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PROPEL SCHOOLS

YWCA HOMEWOOD-BRUSHTON ☐
YWCA PROPEL BRADDOCK HILLS SCHOOL ☐

Revised Nov 2022

Emergency Contact Parental Consent/Enrollment Agreement

Child's Information

Child's name		Nickname?	Birthdate
Child's home address	City	State	Zip
MALE ☐ FEMALE ☐	Primary language?		Check box if foster child ☐

Family Information

Parent/guardian/sponsor	Relationship to child	Home phone	Cell phone
Home address ***if different from above***			
Employer		Email	
Work Phone		Employer Address	
Other parent/guardian/sponsor	Relationship to child	Home phone	Cell phone
Home address ***if different from above***			
Employer		Email	
Work Phone		Employer Address	

Child Emergency Contact and Person(s) to whom child may be released Information (do not include parents/guardians/sponsors)

Please notify the center if an Emergency Release Contact will pick up your child on a given day.
[For the safety of your child, we request that all authorized pick up persons with whom staff is not familiar provide a photo ID at the time of pick up.]

Person #1	Relationship to child	Telephone number when child is in care	
Home address	City	State	Zip
Person #2	Relationship to child	Telephone number when child is in care	
Home address	City	State	Zip
Person #3	Relationship to child	Telephone number when child is in care	
Home address	City	State	Zip
Primary physician's name/Primary physician's practice name		Phone	
Physician's practice address	City	State	Zip
Preferred hospital/clinic for emergency care			
Child's health insurance provider name		Policy number (***REQUIRED)***	
Special Disabilities (If any)		Allergies (Including Medication Reaction)	
Medical or Dietary information necessary in an emergency situation		Medication Special Conditions	

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	**TRANSPORTATION BY THE FACILITY**

_____ _____
SIGNATURE OF PRIMARY PARENT OR GUARDIAN DATE

******6 Month Review******

_____ _____
SIGNATURE OF PRIMARY PARENT OR GUARDIAN DATE

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Child Name_____

Additional Medical Policies

	Initial
1. Prior to enrollment, I must provide the center with updated medical and immunization information for my child. This information is to be kept current and updated in accordance with state child care regulations.	
2. I agree to provide information to the child care center about my child's conditions, illnesses, allergies or other needs.	
3. If my child becomes ill with a reportable contagious disease, I understand that he/she will not be able to return until I bring in a physician's note stating that he/she is no longer contagious.	
4. If my child becomes ill during his/her time at the child care center, the staff will contact me to pick up my child. I will arrange for pick up as soon as possible and no later than 2 hours after being contacted. If I cannot be reached, the staff will contact those listed in the *Child Emergency Contact and Release*.	

Emergency Medical Authorization & Consent

	Initial
In case of a medical emergency, the staff will attempt to contact me, those listed in the *Child Emergency Contact and Release*, and lastly my physician.	
In case of a medical emergency, I agree that my child may receive first aid and/or CPR.	
In case of a medical emergency, I permit the transportation of my child to a local hospital or other urgent care facility, if necessary by paramedics or other emergency personnel.	
In case of a medical emergency, I will be responsible for the emergency medical expenses.	
In case of an accidental ingestion of a poisonous substance, I consent to my child being treated as directed by the Poison Control Center.	

	Initial
I give my permission to this center to apply □ sunscreen and □ insect repellant to my child. *Please check which product you will permit.*	
I understand that I must supply my own sunscreen and/or insect repellant with a valid expiration date, and it will be labeled with my child's name.	
I have special instructions for the application process. □ None □ _____	

Private Employment Acknowledgement and Release

	Initial
Any arrangement/employment between me and staff of this center (i.e., babysitting), outside of the programs and services offered by this center, is an individual endeavor and private matter not connected or sanctioned by this center. This center shall remain harmless from any such arrangement.	

Handbook Acknowledgement

	Initial
I understand and agree that it is my responsibility to read and familiarize myself with policies and procedures outlined in the Family Handbook and agree to abide by them.	
I understand that it is my responsibility to go directly to management with any questions I may have regarding the policies and procedures and information contained in this Enrollment Agreement.	
Information contained in the **Family Handbook** may be subject to change.	

Contract Approval

I certify that I have read, understand, and accept all of the terms and conditions described in this *Enrollment Agreement* and the *Family Handbook*.

Primary Parent/Guardian/Sponsor Signature	Date	Center Staff Signature	Date

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Agreement

NAME OF CHILD

FEE AMOUNT	**PER: DAY – WEEK**	**DAY PAYMENT TO BE MADE**

FEE AMOUNT PER WEEK **(Payments are to be made each Monday.)** **** PLEASE CHECK ONE ****

☐	Infant	$ 250.00	☐ PA Pre-K Counts I, II and III 8:30 – 4:00	$ FREE
☐	Young Toddler	$ 236.70	☐ PA Pre-K Counts Propel 9:00 – 3:15	$ FREE
☐	Older Toddler	$ 229.00	☐ PA Pre-K Counts Extended Care - AM	$ 53.75
☐	Preschool/Pre-kindergarten	$ 215.00	☐ PA Pre-K Counts Extended Care - PM	$ 53.75
☐	Other _____	$_____	☐ Summer Camp (8:30 AM - 5:30 PM)	$ 215.00
(Please specify: _____)			☐ Summer Camp Extended Care - AM	$ 53.75

Initials _____

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.):

- Quality Care
- Social, educational, emotional and physical development
- Meals (breakfast, lunch, PM snack)
- Activities and field trips

Child's Arrival Time	**Child's Departure Time**	**Person(s) Designated By Parent Whom Child May Be Released:**

Late Pick Up Fee is $2.00 per minute

Extra services to be provided at an additional fee if applicable. *Subsidy payments are accepted as full payment.*

☐ Subsidy ☐ ELRC ☐ CAO ☐ CYF ☐ Other: _____

* Weekly co-pay amounts are determined by the subsidy provider.

Please note:

☐ I agree to give a two-week notice of withdrawal and be responsible for the payment of the final two weeks.

☐ I agree to pay the $37.00 registration fee prior to first day of service.

Initials _____

To the parent/guardian,

☐ I received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ I agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minimum (§ 3270.124, 3280.124, 3290.124)

Signature – Parent / Guardian	**DATE**	**Signature – Operator**	**DATE**

(Office Use Only)

DATE OF CHILD'S ADMISSION

_____

DATE OF WITHDRAWAL

SIX MONTH PERIODIC REVIEW

Signature Parent or Guardian Date

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Child Name_____

Fee Policy (to be completed at center with staff; reviewed and initialed by the parent/guardian/sponsor)

	Initial
- Starting on _____ a fee of **$**_____ is due □ weekly. □ bi-weekly. □ monthly.	
- Tuition is due and payable on the □ first business day of the week. □ the 1st and 15th of the month or next business day. □ first business day of the month.	
- Tuition is not subject to discounts for holidays, emergency closures (i.e., weather), or absence other than hospitalization, contagious illness, or absence at the request of a doctor (a written doctor's note is required to receive credit).	
- I agree to pay the full tuition in advance of services rendered.	
- I agree to pay the full tuition fee even if my child is absent for one or more days.	
- A non-refundable registration fee of **$37.00** is due upon enrollment.	
- A late pick-up fee of **$2.00** per minute per child is due by the next day, if my child is not picked up before closing.	
- Accounts two weeks in arrears may result in immediate termination of service and/or CCIS notified.	
- My child may have the opportunity to participate in a special program or field trip that may have an additional fee due before the day of the event. A specific permission slip may be required.	
- All returned checks will be charged a fee up to the maximum amount allowed by law. Two or more returned checks will result in my account being place on "money order only" status.	
- A receipt for income tax purposes will be provided at my request.	

_____ _____

SIGNATURE OF PRIMARY PARENT OR GUARDIAN DATE

*** ***SIX MONTH PERIODIC REVIEW*** ***

_____ _____

SIGNATURE OF PRIMARY PARENT OR GUARDIAN DATE

MULTIMEDIA PERSONAL/PUBLICITY RELEASE

I give permission to YWCA Greater Pittsburgh, ("YWCA"), its affiliates and their successors and assigns (collectively the "YWCA"), the right, but not the obligation, to use, edit, dub and/or otherwise change, audio and/or video record, publish and re-publish, in whole or in part, without restriction as to changes or alterations, in any media (e.g., newspapers, magazines, other print media, radio, television, the Internet and social media sites, and via any other means) now known or hereinafter developed, for any promotional, advertising, fundraising or commercial purposes, my name, biographical information (specifically excluding any treatment records), photograph(s), voice and/or image (collectively, "My Likeness").

This Release constitutes the entire understanding between me and the YWCA with respect to the subject matter hereof and cannot be amended or revoked except in writing signed by me and sent to YWCA Greater Pittsburgh, 305 Wood Street, Pittsburgh, PA 15222 Any such revocation will only apply prospectively to new uses of My Likeness.

I have read the above authorization and release prior to signing below, am fully familiar with the contents thereof, understand that no royalty or any other fee will be paid to me and agree that it shall be binding upon me and my heirs and assigns. I understand that the YWCA has been induced to proceed with the use of My Likeness in reliance upon this Release.

I hereby release the YWCA from any liability whatsoever which may involve the use and/or publicizing of My Likeness.

Parent/Guardian Signature:_____ Date: _____

Print CHILD'S Name: _____

Email: _____

Phone Number: _____

[IF PERSON IS UNDER 18:] I represent that I am a parent (or legal guardian) of the minor who has signed the above Release and I hereby agree that we shall both be bound hereby.

Signature: _____ Date: _____

Print Name: _____

ACCEPTED BY: By: _____

YWCA GREATER PITTSBURGH TITLE: _____

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Child Name_____

Activity/Field Trip Release Agreement

PLEASE READ AND SIGN BELOW

1. I give my permission for my child to attend and participate in all activities and field trips associated with the YWCA Homewood-Brushton Child Care Center. I understand that my signature indicates permission.
2. I authorize the YWCA Homewood-Brushton Child Care Center staff to take my child to the closest medical facility in the event of a medical emergency. I understand that I am financially responsible for all incurred costs not covered by my health insurance.
3. I release the YWCA Homewood-Brushton Child Care Center staff from any liability of any lost or stolen property.

My signature indicates that I have read, understand, and am willing to abide by all rules and regulations put forth the Family Handbook. My signature also indicates that I am the parent/guardian of the child I have registered. I give my permission indicated in #1; I give my permissions as indicated in #2; and I agree to release YWCA staff from liability as indicated in #3.

_____ _____

Parent/Guardian Signature Date

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PROPEL SCHOOLS

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

Parents may write immunization dates; health professional should verify and complete all data.

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

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Child and Adult Care Food Program

Child Enrollment Form

Enrollment Date:

Child _____
Address _____
_____
Birth date _____

Parent/Guardian _____
Address _____
_____
Telephone (home)_____(work)_____

Sponsoring Organization _YWCA Greater Pittsburgh___
Address ___6907 Frankstown Avenue_____
___Pittsburgh, PA 15208_____

Center/Home ___YWCA Homewood-Brushton Child Care___
Address _____6907 Frankstown Avenue_____
_____Pittsburgh, PA 15208_____

Normal Hours of Care (Please write in times for each day`) *

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start: End:	Start: End:	Start: End:	Start: End:	Start: End:		

* If more than 8 hours of care per day, please attach an explanation to this form.

Daily Expected Meal Service Participation (Please check box)

Breakfast	AM Snack	Lunch	PM Snack	Supper	Eve Snack

Is this child of school age? ___Yes ___No If yes, will additional meals be provided when school is not in session? ___Yes ___No If yes, please specify the meal: ___Breakfast ___Lunch ___Snack ___Supper

Parental Contacts: This childcare facility participates in the Child and Adult Care Food Program. In order to receive federal funds, representatives of the sponsoring organization or the State Agency may contact you to verify your child's participation. Please indicate what time and method of contact you prefer:

_____Day _____Evening _____Time

_____Letter _____Telephone (home) _____Telephone (work)

Signature _____ **Date** _____
Parent/Guardian

Signature _____ **Date** _____
Center Administrator/Home Provider

"In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs). "

" To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer."

CHILD WITHDREW ON: _____

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PROPEL SCHOOLS

Child and Adult Care Food Program
Child Care Center Meal Benefit Income Eligibility Form

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your center director, Homeless Liaison, Migrant Coordinator at Phone #]** Homeless ❑ Migrant ❑ Runaway❑

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: _*_*_*-_*_*-_ _ _ _ ❑ I do not have a Social Security Number

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Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: _____ Eligibility: Free_____ Reduced_____ Denied (Paid)_____ Date Withdrawn: _____

Reason for Denied:___ _____

Temporary: Free Reduced Time Period: (expires after days)

Determining Official's Signature: Date:

Confirming Official's Signature: Date:

Follow-up Official's Signature: _____ Date:_____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly (effective 7-1-22 to 6-30-23)
One	$25,142
Two	$33,874
Three	$42,606
Four	$51,338
Five	$60,070
Six	$68,802
Seven	$77,534
Eight	$86,266
For Each Additional Family Member	+$8,732

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

Fax: (202) 690-7442

Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT SUPPLEMENT FOR INFANTS

Directions: This enrollment supplement must be completed for all infants in care at the time of enrollment to determine responsibility for providing infant formula as part of the Child and Adult Care Food Program. Please have the parent sign and date two forms. Send one to your sponsoring organization and keep the other as part of the infant's enrollment file.

Infant Name: _____ Date of Birth: _____

Home/Center Site: _____

PARENT CHOICE:

_____ The Parent/Guardian will furnish the infant's formula:

_____
Indicate Breast milk or Type of Formula

NOTE: If the above type of formula does not meet CACFP requirements, please attach a copy of the physician's medical statement recommending this type of formula.

Are there any special circumstances or conditions indicated by the infant's physician?

_____

_____

_____

As parent of the above-named child, understand that I may change my decision regarding furnishing infant formula with proper two (2) week notice prior to change.

_____

Parent's Signature and Date

YWCA Homewood-Brushton Early Learning, Child Development & Education

6907 Frankstown Avenue, Pittsburgh, PA 15208 ♦ Phone: (412) 361-6433 ♦ Fax: (412) 361-8601

Getting to Know Your Questionnaire

Dear Family,

We look forward to developing a partnership with your family in our program. You provided us with a lot of important medical and contact information during enrollment. We'd like to ask you a few more questions that will allow us to get to know you and your child a little better. Please let us know if you have special needs such as handicap access or translation services. Our goal is to do the best job we can do, welcoming your family into our program and creating a comfortable environment for your child. Would you kindly take a few minutes to complete this questionnaire and bring it with you to your "Getting to Know You" meeting with your child's teacher?

With much appreciation,

Cheryl Smith

Cheryl Smith, M.Ed
Program Director of Homewood-Brushton Early Learning, Child Development & Education

Name of Child _____ Child's Age _____

Enrollment Date _____ Meeting Date _____

1. Does your child have a nickname? Please provide it if you would like us to use it.

2. In what language do you and your child communicate at home?

3. Is there information about your family composition or household members that you would like to share?

4. What are some of your child's favorite things?

5. Are their cultural or religious holidays that your family observes that you would like to share with the program?

6. What are your child's toileting and napping behaviors?

7. Does your child have any special needs?

8. What are your child's favorite foods?

9. Is there anything else you can share with us about your child that will help us ease the transition for your child?

10. Is there anything else you would like to share about your child, you or your family?

11. Strong involvement is one of our keys to success. Here are some volunteer opportunities. In which of these would you like to participate?

    a. Family Fun Night Volunteer _____
    b. Fundraisers _____
    c. Classroom Parties and Celebrations _____
    d. Field Trips _____
    e. Parent Committee / Parent Council

We would love to have the opportunity to meet with you to talk about the information you have shared with us. If you would like to set up a "Getting to Know You Meeting" with your child's teacher and/or the Director, please check the following as it applies:

_____ Yes, I would like to set up a meeting. I am available to meet in person on _____ at _____.

_____ I am not able to meet in person, however, I am able to schedule a phone conference on _____ at _____.

_____ No thank you, I am not interested at this time.

_____ _____

Parent / Guardian Signature Date

*** YWCA Alert System ***

Dear Parents,

The YWCA Greater Pittsburgh has an alert system to notify you of school closings, delays, and other important information regarding the child care center. Please complete the following information to ensure we have your most current contact information on file.

I would like to receive alert notices sent to my: (check <u>ONE</u> of the following) *Please PRINT*

☐ Cell Phone (text and voice message) _____

☐ Home Email _____

☐ Work Email _____

Parent/Guardian Name _____

Child(ren) Name(s) _____

_____

_____

_____ _____

Parent/Guardian Signature Date