YMCA of Long Island
Preschool Forms
2020-2021 School Year
ymcali.org/childcare2020

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

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ENROLLMENT FORM

SELECT YMCA PRESCHOOL LOCATION

☐ Great South Bay YMCA
☐ Huntington YMCA
☐ Patchogue Family 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	___ Diphtheria	___ Mumps
___ Asthma	___ Earaches	___ Pneumonia
___ Bronchitis	___ Ezcema	___ Polio
___ Chicken Pox	___ Frequent Colds	___ Rheumatic Fever
___ Convulsions	___ Influenza	___ Tonsillitis
___ Croup	___ Measles	___ 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

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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

Email us: Childcare@ymcali.org

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

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). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

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

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

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)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

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

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

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)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

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

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER: ( ) -

CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:	DATE OF BIRTH: / /	GENDER:

CHILD'S HOME ADDRESS:

NAME OF PERSON ENROLLING CHILD:	RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____

PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text **EMAIL ADDRESS:**	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /	***FOR PROGRAM USE ONLY*** DATE OF DISENROLLMENT: / /

CHILD'S FULL NAME:	DATE OF BIRTH: / /

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:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

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: / /

OCFS-6010 (5/2015)

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 repellant.
- 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 eye, ear, 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)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
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

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.*