

**Please fill out the following forms and either mail it or drop it off to MacColl YMCA's office**

**Please Note:**

**Please call and check for availability - enrollment is not guaranteed.**

A registration fee of \$35.00 is due at time of registration  
and is non-refundable

**MacColl YMCA**

Attn: Child Care Registration  
26 Breakneck Hill Road  
Lincoln, RI 02865  
(401) 725-0773



MACCOLL YMCA  
CHILD CARE SERVICES APPLICATION

**Cumberland**  
Kindergarten Child Care  
2011-2012



Servicing



Cumberland: BF Norton, Garvin



Child's Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Kindergarten Session: \_\_\_\_\_ AM \_\_\_\_\_ PM

Please provide a preferred E-Mail address that you would like us to use to contact you:

\_\_\_\_\_

Estimated Drop Off Time: \_\_\_\_\_ / Pick Up Time: \_\_\_\_\_

**\*\*REGISTRATION FEE of \$35.00 IS DUE AT TIME OF REGISTRATION AND IS NON-REFUNDABLE\*\***



WEEKLY CHARGES

\*\*\*\*Prices Subject to Change\*\*\*\*

(Am or Pm Program Includes Bussing)

\*Applies to Public School Sessions\*



**\*Am Kindergarten Session\***

**Rates**

**\*Pm Kindergarten Session\***

Member Participant

\_\_ 6:30am-9:00am Early Risers Only

\$40

\$60

Early Risers Only -Not Available-

\_\_ 6:30am-9:00am & Dismissal-5:45

\$140

\$155

\_\_ 6:30am-School & Dismissal-5:45

\_\_ Mid-Day Dismissal - 5:45

\$130

\$145

\_\_ 6:30am - School (not returning to Y)

\_\_ Mid-Day Dismissal - 3:00pm\*

\$70

\$85

\_\_ End of Day Dismissal - 5:45\*

\*Must be picked up by 3:00pm or full day rate applies\*

\*No AM Care needed / drop off 9am - School Only\*

I have received a copy of the MacColl YMCA Parent Handbook

(Parent / Guardian Signature) \_\_\_\_\_

\_\_\_\_\_ Start Date

\_\_\_\_\_ Medical Form

\_\_\_\_\_ Payment Form

\_\_\_\_\_ Processing Fee

\_\_\_\_\_ Staff Initials

\_\_\_\_\_ Today's Date

*All applications are updated annually. Parents must **immediately** notify the site and MacColl YMCA of any changes on the child's information sheet, and on the pick-up list.*

### CHILD'S INFORMATION SHEET

Child's name: \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Date of birth: \_\_\_\_\_

Child resides with:  Both parents  Mother  Father  
 Other (please specify) \_\_\_\_\_

#### Parent / Guardian information

Male:  Female:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Place of employment/ school: \_\_\_\_\_

Work number: (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Cell/Other: (\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

#### **If different than child's;**

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_

#### Parent / Guardian information

Male:  Female:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Place of employment/ school: \_\_\_\_\_

Work number: (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

#### **If different than child's;**

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_

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#### **Emergency Contact (other than parent)**

1) Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

2) Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

**Rhode Island Department of Health  
Immunization Program**

Pre-screen form for pre-school/day care and kindergarten records

**Please complete the following and attach to the child's record:**

1. **Child's Name** \_\_\_\_\_
2. **Date of Birth** \_\_\_\_\_
3. **Gender**     \_\_M            \_\_F
4. **Ethnicity**   \_\_Hispanic   \_\_Non-Hispanic
5. **Race**        \_\_White        \_\_Black/African American        \_\_Asian  
                  \_\_American Indian / Alaskan Native  
                  \_\_Other (specify) \_\_\_\_\_
6. **Place of Birth**        USA: \_\_yes   \_\_no            Rhode Island: \_\_yes   \_\_no
7. **Lead screening**        \_\_yes            \_\_no
8. **Date of last physical** \_\_\_\_\_
9. **Height** \_\_\_\_\_            **Date taken if different than # 8** \_\_\_\_\_
10. **Weight** \_\_\_\_\_           **Date taken if different than # 8** \_\_\_\_\_

All information is confidential and is reported only in aggregate, with no identifying information about any individual child.

School Name & Address:



Health Care Provider Name and Address:

**STATE OF RHODE ISLAND  
SCHOOL PHYSICAL FORM**

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex
Address: Street	Apt #	City	State	Zip Code
			Home Phone	

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS					
Please enter dates in MM/DD/YYYY format					
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTP/DTaP	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT	Check <input type="checkbox"/> if DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella	<input type="checkbox"/> Student has history of varicella disease				
Tetanus-Diphtheria-Pertussis TdaP/Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td	Check <input type="checkbox"/> if Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption:  Medical  Religious

Hep B  DTaP  PCV  Polio  Hib  MMR  Varicella  Td/Tdap  Rotavirus  Hep A  Mening  HPV

**PHYSICAL EXAMINATION**

Date of PE \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

ASTHMA: No  Yes       DIABETES: No  Yes       OTHER: \_\_\_\_\_

Significant Systems Findings: \_\_\_\_\_

ALLERGIES: No  Yes  (Please explain) \_\_\_\_\_ EPINEPHRINE AUTO-INJECTOR REQUIRED: No  Yes

Treatment Plan: \_\_\_\_\_

MEDICATION (REQUIRED AT SCHOOL): No  Yes  (Please list) \_\_\_\_\_

Other medication(s) that may affect behavior or health at school: \_\_\_\_\_

RESTRICTIONS: Can participate in physical education: Fully  With limitation  \_\_\_\_\_

Can participate in sports: Fully  With limitation  \_\_\_\_\_

LEAD SCREENING (Required for children < 6 years of age only) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>	SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>	VISION SCREENING (Children entering Kindergarten) <input type="checkbox"/> Passed screening <input type="checkbox"/> Screened and referred for comprehensive exam <input type="checkbox"/> Referred for comprehensive exam, but not screened Screening Date: _____ Comprehensive Exam Date: _____
TUBERCULOSIS (If required by school district) Date of TB test: _____		

HEALTH CARE PROVIDER SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

*All applications are updated annually. Parents must **immediately** notify the site and MacColl YMCA of any changes on the child's information sheet, and on the pick-up list.*

**MACCOLL YMCA  
PICK UP LIST**

**Child's name:** \_\_\_\_\_

**Home phone:** (\_\_\_\_) \_\_\_\_\_

Please fill out the following information for parents/ guardians who are **ALLOWED** to pick up the child:

**Mother's name:** \_\_\_\_\_

Work phone: (\_\_\_\_) \_\_\_\_\_ Cell/Other: (\_\_\_\_) \_\_\_\_\_

**Father's name:** \_\_\_\_\_

Work phone: (\_\_\_\_) \_\_\_\_\_ Cell/Other: (\_\_\_\_) \_\_\_\_\_

List the names and addresses of individuals **ALLOWED** to pick up your child from the MacColl YMCA program sites.

NAME	ADDRESS	RELATIONSHIP	PHONE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

\*\*\*\*\*

List the names and addresses of individuals **NOT ALLOWED** to pick up your child from the MacColl YMCA program sites.

**(Please attach a copy of any custody or restraining orders in effect.)**

NAME	ADDRESS	RELATIONSHIP	PHONE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**MACCOLL YMCA  
AGREEMENT OF SERVICES**

I/ We will pick up \_\_\_\_\_ by 5:45pm.

I/We recognize that we will be charged a late fee if child is picked up after 6:00pm. \_\_\_\_\_ **(parent initials required)**

I/ We understand we must call the child care site if our child is to be absent on any given day. \_\_\_\_\_ **(parent initials required)**

I/ We give permission to photograph and display pictures of our child. \_\_\_\_\_ parent initials. (If you do not want your child's picture taken and displayed, **do not** initial this line.)

I/ We understand any child whose behavior is consistently disruptive to the smooth and safe operation of the child care program may be dismissed from the program, after sufficient warnings to the child and the parents to change this behavior. \_\_\_\_\_ **(parent initials required)**

Corporate/ Subsidized child care for my child is as follows:

\_\_\_\_\_ **DHS/ Pathways** certificate # \_\_\_\_\_

\_\_\_\_\_ **Financial Aid**

\_\_\_\_\_ **Corporate/Other (please specify)** \_\_\_\_\_

**Written verification for any of the above subsidized child care must be approved and on file before the child begins in our program.**

**I/We understand the above information and agree to abide by the rules and regulations set forth by the MacColl YMCA.**

X \_\_\_\_\_  
**Parent/ Guardian's Signature** \_\_\_\_\_ **Date**



**Special Care Plan**

**This must be filled out for any child with a medical concern/ condition or allergy listed on the previous page**

Child's Name \_\_\_\_\_ DOB \_\_\_\_\_

Parent(s) or Guardian(s) Name \_\_\_\_\_

Primary Physician \_\_\_\_\_ phone \_\_\_\_\_

Secondary Physician (if applicable) \_\_\_\_\_ phone \_\_\_\_\_

Medication(s)

\_\_\_\_\_

Reason special care plan is needed (allergy or medical concern)

\_\_\_\_\_

\_\_\_\_\_

Known Triggers:

\_\_\_\_\_

\_\_\_\_\_

Activities that may need special attention:

\_\_\_\_\_

\_\_\_\_\_

Typical signs and symptoms:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
date

\_\_\_\_\_  
Special Care Plan Coordinator

\_\_\_\_\_  
date

**A copy will be returned to you once signed by our special care plan coordinator**

**MacColl YMCA**  
**School Cancellation, Early Release, & Delay Policy**  
**\*\*\*\*\*Keep for your Refrigerator\*\*\*\*\***

What to do if...

**School's Cancelled:**

- Watch Channel 10 or Channel 12 for delay/closure announcement for the Y
- Use the Internet and go to [ribroadcasters.com](http://ribroadcasters.com) or [turnto10.com](http://turnto10.com) or [wpri.com](http://wpri.com) for delay/closure announcement for the Y
- Get a Twitter up date at [www.twitter.com/MacCollYMCA](http://www.twitter.com/MacCollYMCA)
- Call MacColl at 725-0773 after 6:30am to check on opening time

**School's Delayed in Lincoln/North Providence:**

- All sites will open at normal time 6:30 at MacColl, 7:00am at Saylesville, and Northern

**School's Delayed in Cumberland:**

- All sites will have a delayed start time (same delay time as school) example school is delayed one hour sites will open at 8:00am instead of the normal 7:00am opening time

**Schools Cancel Afterschool Activities:**

- All Y programs will run as normal, but we ask that parents do their best to arrive as early as possible for the safety of their children, themselves and our staff

**School is Dismissed Early:**

- There will be NO Y after school program
- Children must follow their designated plan to either take the school bus home or parent will pick up
- The Y will attempt to call all parents in this situation
- We encourage any parents of Kindergarten or preschool to pick up as early as possible for the safety of their child, themselves and our staff

Note to Self: My child will take Bus # \_\_\_\_\_ home or I will pick my child up from school and I need to call the school to let them know what my child's plan is.

Please complete the attached form with your child's Early School Dismissal Plan and return with the packet.

### Early School Dismissal Plan

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

School Attending: \_\_\_\_\_

Please check off one of the following:

\_\_\_\_\_ My child will take Bus # \_\_\_\_\_ home from school

\_\_\_\_\_ I will pick my child up from school.

Office Use  
Unit ID # \_\_\_\_\_

**YMCA of Pawtucket, Inc.  
MACCOLL YMCA BRANCH**



**Child Care Weekly Payment Agreement**

I/We agree to pay the weekly fee of \$ \_\_\_\_\_ by Friday prior to the week services are offered. I/We understand the full week fee is due whether or not our child \_\_\_\_\_ participates in the program all week.

(print child's full name)

I/We receive child care subsidy from \_\_\_\_\_  
My co-payment is \$ \_\_\_\_\_ per week.

***Express Payment Plan***

I/We wish to participate in one of the *Express Payment Plans* (choose only one):

\*\* \_\_\_\_\_ **Bank Draft** (weekly draft from checking or savings account) **VOIDED CHECK NEEDED**

**Option I**

\_\_\_\_\_

PRINT NAME ON THE ACCOUNT

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NAME OF BANK	Checking	Savings
	(Circle One)	

---

9 DIGIT ROUTING NUMBER	7-10 DIGIT ACCOUNT NUMBER or SAVINGS #
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AUTHORIZED SIGNATURE	DATE
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\*\* \_\_\_\_\_ **Credit Card** (weekly charge to credit card) or Debit Card (weekly charge to debit account)

**Option II**

\_\_\_\_\_

PRINT YOUR NAME AS IT APPEARS ON CARD

CIRCLE ONE: MASTER CARD OR VISA ONLY    CIRCLE ONE: CREDIT / DEBIT CARD TYPE

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CREDIT CARD #	EXP DATE
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AUTHORIZED SIGNATURE	DATE
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**\*\*Please note:**

- ✘ I / We understand, I / we must submit a 2 week written notice prior to withdrawing my / our child from the childcare program I / we have registered for or my / our account will be charged the full amount.**
- ✘ I / We understand the full week's fee is due whether or not my / our child participates in the program all week.**

\_\_\_\_\_  
(Authorized Signature)



## MACCOLL YMCA

# HEALTH CARE POLICY

### \*\*\*Keep for your Records\*\*\*

- Please use good judgment when sending your child to child care.
- Children must be able to participate in all activities.
- All allergies must be noted at time of registration.
- Any child who is sent home with a rash or fever, or wakes up with such, must remain home for 24 hr. **NO EXCEPTIONS.**

### **FIRST AID**

- A counselor will administer First Aid to your child. All are currently certified in First-Aid and CPR. Parents will be notified, within 24 hours, or sooner when first aid has been applied.

### **MEDICATION**

- All medication must be in the original container.
- Please hand medication in to the site director only.
- Please do not leave in lunchbox or child's backpack.
- A written note from the physician must accompany non-prescription medication. It needs to state the specific medication, and the exact dose and length of time to be given **NO EXCEPTIONS.**
- Parents need to fill out a medical release form which can be found at the parents table, for all medications
- Children with asthma may, with written parental consent, and authorization from the physician, carry their own inhalers and use them as needed. Any use of the inhaler will be documented on the child's medical log.
- Children with allergies to bee stings may carry epi-pens to be used as needed. Use will be documented on the child's medical log.
- If your child becomes ill, he/she will be separated from the group to rest quietly. We will contact a parent or emergency contact to pick up the child. Please assure that your contact numbers are accurate.

### **COMMUNICABLE DISEASE**

- Any child who contracts a fever or rash during child care hours will be isolated from the others, and contacts will be called to pick up child immediately.
- Head Lice: are insects that feed off the human body to survive. They lie in the human scalp and are about the size of a sesame seed. Head lice hatch from eggs called nits. These tiny eggs are grayish white, and shaped like tear drops. They attach themselves to the hair shaft and are very difficult to remove. Head lice are very contagious. **The YMCA maintains a no nit policy. Children may not return to childcare until they are nit free.**

## Child Fact Sheet

Please fill out the following information to help our staff get to know your child better.

Child's Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Siblings (names/ages) \_\_\_\_\_

Pets \_\_\_\_\_

Parent's occupation \_\_\_\_\_

Favorite toy to play with \_\_\_\_\_

Favorite activity \_\_\_\_\_

3 words to describe your child \_\_\_\_\_

Language(s) spoken at home \_\_\_\_\_

Preferred language for communication \_\_\_\_\_

Family traditions celebrated at home \_\_\_\_\_

What is your philosophy on discipline \_\_\_\_\_

Questions or concerns for the year \_\_\_\_\_

Any prior childcare experience (if yes, where?) \_\_\_\_\_

Any additional information that you believe would be helpful