TUITION FORM

SELECT YMCA PRESCHOOL LOCATION
☐ Great South Bay YMCA
☐ Huntington YMCA
☐ Patchogue Family YMCA
☐ YMCA at Glen Cove

CHILD’S NAME _______________________________________________________________________________________

PARENT(s)/GUARDIAN(s) NAME: ____________________________________________________________________________

PARENT PHONE #: ___________________________ EMAIL: ____________________________

TUITION SCHEDULE AND PAYMENTS
Thank you for choosing the YMCA as your child care provider for the school year 2020-2021! To secure a spot in Preschool, your first month’s tuition payment must be made, in addition to a YMCA Youth Program Membership (or full/family membership). All membership rates and child care tuition monthly rates can be found online. All tuition is due by the 1st of each month. Tuition invoices are sent out on or about the 15th of the month prior. If payment has not been received by the 6th, a late fee of $25 will be applied. If you have any concerns regarding your tuition, please contact the business office. Payment can be made by major credit or debit card – either online, in person, or by mail (send in this form completed). For withdrawal or changes to your child’s enrollment, a modification form must be filled out for all child care days and times being modified with at least 30 days in advance notice to the Child Care program director.

PAYMENTS BY MAIL: Address envelope: YMCA Child Care Program
Great South Bay YMCA 200 West Main Street, Bay Shore, NY 11706 (631) 655-4255
Huntington YMCA 60 Main Street, Huntington, NY 11743 (631) 421-4242
Patchogue Family YMCA 255 West Main Street, Patchogue, NY 11772 (631) 891-1800
YMCA at Glen Cove 125 Dosoris Lane, Glen Cove, NY 11542 (516) 671-8270

PAYMENTS ONLINE:
Visit www.ymcali.org, click Sign In at upper right-hand corner of website, and use email and password to access tuition invoice and Tax Statements. Contact branch with any questions about accessing your account online.

CREDIT CARD INFORMATION:
☐ American Express ☐ Mastercard ☐ Visa ☐ Discover

Card Number: _______________________________________________________________________________________

Cardholder Name: ____________________________________________________________________________________ Exp. Date: ______________________________________________________________________

Security Code: __________ Signature: ______________________________________________________________________

Email us: Childcare@ymcali.org
ENROLLMENT FORM

SELECT YMCA PRESCHOOL LOCATION
☐ Great South Bay YMCA
☐ Patchogue Family YMCA
☐ Huntington YMCA
☐ YMCA at Glen Cove

CHILD’S NAME: __________________________________________ DOB: ____ / ____ / _______ SEX: M __ F ____

CHILD’S HOME ADDRESS: __________________________________________
City ____________________________ State __________________________ Zip Code __________________________

PARENT1 NAME: __________________________________________ EMAIL: __________________________
ADDRESS: ☐ Same ________________________________________________
HOME #: __________________________ WORK #: __________________________ CELL #: __________________________
EMPLOYER & ADDRESS: __________________________ __________________________

PARENT2 NAME: __________________________________________ EMAIL: __________________________
ADDRESS: ☐ Same ________________________________________________
HOME #: __________________________ WORK #: __________________________ CELL #: __________________________
EMPLOYER & ADDRESS: __________________________ __________________________

EMERGENCY CONTACT / AUTHORIZATION FOR PICKUP INFORMATION
Minimum of 2 contacts, other than parents, to contact in case of emergency that are authorized to pick up child.

1. Name __________________________________ Relation to Child: __________________________
   Home #: __________________________ Work #: __________________________ Cell #: __________________________

2. Name __________________________________ Relation to Child: __________________________
   Home #: __________________________ Work #: __________________________ Cell #: __________________________

3. Name __________________________________ Relation to Child: __________________________
   Home #: __________________________ Work #: __________________________ Cell #: __________________________

4. Name __________________________________ Relation to Child: __________________________
   Home #: __________________________ Work #: __________________________ Cell #: __________________________

CHILD’S HEALTH INFORMATION & HISTORY

Health Insurance Plan: __________________________________________
Group #: __________________________ ID #: __________________________
Child’s Physician: __________________________ Phone: __________________________
Child’s Dentist: __________________________ Phone: __________________________
Are your child’s immunizations up to date?  
Yes (    )  No (    )
Attach copy of immunization records from physician.
If not up to date, please explain:

---

Does child have any known health problems?  
Yes (    )  No (    )
If yes, please attach documentation.

Does your child get colds/flu often?

---

Does your child have any special needs?

---

Please list any hospitalizations or serious prior injuries:

---

Check any of the following health conditions of the child (prior or current):

- [ ] Allergies
- [ ] Asthma
- [ ] Bronchitis
- [ ] Chicken Pox
- [ ] Convulsions
- [ ] Croup
- [ ] Diphtheria
- [ ] Earaches
- [ ] Eczema
- [ ] Frequent Colds
- [ ] Influenza
- [ ] Measles
- [ ] Mumps
- [ ] Pneumonia
- [ ] Polio
- [ ] Rheumatic Fever
- [ ] Tonsillitis
- [ ] Whooping Cough
- [ ] Other: ______________________

Does your child take any medication on a regular basis?  
Yes (    )  No (    )
If yes, please list the name of the medication(s) and the medical condition for which it is taken.

---

Does your child have any speech, hearing, or visual problems?  
Yes (    )  No (    )

---

Has your child ever been tested for the above?  
Yes (    )  No (    )

---

Please provide any other medical or special needs information that the child care provider should be aware of:

---

Email us: Childcare@ymcali.org
MEDICATION AND EMERGENCY CARE AUTHORIZATION

I authorize use of typical first aid supplies including, but not limited to, Neosporin, anti-bacterial ointment, cortisone, sunburn treatment, band-aids, and liquid band-aids. ☐ Yes ☐ No

I authorize use of preventative supplies, such as sunscreen, insect repellant, hand lotion, diaper rash cream, etc. ☐ Yes ☐ No

I authorize the YMCA Child Care program to obtain the following services for this child if necessary: Public Health Nurse, Physician, Emergency Room, EMS and/or Ambulance transport in the event of an emergency. Parent(s)/Guardian(s) will immediately be contacted in an emergency. Ambulance fees and/or health care costs are the responsibility of the parent(s)/guardian(s). ☐ Yes ☐ No

Comments:

______________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________

ACTIVITY CONSENT

I hereby grant ______ do not grant ______ consent to have my child participate in YMCA Preschool activities including swim lessons (if applicable), field trips with his/her teacher and other authorized personnel. Parents/Guardians will be notified in advance of field trips if permitted by NYS during pandemic.

I have read the above and agree to consent on behalf of my child ____________________________________________.

Child Name

______________________________________________________________________________________________________________________________

Parent/Guardian Signature Date

PHOTO/VIDEO AUTHORIZATION

I hereby grant ______ do not grant ______ consent to have my child appear in photographs and/or video footage of YMCA Preschool activities for teaching and/or marketing purposes.

I have read the above and agree to consent on behalf of my child, ____________________________________________.

Child Name

______________________________________________________________________________________________________________________________

Parent/Guardian Signature Date

ADDITIONAL NOTES ABOUT YOUR CHILD:

______________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________

______________________________________________________________________________________________________________________________

Signature of Parent/Guardian Date

Signature of Parent/Guardian Date

Email us: Childcare@ymcali.org
REST TIME AGREEMENT FORM

Child’s Name: _______________________________________________________________
Age: __________________

Rest Time Program

Students enrolled in a full day YMCA Preschool program will have the opportunity to rest quietly or nap each afternoon. Rest time will vary depending on the age of the child/program enrolled. During rest time, the lights are dimmed, and soft music or a children’s audiobook is played in the background.

The preschool provides each student with a cot for them to use during rest time for the duration of the school year. Parents must supply a blanket and/or bedroll, which will be sent home weekly for laundering. All cots are sanitized on a daily basis.

The classroom staff will help to settle those students who need to take a nap. Any non-napping students must lay or sit quietly on their cots (books, puzzles, and tabletop toys are permitted) until quiet time is over.

I have read and fully understand the above Rest Time Agreement.

___________________________________________  __________________________
Signature of Parent/Guardian                  Date
Immunizations required for entry into day care

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

<table>
<thead>
<tr>
<th>Immunization</th>
<th>1st Date</th>
<th>2nd Date</th>
<th>3rd Date</th>
<th>4th Date</th>
<th>5th Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus and Pertussis (DPT)</td>
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<tr>
<td>Polio (IPV or OPV)</td>
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<tr>
<td>Haemophilus influenzae type B (Hib)</td>
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<tr>
<td>Pneumococcal Conjugate (PCV) for those born on or after 1/1/08</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Measles, Mumps and Rubella (MMR)</td>
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<tr>
<td>Varicella (also known as Chicken Pox)</td>
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</tbody>
</table>

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

<table>
<thead>
<tr>
<th>Type of Immunization</th>
<th>Date:</th>
<th>Type of Immunization</th>
<th>Date:</th>
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</table>

Tests

Tuberculin Test Date: / / Mantoux Results: **Positive** **Negative** mm

TB Tests are at the physician’s discretion. Acceptable tests include Mantoux or other federally approved test. If positive, or if x-ray ordered, attach physician’s statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

<table>
<thead>
<tr>
<th>Year</th>
<th>Date</th>
<th>Result</th>
<th>mcg/dL</th>
<th>Venous</th>
<th>Capillary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>/</td>
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<td>2</td>
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</table>

Most recent date of lead screening (if different from above):

<table>
<thead>
<tr>
<th>Year</th>
<th>Date</th>
<th>Result</th>
<th>mcg/dL</th>
<th>Venous</th>
<th>Capillary</th>
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Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)
**CHILD IN CARE MEDICAL STATEMENT (continued)**

<table>
<thead>
<tr>
<th>Health Specifics</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there allergies? (Specify)</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Is medication regularly taken? (Specify drug and condition)</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Is a special diet required? (Specify diet and condition)</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Are there any hearing, visual or dental conditions requiring special attention?</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Are there any medical or developmental conditions requiring special attention?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

**Summary of Physical Exam**
Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. □ Yes □ No

<table>
<thead>
<tr>
<th>Signature of Examiner</th>
<th>Address</th>
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</table>

Please Print Name ___________ City, State, Zip ___________

(  )-_____/_____/_____

Title ___________

Phone ___________

Date ___________
**NEW YORK STATE**
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE ENROLLMENT

<table>
<thead>
<tr>
<th>PROGRAM NAME:</th>
<th>ADDRESS:</th>
<th>PHONE NUMBER:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>CHILD’S FULL NAME:</th>
<th>ADDRESS:</th>
<th>DATE OF BIRTH:</th>
<th>GENDER:</th>
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<thead>
<tr>
<th>PREFERRED NAME/NICKNAME:</th>
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<thead>
<tr>
<th>CHILD’S HOME ADDRESS:</th>
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<table>
<thead>
<tr>
<th>NAME OF PERSON ENROLLING CHILD:</th>
<th>RELATIONSHIP TO CHILD:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Parent</td>
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</table>

<table>
<thead>
<tr>
<th>PHONE NUMBER(S) OF PERSON ENROLLING CHILD:</th>
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<table>
<thead>
<tr>
<th>EMAIL ADDRESS:</th>
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**EMERGENCY INFO**

<table>
<thead>
<tr>
<th>EMERGENCY CONTACT NAMES / ADDRESSES</th>
<th>Authorized to Pick Up Child</th>
<th>PRIMARY PHONE NUMBER</th>
<th>OTHER PHONE NUMBER / EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CONTACT:</td>
<td>□ Yes □ No</td>
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**FOR PROGRAM USE ONLY**

DATE OF ENROLLMENT: / /

**FOR PROGRAM USE ONLY**

DATE OF DISENROLLMENT: / /

**Check boxes below to indicate if your child has any special needs/services:**

- [ ] None
- [ ] Early Intervention/Special Education
- [ ] Occupational Therapy
- [ ] Speech/Language
- [ ] Physical Therapy
- [ ] Allergies (Please list) __________________________________________
- [ ] Other _________________________________________________________

Please provide information here AND discuss with your child care provider:

<table>
<thead>
<tr>
<th>CHILD’S PRIMARY CARE PHYSICIAN’S NAME/ GROUP:</th>
<th>PHONE NUMBER:</th>
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<th>PREFERRED HOSPITAL:</th>
<th>PHONE NUMBER:</th>
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<thead>
<tr>
<th>CHILD’S DENTAL CARE:</th>
<th>PHONE NUMBER:</th>
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Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

** AGREEMENTS **

- I consent to emergency medical treatment for my child................................................................. □ Yes □ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision................................................................. □ Yes □ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips................................................................. □ Yes □ No
- I provided information on my child’s special needs to the program to assist in caring for my child................................. □ Yes □ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation................................................................................................. □ Yes □ No
- I agree to review and update this information whenever a change occurs and at least once every year................................. □ Yes □ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE: DATE: / /
NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
NON-MEDICATION CONSENT FORM
Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellent.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and ear, eye, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent’s instructions differ from the instructions on the product’s packaging, permission must be received from a health care provider or licensed authorized prescriber.

**PARENT TO COMPLETE THIS SECTION (#1 - #14)**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Child’s first and last name:</td>
<td>2. Date of birth:</td>
<td>3. Child’s known allergies:</td>
</tr>
</tbody>
</table>

4. Name of product (including strength): | 5. Amount to be administered: | 6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: ____________________________________________________________________________

**OR**

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): ____________________________________________________________________________

8A. Possible side effects: [ ] See product label for complete list of possible side effects (parent must supply)

**AND/OR**

8B. Additional side effects:

9. What action should the child care provider take if side effects are noted:

[ ] Contact parent

Other (describe): ____________________________________________________________________________

10A. Special instructions: [ ] See package insert for complete list of special instructions (parent must supply)

**AND/OR**

10B. Additional special instructions:

11. Reason(s) for use (unless confidential by law):

12. Parent name (please print):

13. Date authorized:

14. Parent signature:

X

**DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)**

15. Program name:

16. Facility ID number:

17. Program telephone number:

18. I have verified that #1, #14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff’s name (please print):

20. Date received from parent:

21. Staff’s signature:

X
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.