select days)	
Before School 5 Day (2.9-5yrs/ 7-9AM)						$40/weekly (Select days)	
After School 2 Day (2.9-5yrs/ 3-5 PM)						$22/weekly (Select days)	
After School 3 Day (2.9-5yrs/ 3-5 PM)						$28/weekly (Select days)	
After School 5 Day (2.9-5yrs/ 3-5 PM)						$40/weekly (Select days)	

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PAYMENT OPTIONS

EFT DRAFT AUTHORIZATION

Checking Account Information

Name of Bank	
Account Holder	
Routing #	
Account #	

Credit / Debit Card Information

Name on Card	
Card Type (Please Circle)	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?
_____

_____

_____

_____

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Department of Early Education and Care

THE COMMONWEALTH OF MASSACHUSETTS

Small Group, Large Group and School Age Child Care Licensing

POLICY STATEMENT: Individual Health Care Plans

All programs must maintain as part of a child's record, an Individual Health Care Plan (IHCP) for each child with a chronic medical condition which has been diagnosed by a licensed health care provider as required by 606 CMR 7.11(3)(a)-(c). An IHCP ensures that a child with a chronic medical condition receives health care services he or she may need while attending the program.

Programs must develop an IHCP in collaboration with the parents/guardians, school age child who is 9 years or older (when appropriate), program educators and the child's licensed health care practitioner, who must authorize the IHCP.

The IHCP must include the following:

* description of the chronic condition which has been diagnosed by a licensed health care practitioner
* description of the symptoms of the condition
* outline of any medical treatment that may be necessary while the child is in care
* description of the potential side effects of the treatment
* outline of the potential consequences to the child's health if the treatment is not administered

An educator must have successfully completed training relative to a child's ICHP. This training must be given by the child's health care practitioner or, with the child's health care practitioner's written consent, by the child's parent or the program's health care consultant. The training must specifically address the child's medical condition, medication and other treatment needs. Some examples of an ICHP would include children with asthmatic conditions, allergic reactions, ADHD, or diabetic conditions. IHCP's are *not* required for children *without* chronic conditions needing oral or topical medications.

In the event of an ***unanticipated***, non-life-threatening condition requiring treatment (as specified in the IHCP) the educator must make a reasonable attempt to contact the parents/guardians prior to administering the unanticipated medication or beginning the unanticipated treatment. If parent/ guardians cannot be reached immediately, they should be notified as soon as possible after the medication or treatment has been administered to the child.

Educators must ensure that they document the administration of all medications and medical treatments in the child's medication/treatment log.

Written parental and licensed health care practitioner authorization shall be valid for one year, unless withdrawn sooner and must be renewed annually, *or when the child's condition changes*, for administration of medication and/or treatment to continue.

Additional information regarding Individual Health Care Plans:

- Educators with written parental consent and authorization of a licensed health care practitioner may develop and implement an Individual Health Care Plan that permits older school age children *who are 9 years or older* to carry their own inhalers and epinephrine auto-injectors and use them as needed, without the direct supervision of an educator. All educators must be aware of how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an IHCP provides for a child to carry his or her own medication, the licensee must maintain an on-site back-up supply of the medication for use as needed.
- A copy of the IHCP must be maintained in the child's file. It is recommended that a copy of the IHCP also be located in the classroom.
- There must be one person trained in the implementation of a child's IHCP whenever the child is in the care of the program.
- In addition to a licensed health care practitioner, training to implement an IHCP may also be given by the child's parent or the program's health care consultant with the licensed health care practitioner's written consent.

Additional medication requirements to consider:

- Emergency medication such as Epipens must be immediately available for use. For example, Epipens must be brought with children for outdoor play or walks as required by 7.11(2)(f). Training by a licensed health care practitioner for the specific administration of an Epipen is ***highly*** recommended but not required.
- All staff who administer medication of any kind must be trained in medication administration as required by 7.11(1)(b)2.

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: _____