



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

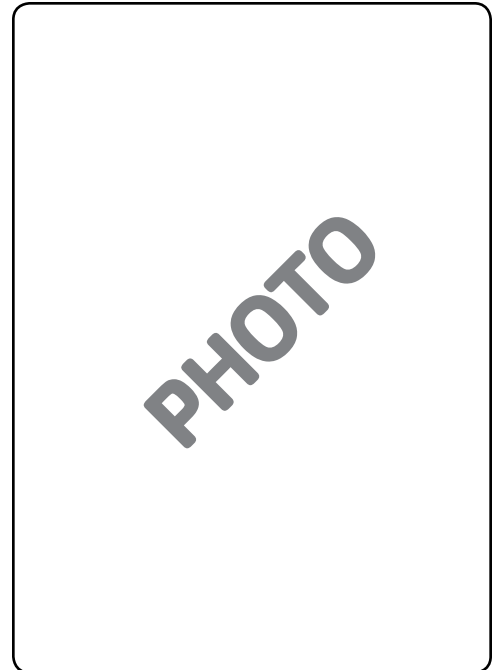
YMCA BUFFALO NIAGARA PRESCHOOL PROGRAM ENROLLMENT FORM

Name _____

Site _____

Age _____

Start Date _____



ALLERGIES/MEDICATION

Will your child require prescription medications? Yes No

Does your child have allergies? Yes No

If "yes" to either question, please describe in detail inside.

PROGRESSIVE DISCIPLINE POLICY

The safety and well-being of each child in our care is our number one priority. When behavior expectations are not met, YMCA staff will implement our progressive discipline policy to help correct the undesired behavior. Listed below are the steps utilized by our staff:

- a. Verbal warning given: explain why behavior is inappropriate.
- b. Time out - time to refocus and redirect.
- c. Verbal communication between parent and site coordinator.
- d. Parent conference with site coordinator and program director, followed by a written summary of meeting. Child, parent and site coordinator sign a written contract agreeing to acceptable behavior and alternative solutions.
- e. If inappropriate behavior continues, child may be suspended from program for up to one week.
- f. Prolonged disruptive and inappropriate behavior will result in dismissal from the UPK program.

Extreme Behavior Issues

In extreme cases, a child's behavior may warrant immediate suspension or expulsion from the program. Such cases include the use of profane or abusive language or any aggressive behavior which threatens or causes physical harm to other participants or staff.

CHILD INFORMATION

Name _____ Nick Name _____ Male Female

Grade in Fall _____ Date of Birth _____ Phone _____

Home Address _____ City _____ State _____ Zip _____

APPLICANT INFORMATION

Name of person applying for child _____ Relationship to child _____

Address _____ City _____ State _____ Zip _____

Employer _____ Day Phone _____

Cell Phone _____ E-mail Address _____

In case of an emergency, notify: (List contact information for hours during Day Care - for example work address and phone if at work)

Mother _____ DOB _____ Address _____

Day Phone _____ Cell Phone _____

Father _____ DOB _____ Address _____

Day Phone _____ Cell Phone _____

Other _____ Address _____

Day Phone _____ Cell Phone _____

Physician or Medical Svc _____ Address _____ (p) _____

Names of individuals authorized to pick up child who are NOT listed above:

Name _____ Address _____ (p) _____

Name _____ Address _____ (p) _____

Name _____ Address _____ (p) _____

Name _____ Address _____ (p) _____

HEALTH INFORMATION

The following information must be filled in by the parent/guardian. The intent of this information is to provide staff the background to provide appropriate care. Provide complete information so that we can be aware of your child's needs. In addition to this form current immunization records and a physical are needed.

Allergies

Describe reaction and management of the reaction

• Medications (e.g., penicillin) _____

• Food (e.g., eggs, dairy) _____

• Other (e.g., insect stings, hay fever) _____

Medications

Medications require a separate form. Please contact the Child Care Program Director for more information.

Insurance

Is participant covered by family medical/hospital insurance? Yes No Carrier/plan name _____

Name of insured _____ Relationship to child _____

Policy holder SS# or insurance ID # _____ Group # _____ Carrier Address _____

Health History

Any activities that child cannot participate in or needs one-on-one assistance? Yes No

If yes, please explain _____

Is your child currently being treated or followed by a medical professional for any of the following:

- | | | | | | |
|-------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diarrhea/constipation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sickle Cell Trait | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizures/Convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please explain any "YES" answers _____

Any additional information about the child's behavior and physical, emotional or mental health the staff should be aware of?

Special Information – AFO's, walkers, wheelchairs, assistance with toileting, behavior issues, Diets, habits, etc.

Publicity Photographs

May we use your child in publicity photographs? Yes No

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, give permission for _____ to discuss my child's medical
(Mother, Father, Guardian) (Health care provider)

information, diagnosis and treatment, including medications with a representative of the YMCA's UPK program.

Signature of parent or guardian _____ Date _____

Health Care Provider's phone _____ Fax _____



As the Y is for youth development, we would like to know why you chose the YMCA. (Ex: I wanted my child to improve his or her social skills. I wanted to help my child stay healthy by being more physically active. I wanted my child to improve his or her academic performance.)

AGREEMENT

- **Enrollment:** I consent to the enrollment of the child listed above in this facility and have been advised of the policies, transportation, and the services provided by the facility and the New York State Department of Social Services regulations under which it operates.
- **Field Trips and Transportation:** My child is is NOT permitted to take part in field trips or excursions away from the facility under proper supervision, including transportation provided by or arranged for by the UPK program.
- **Emergency Medical Care:** I agree that in the case of accident or injury, emergency medical care may be given in the event I or the person(s) designated cannot be reached.
- **Correct Information provided:** I have provided special information on this registration to assist the facility in caring for this child (diet, habits, allergies, medical issues, etc)
- **Parent Handbook:** I accept the policies and procedures contained in the Preschool Education parent handbook. I have read and fully understand all policies and procedures contained within and agree to abide by them. I further understand that failure to abide by the policies and procedures contained in this handbook could result in dismissal from the program.

Signature of Parent/person(s) legally responsible: _____ Date: _____

OFFICE USE ONLY		
_____	_____	Program Director notified of allergies & medication
Date	Initials	
_____	_____	Form is complete (check boxes, allergy/medications)
Date	Initials	