Child's Name: _____

School _____**Before care** _____**After care**_____

SACC Registration Checklist

_____ YWCA Family SACC Registration fee $75

_____ Payment of first month of program for the child/ren Receipt# _____

_____ Front Desk autopay payment sheet

_____ Enrollment Form with E-mail section complete and legible

_____ Financial Acknowledgement signed & dated

_____ Medical Health History Form completed by parent, signed and dated

_____ Copy of most recent shot record

_____ Current Physical- Not older than 2 years (If we have one on file, this may be used)

_____ Written Medication Consent (if needed for on site medications)

_____ OCFS Health Screening Form signed and dated

_____ SACC Handbook Acknowledgement – Please keep & read this for important information

_____

DSS Clients: ___ Approval Letter from DSS

___Caseworker Name: _____Phone#_____

INCOMPLETE REGISTRATIONS WILL NOT BE ACCEPTED

PLEASE NOTE: All completed paperwork must be submitted to the YWCA by 4:30pm Friday, August 20th to start the first week of school.

NO EXCEPTIONS

If any registration paperwork is submitted after Aug. 20th, your child will not be able to begin the SACC program until week of Sept 13th.

ENROLLMENT DATE (m/d/year) _____ **SCHOOL**_____

YWCA OF THE NIAGARA FRONTIER
SCHOOL AGE CHILDCARE PROGRAM ENROLLMENT FORM

Start Date. _____

Days enrolled per week: Before School Program _____ am	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri	
Days enrolled per week: After School Program _____ pm	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri	

Child's Name_____ Age_____ Birth Date _____

Gender M / F Grade _____ Teacher Name & Room #_____

Address _____ City, State, Zip_____

Parent/Guardian Name_____ Ph. # (Home) _____

Parent/Guardian Address_____ Ph. # (Cell) _____

Email Address: (Please Print) _____

****

Parent/Guardian Name _____ Ph. # (Home) _____

Parent/Guardian Address _____ Ph. # (Cell) _____

Email Address: (Please Print): _____

CAN CHILD BE PICKED UP BY BOTH PARENTS? ☐ YES ☐ NO *(If not, provide written documentation)*

Child lives with ☐ both parent's ☐ mother ☐ father ☐ other _____

Custody Restrictions? Please elaborate_____

_____

Emergency Contact Names/Addresses	**Authorized to pick up**	**Primary Phone**		**Other phone number/email**	
Primary Contact:			___ ok to text		___ ok to text
			___ ok to text		___ ok to text
			___ ok to text		___ ok to text
			___ ok to text		___ ok to text

NEWFANE SCHOOLS ONLY
WILL YOUR CHILD BE COMING TO SCHOOL BY BUS?
MORNING BUS……. BUS #……

LOCKPORT SCHOOLS ONLY
CHILD CARE AVAILABLE
HALF-DAY: SEPTEMBER 7TH
YES……. NO…….

YWCA of the Niagara Frontier

PARENT FINANCIAL OBLIGATION /ACKNOWLEDGMENT STATEMENT

FINANCIAL OBLIGATION

- **All payment are due on the 25th of the month before. Any account not paid by the 30th of the month will be considered delinquent and is subject to suspension for non-payment. A late fee of $15.00 will automatically be incurred.**
- The YWCA reserves the right to suspend children from the SACC program due to non-payment of fees.
- Under **no** circumstance should an addition be done at the SACC site. Additions require payment at the time of the addition and must be done by contacting the main office, 32 Cottage Street at 433-6714.
- All Erie/Niagara County Department of Social Services clients must have a letter of approval at the time of registration. The YWCA cannot accept your child without approval. The Department of Social Services can fax the approval letter to the attention of Kelly DeMatteo at 433-1929.
- Erie/Niagara County Department of Social Services will only pay for days and hours that the client is working or attending training. If your child attends the before or after SACC on a day that is not approved by the Department of Social Services, you are financially responsible for payment in advance.

REFUND

- YWCA of the Niagara Frontier registration fees are non-refundable.
- Only fees for programs cancelled by the YWCA are refundable.
- Suspension or dismissal from the program does not result in refund.
- Absence from program does not reduce operation costs.
- **REFUNDS/CREDITS ARE NOT MADE FOR DAYS ABSENT OR CLOSINGS BY SCHOOL OR GOVERNMENT AUTHORITIES**

PARENT ACKNOWLEDGEMENT

- **Medical Release Consent** - In an emergency concerning my child, (i.e. accident or sudden medical problem), I do authorize the YWCA staff/volunteer to be my agent in obtaining emergency medical treatment. I understand that the 911 Emergency team and emergency department staff at Eastern Niagara Hospital/or nearest hospital will be utilized.
- **Photo Release/Consent** - I understand that any photographs taken of me/my children while at the YWCA will be used for public relations purposes and promotions of YWCA programs and services.
- **Acknowledgement of Parent Responsibility** – I understand that I am responsible to notify the YWCA of any changes in writing of my child's normal schedule.
- **Liability Waiver** - We agree to hold the YWCA and the Program staff harmless with regard to any injuries that may be sustained by our child during the operation of this program. Furthermore, we understand that the YWCA is NOT insured against any such contingencies. I give my permission that this disclosure information relating to my child, such as pictures, name and other pertinent information may be used at the discretion of the YWCA staff.
- **Outside Activities Consent**- I give permission for my child to participate in outdoor activities, including the use of school playground equipment, weather permitting under the supervision of SACC staff.
- **Acknowledgement of All Electronic Devices**- Headphones, cell phones, Ipods, gaming devices and media player use is prohibited by the school and the SACC programs EXCEPT upon designated dates. Furthermore, the YWCA of the Niagara Frontier and its staff will not be held responsible for any lost, stolen or damaged devices. Lack of student accountability will result in a verbal warning and/or parent notification.
- **Communication Acknowledgement**- Each SACC site is equipped with an on-site cell phone. This phone will be answered during program hours and is available for messages during times when the program is not in session. During business hours, the SACC Director can be contacted at the business office at 433-6714. If it is urgent please let the office know and they can contact the Director immediately if necessary.
- I acknowledge the receipt of the before and after School Age Child Care Handbook.
- I acknowledge responsibility for receiving this handbook.
- I understand that I am to contact the before and after School Age Child Care Director at 433-6714 if there are any questions about policies outlined in this form.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES

Signature _____ Date _____

Health History Form **PLEASE answer all questions**

Child's Name _____ Date of Birth: _____

Child's Primary Care Physician's Name/Group _____ Phone #: _____

Preferred Hospital: _____ Phone # _____

Child's Dental Care _____ Phone #_____

In case of an emergency, and the ***YWCA of Niagara*** is unable to reach the parent/guardian, the following individual(s) have permission to make decisions regarding the care of my child/me, including permission to pick up my child/me from the YWCA in case of an emergency or dismissal from the ***YWCA of the Niagara Frontier.***

Name_____ Relationship to child/staff_____

Address_____ City/State/Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

HEALTH HISTORY – Indicate and explain as necessary.

Autism	_____	Seizures	_____	**ALLERGIES:**			
Asperger's	_____	ADD/ADHD	_____	Bee Sting	_____	Dairy	_____
ODD	_____	Hearing	_____	Lactose Intolerant	_____	Wheat	_____
Asthma	_____	Vision	_____	Peanut	_____	Insect Bites	_____
Diabetes	_____	Motor Delays	_____	Tree Nuts	_____	Penicillin	_____

Child has any special needs/services: Early Intervention/Special Education ____ Occupational Therapy _____ Speech/Language _____ Physical Therapy _____

Learning Disability _____

Other diseases or details of above_____

Dates of operations or serious injuries/illness_____

Chronic or recurring illness_____

Is the child currently taking any prescribed medications? _____yes _____no.

Please be sure to consult with your physician about bringing these medications to the YWCA of the Niagara Frontier along with the **MEDICATION CONSENT FORM**.

ARE YOU COVERED BY ANY HOSPITALIZATION/MEDICAL CARE POLICY? YES_____ NO_____

Name of Primary Insurance Company_____ Phone # (_____) _____

Address_____

Policyholder's Name_____ Policyholder's Birthdate _____

Policy # _____ Is policy through employer? _____yes _____no

PARENT/GUARDIAN AUTHORIZATION: To the best of my knowledge, this health history is correct and the designated child may engage in all YWCA activities (except where noted by the examining physician or myself).
I authorize the YWCA staff to supervise self-administration of sunscreen products by my child. In an emergency, I authorize the YWCA SACC Director to act for me/my child according to her/his best judgement where medical or surgical treatment is required.
I accept responsibility for all medical bills resulting from the illness or injury while my child is in the care of the YWCA.

Please initial:

- I consent to emergency medical treatment for my child _____
- I provided information on my child's special needs to the program to assist in caring for my child _____
- I agree to review and update this information whenever a change occurs and at least once every year _____
- A current copy of my child's physical and immunization records has been provided to the program. _____

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

Front Desk Information & Payment Information – SACC 2021-2022

Student Name: _____ **School:** _____

Parent/Guardian Information:

Full Name: _____

Address: _____ **city / state / zip** _____

Home phone: _____ **cell phone:** _____

Email Address: _____

Full Name: _____

Address: _____ **city / state / zip** _____

Home phone: _____ **cell phone:** _____

Email address: _____

For automatic payment from your credit card, please provide the information below:

I, _____, authorize the YWCA of the Niagara Frontier to charge my account automatically each month during the School Age Child Care program.

Amount: _____

Account No.: _____

Expiration Date: _____ Security Code (on back of the card): _____

Signature: _____

Month	Payment	Receipt#	Date	Month	Payment	Receipt#	Date
September	_____	_____	_____	February	_____	_____	_____
October	_____	_____	_____	March	_____	_____	_____
November	_____	_____	_____	April	_____	_____	_____
December	_____	_____	_____	May	_____	_____	_____
January	_____	_____	_____	June	_____	_____	_____

To be completed by YWCA Staff: P/T or F/T B/S or A/S

$ _____ SACC Registration Fee

$ _____ First Month Payment Month starting: _____

$ _____ Total Due at Registration Receipt number: _____

$ _____ Monthly Payment Thereafter Date of Registration: _____ Initials: _____

OCFS-6040 (6/2020)

NEW YOK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors ***must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.*** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers "Yes" to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are "Yes," individuals **cannot** enter the program. If the answers are "No" to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer "No" to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing *ANY* of the following symptoms?
   - Cough (new or worsening)
   - Shortness of breath (new or worsening)
   - Trouble breathing (new or worsening)
   - Fever
   - Chills
   - Muscle pain (new or worsening)
   - Headache (new or worsening)
   - Sore throat (new or worsening)
   - New loss of taste
   - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered "NO" to all questions, you have passed and may enter the program.

If you have answered "YES" to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Signature	Date / /
Signature	Date / /

Note: *This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.*