

Emergency Contact Parental Consent/Enrollment Agreement				
Child's Information				
Child's name		Nickname?		Birthdate
Child's home address		City	State	Zip
MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	Primary language?		Check box if foster child <input type="checkbox"/>
Family Information				
Parent/guardian/sponsor	Relationship to child		Home phone	Cell phone
Home address <i>if different from above</i>				
Employer			Email	
Work Phone			Employer Address	
Other parent/guardian/sponsor	Relationship to child		Home phone	Cell phone
Home address <i>if different from above</i>				
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)				
<i>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.]</i>				
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
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

Child Name _____

Additional Medical Policies

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.	Initial
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 <i>Child Emergency Contact and Release</i> .	_____

Emergency Medical Authorization & Consent

In case of a medical emergency, the staff will attempt to contact me, those listed in the <i>Child Emergency Contact and Release</i> , and lastly my physician.	Initial
_____	_____
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.	_____

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

Private Employment Acknowledgement and Release

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.	Initial
_____	_____

Handbook Acknowledgement

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.	Initial
_____	_____
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

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 <input type="checkbox"/> weekly. <input type="checkbox"/> bi-weekly. <input type="checkbox"/> monthly. 	_____
- Tuition is due and payable on the <input type="checkbox"/> first business day of the week. <input type="checkbox"/> the 1st and 15th of the month or next business day. <input type="checkbox"/> 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
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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: _____

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

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:
<input type="checkbox"/> 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

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:

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

Child and Adult Care Food Program

Child Enrollment Form

Enrollment Date: _____

Child _____ Address _____ Birth date _____	Parent/Guardian _____ Address _____ Telephone (home) _____ (work) _____
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Sponsoring Organization <u>YWCA Greater Pittsburgh</u> Address <u>6907 Frankstown Avenue</u> <u>Pittsburgh, PA 15208</u>	Center/Home <u>YWCA Homewood-Brushton Child Care</u> Address <u>6907 Frankstown Avenue</u> <u>Pittsburgh, PA 15208</u>
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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."

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CHILD WITHDREW ON: _____

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
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
	<input type="checkbox"/>			<input type="checkbox"/>
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 <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway <input type="checkbox"/>				
Part 4. Total Household Gross Income—You must tell us how much and how often				
A. Name (List only household members with income) <i>(Example)</i> Jane Smith	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
	\$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>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.</i>				
Sign Here: _____		Print Name: _____		
Date: _____				
Address: _____		Phone Number: _____		
City: _____		State: _____		Zip Code: _____
Last four digits of Social Security Number: * * * - * * - _____ <input type="checkbox"/> I do not have a Social Security Number				

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

Mark one ethnic identity: _____ Mark one or more racial identities: _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| | <input type="checkbox"/> Black or African American | |

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.

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 there any 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 ONE 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