



**FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

ASHLAND YMCA PRESCHOOL "DIP IN" CAMP 2026

Welcome to the YMCA Preschool "DIP IN" Camp! The registration packet has several important documents that must be completed in full for your child to participate in our program. Be sure to answer each question completely, no matter how repetitive they may seem. **ALL** forms, fees (including outstanding bills) and information **MUST** be complete before your child can be accepted. The completed packet needs to be returned a minimum of 48 hours before the intended start date. If the form does not apply to your child, please put your child's name on it and sign with some indication that it does not pertain to you. To receive the member price, you **MUST** have up to date membership or "Membership for All" eligibility at the time of registration. The registration fee is \$25 dollars. The registration fee is non-refundable. After completion of the registration materials, the administrator will review your paperwork, and the registration process will be finalized at that time. You will **receive a welcome email** and updates by way of **email** about important dates and materials, so please be sure to include an email address for updates to be sent to. Payment arrangements will be made through the welcome email. You CAN NOT make payment if returning the packet at the front desk. Most communication will be through email so please check often while attending our program.

"DIP IN" Camp varies from our traditional summer camp program. With this program you can sign up for 4 or 6 specific weeks of the summer to attend our camp. The pricing is a one-time price paid at registration. Once you are registered you can pick 4 or 6 weeks to attend throughout the summer, instead of being committed to the entire summer. You must indicate at registration what weeks you will attend. The weeks are non-refundable so please be sure to mark down what weeks your child will attend when you register. It will be indicated in your welcome letter as well to help you remember. If you have any questions, please feel free to contact me. I am so excited for our summer to begin and look forward to meeting all of your families! If you have any further questions or concerns do not hesitate to reach out, use the phone number or email address listed below.

Most sincerely,

Christie Krumlaw

Christie Krumlaw
Ashland YMCA Child Development Director
ckrumlaw@ashlandy.org
419-289-0626

Preschool Summer Camp Calendar 2026

June

9th - First Day of Summer Camp

July

31st- Last Day of Summer Camp

August

3rd-7th- Weekly Rates for Transition Care

10th-14th- Weekly Rates for Transition Care

17th-21st- Shut Down Week (No Care Provided)

24th-31st- Transition Care for families who will attend the 2026/2027 school year

September

1st-4th- Transition Care for families who will attend the 2026/2027 school year & attended Summer Camp

7th- Labor Day- Center Closed

8th- Preschool closed for prep & Open House 6-7:30pm

9th- First Day of 2026/2027 School Year

YMCA PRESCHOOL SUMMER CAMP T-SHIRTS

Every year you may purchase matching T-shirts to wear on special days at camp. The shirts are \$11.00 and cover the cost of the shirt and the printing. You may also purchase a YMCA drawstring bag for \$7.00. Please send this in with a check made payable to the YMCA of Ashland, Ohio. **This is not required** of the children but we will have days where they will be given the opportunity to wear the shirts to "DIP IN" Camp. Please write a separate check and give to administration for proper record keeping. **This is only an option to buy until camp begins in June.**

*This is not required just something we offer to the children

-----cut here-----

Child's Name _____

Shirt Sizes:

CXS _____ CS _____ CM _____ CL _____ AS _____ AM _____ AL _____

Bag Colors:

Purple _____ Green _____ Red _____ Royal _____ Black _____

Parent/Guardian Signature _____

Administrator use only:

_____ Enclosed \$12.00 for the cost of the shirt

_____ Enclosed \$8.00 for the cost of the bag

_____ Enclosed \$20.00 for the cost of a shirt and bag

Ashland YMCA Preschool "DIP IN" Camp Registration

Is your child a member of the YMCA YES NO Expiration Date _____

Child's **Full** Name _____
(FIRST, MIDDLE AND LAST)

Birthdate _____ Age of child upon enrollment _____

Address _____

City _____ Zip _____

Email Address _____

Cell Phone for Alerts _____

Mother/Guardian _____

Phone(home) _____ (work) _____

Father/Guardian _____

Phone(home) _____ (work) _____

****A non-refundable registration fee of \$25 must accompany this form. You must have a membership to receive member pricing. ****

Days and Times:

Mon _____ Tues _____ Wed _____ Thur _____ Fri _____
IN/OUT IN/OUT IN/OUT IN/OUT IN/OUT

PRICING for "DIP IN" Camp 6:30am-6pm (please circle all that apply)

4 wk	Member	Guest	6 wk	Member	Guest
5 day	\$650	\$820	5 day	\$1110	\$1420
3 day	\$450	\$670	3 day	\$760	\$1020

WK1 6/15-6/19	WK2 6/22-6/26	WK3 6/29-7/3	WK4 7/6-7/10
WK5 7/13-7/17	WK6 7/20-7/24	WK7 7/27-7/31	

Will your child require a nap on the days they attend _____ yes _____ no (please check one)

Parent initials Date

Financial Agreement

I agree to pay the Ashland YMCA "DIP IN" Camp the stated amount of tuition indicated for my child's care. Tuition is due at registration. To receive the member rate, I understand that my child must be an active member. I understand that I do not attend all of the weeks that are registered for that they are non-refundable and will not receive a credit or refund for weeks not used. I understand that I am signing up for a specific amount of weeks and cannot break the weeks into days used in different weeks.

Parent initials

Swimming, Gymnastics and Walking Field Trip Permission

Child's Name _____ DOB: _____

Please check all that apply:

My child has my permission to participate in the YMCA swimming program that will take place in the West Pool in the main building. The center will have two supervising staff and a certified lifeguard on duty at all times.

My child also has permission to participate in gymnastics lessons and activities. Children will be supervised and assisted during lessons, to maintain a safe and healthy environment.

The YMCA preschool will go on walking trips, weather permitting, within a two-block radius. Children will be taught safety while on the walking trips, under the supervision of classroom staff. During walking trips children will not be near water more than two feet. There will not be extra staff above the licensing requirements.

My child is a:

Swimmer

Non-swimmer

**While swimming with the preschool, the child will wear Coast Guard approved water safety device regardless of what is checked here. **

*Parent signature _____ Date _____

Parent notes or relevant information regarding these activities:

I do not give permission to participate in any of the activities listed above

*Parent signature

_____ Date _____

Ashland Family YMCA Preschool
"DIP IN" Camp Emergency Pickup Information

Persons authorized to pick up child from camp other than custodial parent: Must name AT LEAST one.

Child's Name _____

Child's birthdate _____ Email _____

Address _____

Parent who should be contacted **FIRST:**

(name of parent) _____ (phone number) _____

Person to contact **SECOND**/relationship/phone

(name of contact) _____ (phone number) _____

Authorized pick up individuals:

<u>Name</u>	<u>Relationship</u>	<u>Phone</u>
1. _____		
2. _____		
3. _____		
4. _____		

Roster Permission

The State of Ohio requires preschools to have a roster of all children enrolled in preschool. HOWEVER, the only thing I need to have on it is the child's name. I make a roster of parent's names, phone, address and email for your convenience. You are welcome to use this info to invite children to play or for party invitations. We do not use it to solicit or harass our families. You can choose what information you wish to share; all or just a few things

Pick what you wish to be listed on roster:

_____ Mom's name _____ Dad's name _____ Email _____ Future School System

_____ Address _____ Phone _____ Child's birthday

YMCA PHOTO/AUDIO VISUAL/Narrative RELEASE

I am 18 years of age or older and, if not, my parent or legal guardian has also provided their consent by signing below.

Consent & License. For my participation in activities to be conducted by the National Council of Young Men’s Christian Associations of the United States of America (“YMCA of the USA”) or any of its chartered member associations in the United States (collectively “the Y”), and collaborating third parties, I consent, now and for all time, to the making, reproduction, editing, broadcasting or rebroadcasting of:

- 1.video film or footage of me,
- 2.soundtrack recordings of me
- 3.photo reproductions of me
- 4.any narrative account of my experience

My consent includes a perpetual license to the Y and collaborating with third parties for the use of the above materials for publication, display, sale or exhibition in promotions, advertising, education and commercial uses. Use includes reproductions in any form and media currently existing or later conceived, adaptations and/or revisions, throughout the world in perpetuity.

I understand and agree there may be no additional compensation for this license, and I will not make any claim for payment of any kind from the Y or collaborating third parties. I may, or may not be, identified in such licensed uses; however, my name will not be used to endorse any products or services.

Ownership, Confidentiality, and Shared Use. With respect to any of the above uses, I further agree:

- 1.All works shall belong to YMCA of the USA;
- 2.The Y has no duty of confidentiality regarding any licensed uses.
- 3.YMCA of the USA shall exclusively own all known or later existing rights to the uses throughout the world.
- 4.The Y and collaborating third parties may use any video film, footage, soundtrack recordings and photo reproductions of me and/or my narrative account for any purpose without additional compensation to me.

Release from Liability. I agree that my consent is irrevocable. I hereby release and discharge The Y and collaborating third parties, from any and all claims, actions, lawsuits or demands of any kind arising out of my consent, license grants, uses, or the shared uses of any works or materials referenced herein.

Printed Name (of child): _____ Age: _____

Address: _____

I am the parent or legal guardian of [redacted]. I hereby consent and grant the licenses detailed in the foregoing on behalf of my minor child.

Signature of parent or legal guardian: [redacted]

Printed name: _____

Sign this portion only if you give permission to use your child’s picture on the YMCA website, social media or advertisement

Homeroom Page Photo Release

The Ashland YMCA “DIP IN” Camp shares photographs of classes and participants on our gethomeroom.com website to show families what we do all day. We would like your permission to use photographs of our day on our website. If you do not grant permission, please indicate this below.

I give the YMCA permission to use photographs of my child/children on the website. [redacted] Parent initials

OR

I **DO NOT** grant permission, and the YMCA may not use my photos on the website. [redacted] Parent initials

"DIP IN" Camp Scheduled Payment Authorization/Agreement

I _____ authorize my bank to make payment to the Ashland YMCA by method indicated below, and post it to my account for my child _____'s

CHILD'S NAME

care at the Ashland YMCA Preschool. (please circle the appropriate **category** and **amount of days**.)

"DIP IN" Camp		
4 WEEKS	3 DAYS	Member
6 WEEKS	5 DAYS	Non-member

Amount Paid _____ upon registration completion

Checking _____ Bank Name _____

NOTE: for checking account authorization, a voided check is needed

Account # _____ Routing # _____

Credit Card _____ Mastercard _____ Visa _____ Discover _____ Other _____

Account # _____

Expiration Date ____/____/____ (For credit card payments)

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

I understand that I am in full control of my payment, and if at any time I decide to make any change or discontinue the service, I will call or write to the above company. A two-week notice is needed to make any changes. Change of payment will not affect other provisions and terms of my contract. Payment will be scheduled to be paid one week after registration is completed and welcome email has been sent out.

Signature _____ **Date** _____

Scheduled Payment Agreement

I UNDERSTAND that when enrolling in the Ashland YMCA "DIP IN" Camp using Scheduled Payment as the method of payment, I also understand that any outstanding payments not received within 60 days will be turned over to RBC Collection agency. Returned items or denied transactions will have a fee of \$15.00 charged. **Initials** _____

****There is a 3% charge for card payments.**

Support Identification

To provide a supportive learning environment and promote positive behaviors, we recognize supports and accommodation enable children to reach their fullest potential in a safe environment. Therefore, we have identified several types of strategies that may be helpful to participants. We also recognize that the introduction of these strategies may impact our staff to child ratio and the well-being of all the children in attendance.

For all applicants, we are documenting and reviewing supports identified by the parents/caregivers as they enroll their child in the program. With this information we determine if we can provide a safe and effective learning environment, we make decisions on whether we are the appropriate placement for each child who desires to enroll in the YMCA program.

Child's Name _____

_____ needs no supports at this time. Please sign below.

_____ needs the following supports and I have the documentation needed to receive these supports. Please mark appropriate supports and sign below.

_____ Behavioral Supports	_____ Health Supports
_____ Communication Supports	_____ Instructional Supports
_____ Natural Supports	_____ Social Supports
_____ Transition Supports	_____ Universal and Accessible Physical and Program Design Supports

If you have information on recent assessments in the areas listed below that would help identify appropriate strategies. Please provide documentation and sign below.

_____ Behavioral Supports	_____ Health Supports
_____ Communication Supports	_____ Instructional Supports
_____ Natural Supports	_____ Social Supports
_____ Transition Supports	_____ Universal and Accessible Physical and Program Design Supports

***Must be documented by a professional in written form prior to attendance and implementation. Please see the next page for support explanation.**

Parent initials

Support Definitions

Behavioral Supports- intended to minimize challenging behaviors. These behaviors are intended to communicate and when attempting to eliminate behavior child's frustration may be magnified. Professionals need to pinpoint what is being communicated and what environmental factors are contributing to the behaviors. When it is known what is communicated and contributes to the behavior positive support can be implemented to eliminate the risk of behaviors being displayed.

Communication Supports- intended to ensure the child understands thoroughly what is expected. Each intervention must be clear and purposeful in communication through verbal, nonverbal and kinesthetic feedback. Professionals will willingly communicate expectations, requests, and acceptable behavior parameters to create motivating and safe environments. The communication the child receives will assist them in being able to sort out what is important and respond to what they hear.

Health Supports- intended to accommodate physiological well-being and function at their maximum capacity. The use of proper diet, rest, pain management and sunlight exposure is managed. Use of quiet spaces to help regain composure as well as medications and physical activity levels will be monitored to support the child.

Instructional-leadership Supports- intended to support engagement. Professionals will plan and structure predictable environments to focus on strengths and goals.

Natural Supports- intended to be support from a family member whose preferences support the child. Support occurs when there are balanced meals and there are designated areas for appropriate choices.

Organizational Supports- intended to be supports given by collaborative team of professionals and care givers. An inclusive plan will be developed to support the child and a zero-tolerance approach will be taken to implement the support.

Social Supports- intended to help the child gain social competence, become aware of social expectations, gain information through interactions and exchange feelings during an experience.

Transition Supports- intended to help the child transition from one location to another or to another program. This support can also be used to move from one activity to another within the classroom.

Universal Design and Program Supports- intended to assist in designing structures for all children regardless of ability. Barriers are minimized and access is maximized by, for example, signs and checklists to cue children. Multiple engagement opportunities are offered to include children with a range of diverse abilities and skills.

**Family Information For Step Up to Quality
PRESCHOOL**

Child's Name (Last)	(First)	Nicknames (if any)
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By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff while caring for your child

Who is in the child's immediate family?

Who lives at home with the child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, divorce, new home, death or birth of a family member, friend or pet.

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, etc)

Has your child had a previous care arrangement? Yes No (if yes circle one: Center based, in home, with family, with parents, other_____)

Are there foods your child dislikes/ likes that we should be aware of? Yes No

Likes	Dislikes
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Are there any foods that your child should not be fed? (allergies, culture, religion based)
Licensing documentation be completed for children with food allergies and/or dietary restrictions
 Yes No

Describe your child's personality and behavior

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

Other comforting techniques you may use?

What can cause your child to be angry or frustrated? How do you respond?

What is the discipline policy in your home?

Does your child nap? __Yes __No

What is your child's mood upon waking up?	How long does your child nap at home?
Does your child have trouble sleeping?	Does your child need something to comfort them while sleeping?

Does your child need assistance using the toilet? How do they let you know when they need to use the toilet? (words, gestures, signs)

What might you and/or your child be anxious about as he/she starts in this program?

What are you and/or your child excited about as he/she starts in this program?

What are your expectations of this program?

Any other information that would be helpful for the staff caring for your child to know?

Parent Signature

Date

Family Needs Survey for Step up to Quality

We want to support any needs you or your family may have. The information you provide on this for is
CONFIDENTIAL

Please circle Y (Yes) or N (No) to best describe your current situation for each topic. If you circle Y for an item, please briefly list the CONCERN if this is an area of need for your child or family. Our goal is to provide resources to support you and your family, based on your answers.

Child/Children's Name(s):	Caretaker's Name:	Date Completed:
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TOPICS	Briefly List CONCERN
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Child Development and Education- Does anyone in your family have any need for resources or support in the areas listed below?

Y N	Information on growth and development.	
Y N	Guiding and supporting a child's behavior.	
Y N	Medical or disabilities or possible conditions for any child or adult in the family.	
Y N	Obtaining toys or activities to use to help any child in your home.	
Y N	Preparing your child for kindergarten.	

Child and Family Health- Does anyone in your family have any need for resources or support in the areas listed below?

Y N	Health insurance and/or access to regular medical care, dental care or medications.	
Y N	Medical or health supplies or supports that anyone in your family needs.	
Y N	Accessing immunizations.	
Y N	Finding a pediatrician, general practitioner, dentist, therapist, psychologist, optometrist, or other specialty practitioner.	
Y N	Concerns with depression, anger, anxiety, or mental health needs.	
Y N	Concerns with alcohol, drug or addiction problems.	

Financial and Household Supports- Does anyone in your family have any need for resources or support in the areas listed below?

Y N	Help paying for childcare.	
Y N	Help finding housing or safe housing.	
Y N	Help paying your mortgage or rent.	

Y N	Help with food expenses.	
Y N	Finding household items such as furniture, clothing, or school supplies.	
Y N	Access to transportation or transportation expenses.	
Y N	Attending school (such as GED, Certifications or college degrees)	
Y N	Help finding work or job training	

Are there other needs you or your family have that are not listed above:

Parent Signature:	Date:
Administrator or Designee Signature:	Date:

FOR STAFF USE:

Resources provided to the family:
Administrator or Designee Signature and Date:
Referrals provided to the family:
Administrator or Designee Signature and Date:

Ohio Department of Job and Family Services
CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name (<i>print or type</i>)	Date of Birth
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Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

The above named child has been examined.

The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

The above named child does not have allergies OR is allergic to the following (*please list in space below*):

Check below, if applicable:

Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____	Vision _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lead _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight _____	Hearing _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemoglobin _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
BMI _____	Dental _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other: _____		

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
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Name of Examining Health Care Practitioner	Telephone Number
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Street Address	City, State and Zip Code
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ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (Complete ONLY ONE SECTION below)

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases: Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:

The above named child has been immunized against the diseases listed above.

If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):

Initials of Examining Health Care Practitioner
Date

Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S):

I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):

Signature of Parent
Date

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth		First Day at Program/Home	
Home Address				City	
State		Zip Code	Home Telephone Number		
Parent/Guardian Name #1			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip		
Email Address (if applicable)			Cell Phone (if applicable)		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Parent/Guardian Name #2			Relationship to Child		
Home Address <input type="checkbox"/> Same as Child's			Home Telephone Number <input type="checkbox"/> Same as Child's		
City		State	Zip		
Email Address (if applicable)			Cell Phone		
Parent's Work/School Name			Parent's Work/School Telephone Number		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which information above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program/home?					
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached . Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name			Name		
City		State	City		State
Telephone Number		Relationship to Child		Telephone Number	
Relationship to Child		Relationship to Child			
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City		State	Telephone Number		

Child's Name
Allergies, Special Health or Medical Conditions, and Medical Foods
Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.
Does your child have any food, medication or environmental allergies? (<i>check all that apply</i>) <input type="checkbox"/> No <input type="checkbox"/> Yes - <i>check all that apply</i> <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Environmental Please list and explain:
Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (<i>check one</i>) <input type="checkbox"/> No <input type="checkbox"/> Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.
Does your child have a developmental delay or special health or medical condition? (<i>check one</i>) <input type="checkbox"/> No <input type="checkbox"/> Yes - please explain
Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (<i>check one</i>) <input type="checkbox"/> No <input type="checkbox"/> Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.
Is your child currently using any medication or medical food? (<i>check one</i>) <input type="checkbox"/> No <input type="checkbox"/> Yes - please explain
If yes, does this medication or medical food need to be administered at the child care program/home? <input type="checkbox"/> No <input type="checkbox"/> Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.
Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (<i>check one</i>) <input type="checkbox"/> No <input type="checkbox"/> Yes - please explain
Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group? <input type="checkbox"/> No <input type="checkbox"/> Yes - written instructions from the child's health care provider must be on file. <input type="checkbox"/> N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or **medical personnel** in an emergency situation.

Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

Not applicable

Child's Name

This portion does not pertain to this program

Diapering Statement

Is your child toilet trained? Yes (If yes, skip to Emergency Transportation Authorization section)
 No (If no, fill out the following:)

The program's policy is to check diapers every N/A hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

I agree with the program's schedule I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport		OR	Do Not Give <u>Permission</u> to Transport	
Program or Home Name Ashland YMCA has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			Do not sign both	Program or Home Name does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature	Date	Parent's Signature		Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. Yes No (check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:

This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

****We are a fully potty trained facility.**

We cannot diaper the children in our care.***