West Suburban YMCA Out-of-School Time Program

Registration Form 2020-2021 School Year

Child's Name:	Program Start Date:
Gender:	Date of Birth:
School Name for 2020-2021 School Year:	Grade for 2020-2021 School Year:
Parent/Guardian's Name:	Telephone number:
Address, City, Zip:	Email:
Parent/Guardian's Name:	Telephone number:
Address, City, Zip:	Email:

I wish to enroll my child in the WSYMCA Out of School Time Program which operated 7:45am-5:00pm (Circle one)

Monday and Tuesday

Monday, Tuesday, and Wednesday

Wednesday, Thursday, and Friday

Thursday and Friday

Monday, Tuesday, Wednesday, Thursday, and Friday

2-Days $180 a week, 3-Days $270 a week, 5-Days $420 a week (Financial Aid is available to families who qualify.)

Please note that once you are registered you will receive a link to complete the remaining application forms online

West Suburban YMCA Out-of-School Time Program Policies

Registration Fee: I have enclosed the required **non-refundable** deposit of $200.00, via check. This deposit will be credited towards your first month's tuition.

WSYMCA Membership: All OST participants are required to have an active WSYMCA Youth or Family Membership. This membership must remain current throughout the entire school year. Children who do not have a current membership at the time of registering for OST 2020-2021 will be required to have one by September 14th, 2020. Please check the appropriate box below:

☐ – My child has an active WSYMCA Youth or Family Membership

☐ – My child will have an active WSYMCA Youth or Family Membership by September 14th, 2020.

Billing Policies: Tuition is based on a weekly fee depending on which days child(ren) are registered for. The weekly rate will be the same regardless of snow days, school vacations, half days, and holidays. Parents will be charged on Monday for the following week, starting September 14th through the end of the school year. The West Suburban YMCA reserves the right to suspend any child if payment is more than thirty days late. Parents will be notified by a "hand delivered" letter two weeks after payment is due. If the parent does not make the payment by the date stated on the letter, the child will not be allowed to attend program for the following week. Child(ren) will be welcome to participate in the program when balance is paid in full and if space is available. Please be aware that if your child is suspended from the program, his/her space will become available to other children on the waitlist. I understand that my child may not be enrolled while having any outstanding WSYMCA balance.

Cancellation/Drop Policy: When enrolling in the West Suburban Out of School Time program it is our expectation that you are enrolling for the entire school year. We understand that there are unforeseen circumstances that you will have to withdraw your child from the program or make changes to their schedule; in this case we require a two-week advanced written notice. **You will be required to pay tuition for these two weeks**. **Families are responsible for cancelling their Youth or Family Membership at the WSYMCA Welcome Center Desk.**

Registration Information:

1. Your child must have a **current** Youth or Family Membership at the West Suburban YMCA throughout enrollment in the program.
2. Complete an Out of School Time After School Program Application.
3. A recent physical dated no later than 12 months from the date of enrollment. Please note that this documentation is required by the Department of Early Education and Care through the State of Massachusetts and your child may not start in the program until this documentation is obtained. This documentation will be stored in your child's confidential file.
4. A **Non-Refundable** $200 payment is required when submitting your child's application.
5. Any child that has a special health care need including an allergy needs to have an Individualized Health Care Plan (IHCP),and is required at time of registration.
6. If applicable, Medication Consent forms, custody agreements, court orders, restraining orders are required at time of registration.
7. If your child has an IEP, a copy of current IEP is required at time of registration and a meeting with the OST Director before being admitted into the program.
8. If we are unable to accommodate your child, s/he will be placed on our waitlist and we will contact you when space becomes available.
9. All enrollment and registration forms need to be completed yearly.

Financial Aid: Financial Aid is available to families accepted into the program. Applications can be requested from the Out of School Time Director or found on our website http://www.wsymca.org. If you are eligible to receive financial aid, a letter stating your award will be sent within 7 days of receiving all required information. Please be aware that if you submit an incomplete application or do not provide all required documentation, your application will not be processed and the amount of your award, if any, may be affected. **Families must re-apply for financial aid each school year.** Please check the appropriate box regarding Financial Aid:

- – I do not anticipate needing financial assistance
- – I plan on applying for financial assistance
- – I have an EEC Voucher

Parent Signature: _____ Date _____

Child's Name: _____ Date of Birth: _____ 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+ years of age)
____ Other: _____

Plan is maintained by:

_____ Director
_____ Assistant Director
_____ Child's Educator
_____ Other: _____

Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signature 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: _____

Parent/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 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: _____

Administrator's Signature: _____ Date: _____

Commonwealth of Massachusetts
Department of Early Education and Care
Medication Consent Form 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please √ one of the following: Prescription _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms _____

Tropical Non-Prescription (applied to open wound/broken skin) _____

My child has previously taken this medication _____

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:
_____
Child's Health Care Practitioner _____ Date: _____

I, _____, (PRINT NAME of parent or guardian) gives permission to authorize educator(s) to administer medication to my children as indicated above.

Parent/Guardian Signature: _____ Date: _____
For topical, non-prescription NOT applied to open wound/broken skin (Parent signature only)