YELLOW SPRINGS
Community
Children's Center

Name of Child: _____ **D.O.B** _____

Name of Parents: _____

Application pick up date: _____ **Application drop off date:** _____

Start Date: _____

Enrollment paperwork Checklist:

_____ Enrollment Contract

_____ Payment Policy/ Liability release

_____ Income Eligibility Application (Child and Adult Food Care Food Program) *Must be filled out

_____Enrollment Form (Child and Adult Care Food Program)

_____Medical Statement & Immunization records ***Due within 30 days of Enrollment**

_____State of Ohio Immunization Exemption (Optional)

_____ Health Assessment

_____Special Diet Form *Must be signed by parent (Optional)

_____ Family information for Step Up to Quality

_____Assessment Permission

_____ Behavioral Policy Acknowledgement

_____Routine Trip Permission

_____Photo/Video/ Audio Release statement

_____Handbook Acknowledgement

Yellow Springs Community Children's Center

Tuition Rates as of April 1, 2023

Center Hours of Operation 6:30 am - 6:00 pm

After Care hours of operation 2:45 pm - 6:00 pm

Additional day charge $55.00 per day

5% discount for 3 months advance pay

10% Sibling discount

15% Military discount (Please bring ID)

Infant Program (6 weeks -17 months)

Attendance	Monthly
5 Full Days	$1172
5 Mornings or Afternoons	$980
4 Full Days	$1135
4 Mornings or Afternoons	$877
3 Full Days	$1017
3 Mornings or Afternoons	$819

Preschool Program (3 years - 5 years)

Attendance	Monthly
5 Full Days	$803
5 Mornings or Afternoons	$584
4 Full Days	$733
4 Mornings or Afternoons	$511
3 Full Days	$639
3 Mornings or Afternoons	$450

Three-day options are not available for new enrollees after April 1, 2023

Toddler Program (18 months - 3 years)

Attendance	Monthly
5 Full Days	$984
5 Mornings or Afternoons	$768
4 Full Days	$945
4 Mornings or Afternoons	$664
3 Full Days	$872
3 Mornings or Afternoons	$562

After School School-Age Program (K – Age 12)

*Includes snack in afternoon, school closings, snow days and holidays

Attendance	AFTER School Care
5 Days Per Week	$428
4 Days Per Week	$417
3 Days Per Week	$342

Summer Camp Program (K – Age 12)

Camp Includes Breakfast, Lunch, Snack

Additional one-time $130 fee for field trips & classroom materials.

Attendance	Monthly
5 Days Per Week	$728
4 Days Per Week	$706

Approved by YSCCC Board March 15, 2023

YSCCC Enrollment contract

Enrollment Date: _____

Parent/Guardian name & email address: _____

Parent/Guardian name & email address: _____

Child Full name/Birthday/ Classroom _____

Child Full name/Birthday/Classroom _____

Child Full name/Birthday/Classroom _____

Contracted Days: (*Circle minimum of 3 days /Days cannot change on a weekly basis):

Monday, Tuesdays, Wednesday, Thursday, Friday ~ Full time or Part time ~

Private pay families: Monthly Tuition fee: _____

* A $25 registration fee is due upon initial enrollment date.

* A late fee of $35.00 will be applied to your account if payment is received after the 5th.

* We do not offer adjustments due to illness, vacations or inclement weather closings.

Title XX families: Weekly co pay: _____

*A registration fee of $25. 00 is not required but if you owe a weekly co-pay, it must be paid consistently each month.

* Fees are due on a weekly or monthly.

*We do not offer adjustments due to illness, vacations or inclement weather closings.

* A late fee of $35.00 will be applied to your account if payment not received.

This is a legal binding contract between you and YSCCC. You are responsible for monthly payment of tuition/ Title XX co pays.

____ I understand that I am responsible for any and all charges associated with my account and that if I fail to pay any amount due in a timely manner, I will forfeit my child's enrollment spot at the end of the month.

Preferred method of payment: Cash____ Check____ Money order____ Credit card____

Credit card number: _____ Expiration date: _____

YSCCC payment policy and Liability Release

The following terms and conditions apply to the youth program accounts for our students enrolled in the center, aftercare program at Mills Lawn and Summer camp program.

(please read and initial each item)

_____ A registration fee of $25.00 is due at the time of enrollment including your first month's tuition. (Excluding all families enrolled in the Title XX program)

_____ An invoice will be provided via email or can be sent to your mailing address on file. Please update changes to your email and mailing address accordingly.

_____ Services are billed according to the youth program schedule for which you have contracted. Any changes to your contracted schedule must be submitted in writing (two weeks) prior to the change. Changes not submitted within the required time frame will not be adjusted on the current billing cycle.

_____ Fees are not adjusted based on your child's absences on a day to day basis. Sick days and other short-term absences do not qualify for any type of credit. YSCCC will not credit accounts on days of inclement weather closings or delays.

_____ The payment schedule is based on a month to month basis. All payments are due on the first of the month or no later than the 5th of the month. All late payments are subject to a late fee of $35.00. ***If payment is not received/payment plan is not discussed with Director or Business Manager by the end of the month, your child will not be admitted to attend the center until your full past due balance is received by the end of the following month.***

_____ If your check/ credit card payment does not process (payment rejected), a $25 returned item charge will be added to your account in addition to your required monthly tuition fee.

_____ Late pick up policy will take into effect if your child is picked up past the closing time. Our center and aftercare program closes at 6:00. **The late fee charge is $5.00 for each minute after our closing time and will increase to $10 per 5 minutes after a half hour has passed.**

_____ If your child will be absent from the program on a scheduled day for any reason, please call the center to notify the Director or administrator of their absence.

Liability: This is to certify that I give my child permission to attend YSCCC. I release the YSCCC from any liability. I understand that is it my responsibility to arrange transportation daily at the specified pick up time. I will be responsible for any late fees that accumulate due to late pick up, late payments and/or rejected payments.

*Our program cares for children ages 18 months – 12 years of age. Once your child turns 13, he/she will not be allowed to attend the center based on state rules and regulations. I understand that my student must abide by the code of conduct established by YSCCC and also the discipline code set up by the school and the school district.

Print name of Parent/Guardian _____ Date: _____

Signature of Parent/Guardian _____ Date: _____

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number
Parent/Guardian Name #1		Relationship to Child
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's
City	State	Zip
Email Address *(if applicable)*		Cell Phone *(if applicable)*
Parent's Work/School Name		Parent's Work/School Telephone Number
Parent's Work/School Address		City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2		Relationship to Child
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's
City	State	Zip
Email Address *(if applicable)*		Cell Phone
Parent's Work/School Name		Parent's Work/School Telephone Number
Parent's Work/School Address		City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Please review in detail our Communicable Disease Policy from the Parent/Guardian Handbook. The State of Ohio mandates that a child be **SYMPTOM-FREE** for a full 24 hours before returning to the center.

COMMUNICABLE DISEASE POLICY

-When we send a Child home-

Each child, as required by law, has a physical exam upon entering the program. This exam is to be renewed each year (except for school-age children). It is vital that all parents/guardians communicate any and all information pertaining to their child's past and current medical history with the Center Staff.

Any child exhibiting any of the following symptoms will be considered to be carrying a communicable disease and should not be brought to the Center. Any staff member exhibiting any of the following symptoms will be sent home and a substitute staff member will replace them.

- **Diarrhea (three or more abnormally loose stools within a twenty-four hour period)**
- **Severe coughing (child's face turns red or blue, or whooping or barking sound is heard)**
- **Difficult or rapid breathing**
- **Yellowing skin or eyes**
- **Redness of the eye, obvious discharge, matted eyelashes, burning, itching**
- **Temperature of 100 degrees Fahrenheit or more**
- **Untreated, infected skin patch(es)**
- **Unusually dark urine and/or gray or white stool**
- **Stiff neck with elevated temperature**
- **Vomiting more than one time or when accompanied by any other sign/symptom**
- **Evidence of lice, scabies or other parasitic infestation**
- **Sore throat or difficulty in swallowing**

Teachers carefully observe children throughout the day. Any child who is suspected of having a communicable disease is isolated from the rest of the children and brought to the front office where they are made as comfortable as possible. The parent/guardian will be notified, and if they cannot be reached, "emergency contacts" will be called. An adult will be within sight and hearing of any child who is isolated due to illness.

Children are readmitted to the Center when symptom free for a period of 24 hours (or nit free in the case of lice). Because physicians and medications differ from case to case, written verification that the child is no longer contagious is required in order to return the child to the Center before the 24-hour symptom free time period.

Children who are not feeling well and are not exhibiting any of the above symptoms are considered "mildly ill" and will be cared for and observed for further signs of illness. The Center is not able to care for mildly ill children who cannot participate in the daily activities of the Center.

Please call the Center and let us know how your child is feeling and inform us of any diagnosis. Notifications of possible exposures are posted on the front door of the Center.

Ohio Department of Job and Family Services

CHILD MEDICAL STATEMENT FOR CHILD CARE

Child's Name *(print or type)*	Date of Birth

Note: Sections A and B must be completed by the examining Health Care Practitioner (Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner):

Section A- EXAMINATION

√ The above named child has been examined.

√ The above named child is in suitable condition for participation in group care (i.e. free of infectious disease, mentally and physically fit to be in group care).

√ The above named child does not have allergies OR is allergic to the following *(please list in space below)*:

Check below, if applicable:

☐ Additional information that will assist the child care program in providing appropriate child care for the above named child (special health care and developmental considerations) accompanies this form.

Optional: Measurements and Recommended Assessments/Screenings

Height _____ Vision _____ ☐ Yes ☐ No Lead _____ ☐ Yes ☐ No

Weight _____ Hearing _____ ☐ Yes ☐ No Hemoglobin _____ ☐ Yes ☐ No

BMI _____ Dental _____ ☐ Yes ☐ No Other: _____

Notes:

Signature of Examining Health Care Practitioner	Date of Examination
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City, State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES (MM/DD/YYYY FORMAT) OF DOSES OF ALL IMMUNIZATIONS.

IMMUNIZATION (*Complete ONLY ONE SECTION below*)

Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:

Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertussis, Pneumococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.

Section B - To be completed by the EXAMINING HEALTH CARE PRACTITIONER:	**Initials of Examining Health Care Practitioner**
☐ The above named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	Date
Section C - To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent** Date

STATE OF OHIO
LEGAL IMMUNIZATION EXEMPTION
Per OHIO STATUTE 3313.671 (Exemptions)

Religious, Good Cause, and Medical Exemption Form
Amended Substitute Senate Bill No. 282. Ohio Revised Code.
Sections 3313.671. Pat (3) and (4)

Section 3313.671, part (3): A pupil who presents a written statement of his parent or guardian in which the parent or guardian objects to the immunization for good cause, including religious convictions, is not required to be immunized.

Section 3313.671 part (4): A child whose physician certifies in writing that such immunization against my disease is medically contraindicated is not required to be immunized against that disease. This section does not limit or impair the right of a board of education of a city, exempted village, or local school district to make and enforce rules to secure immunization against poliomyelitis, rubeola, rubella, diphtheria, pertussis, and tetanus of the pupils under it jurisdiction.

I understand that the immunization Law permits me to sign a waiver on my child taking the immunization.

I hereby object and request the school to waiver the immunization of my child against the following:

D.P.T.	**Polio**	**Rubeola**
Rubella	**Mumps**	**Hepatitis B**
Varicella	**Hib**	**MMR**

Child's Name: _____

Religious: List name of denomination _____

Good Cause: Please Explain _____

Medical Reason: You must have a signed statement from your physician stating the condition and attach it to this form.

I further understand that during the course of an outbreak of any of the aforementioned vaccine preventable diseases, that the student named here is subject to exclusion from school for the duration of the outbreak.

~~**This action is necessary not only to protect this student, but the remainder of the students and faculty of the school.**~~

Parent/Guardian Signature: _____

Address: _____ **Date:** _____

Yellow Springs Community Children's Center Health Assessment

Parent/ guardian Health Assessment

Community Children's Center

Child's Name:_____

Parent/Guardian Name: _____

1. My child has a regular physician. (Yes/No)
   Name of Physician:

2. My child's birth followed a full- term pregnancy with no complications prior to/immediately following the delivery. Yes/ No * If no, please describe.

3. My child takes medication on a regular basis. Yes/ No
   - If Yes, please list medications, frequency and reason.

4. My child has been hospitalized and/ or undergone surgery. (Yes/ No)

5. My child has participated in therapy. (Yes/No)

6. There is a history of learning disabilities, attention deficit disorder or language delays in the family. (If yes, describe)

7. I have concerns about my child's development. (Yes/ No)

8. If applicable, please describe health/ nutrition concerns, major childhood illnesses or diagnosed syndromes:

9. I would like to share the following additional health related information about my child:

Parent/Guardian signature: _____ Date: _____

ORIGINAL

Ohio Department of Job and Family Services

FAMILY INFORMATION
FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

Child's Name *(Last)*	*(First)*	Nickname *(If any)*

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

ORIGINAL

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. *(Check the one that applies.)*

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

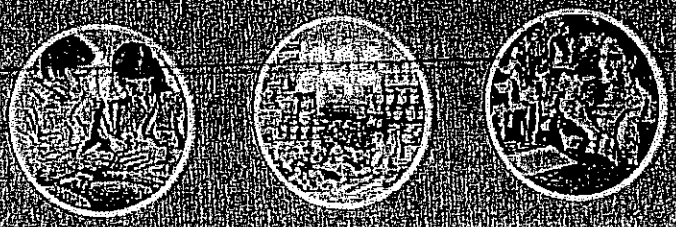
ORIGINAL

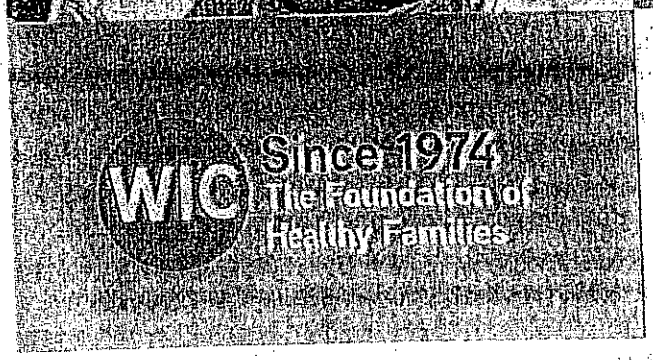
Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.
What might you and/or your child be anxious about as he/she starts in this program?
What are you and/or your child excited about as he/she starts in this program?
What are your expectations of this program?
What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature	Date

USDA United States Department of Agriculture

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program)





What is WIC? WIC was established as a permanent program in 1974 to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk. This mission is carried out by providing nutritious foods to supplement diets, nutrition education (including breastfeeding promotion and support), and referrals to health and other social services. Find out more: http://www.fns.usda.gov/wic/about-wic-wic-glance

Where is WIC available?

The program is available in all 50 States, 34 Indian Tribal Organizations, American Samoa, District of Columbia, Guam, Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands. While funded through grants from the Federal Government, WIC is administered by 90 State agencies, with services provided at a variety of clinic locations including, but not limited to, county health departments, hospitals, schools, and Indian Health Service facilities. To find the WIC offices serving your area go to: http://www.fns.usda.gov/wic/contacts

What food benefits do WIC participants receive?

The foods provided through the WIC Program are designed to supplement participants' diets with specific nutrients. WIC authorized foods include infant cereal, baby foods, iron-fortified adult cereal, fruits and vegetables, vitamin C-rich fruit or vegetable juice, eggs, milk, cheese, yogurt, soy-based beverages, tofu, peanut butter, dried and canned beans/peas, canned fish, whole wheat bread and other whole-grain options. For infants of women who do not fully breastfeed, WIC provides iron-fortified infant formula. Special infant formulas and medical foods may also be provided if medically indicated. Learn more about food benefits here: http://www.fns.usda.gov/wic/wic-food-packages

Program benefits include more than food.

WIC benefits are not limited only to food. Participants have access to a number of resources, including health screening, nutrition and breastfeeding counseling, immunization screening and referral, substance abuse referral, and more. Find out more: http://www.fns.usda.gov/wic/wic-benefits-and-services

Am I eligible?

Pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 who meet certain requirements are eligible. These requirements include income eligibility and State residency. Additionally, the applicant must be individually determined to be at "nutrition risk" by a health professional or a trained health official. To find out if you might be income eligible for WIC benefits go to: http://wic.fns.usda.gov/wps/pages/start.jsf

How WIC Helps

WIC supplemental foods have shown to provide wide-ranging benefits. They include longer, safer pregnancies with fewer premature births and infant deaths; improved dietary outcomes for infants and children; improved maternal health; and improved medical care at birth, among others. In addition to health benefits, WIC participants showed significant savings in healthcare costs when compared to non-participants. Learn more about how WIC helps:
http://www.fns.usda.gov/wic/about-wic-at-a-glance

What is "nutrition risk" and why is it important?

Two major types of nutrition risk are recognized for WIC eligibility: medically-based risks such as anemia, underweight, history of pregnancy complications, or poor pregnancy outcomes; and dietary risks, such as inappropriate nutrition/feeding practices or failure to meet the current Dietary Guidelines for Americans. Women, infants, and children at nutrition risk have much greater risk of experiencing health problems. Learn more about nutrition risk:
http://www.fns.usda.gov/wic/wic-eligibility-requirements

I'm eligible, what do I do next?

Those who are interested in applying for benefits should contact their State agency to request information on where to schedule an appointment. Applicants will be advised on what to bring to the appointment in order to verify eligibility. Contact your State agency here:
http://www.fns.usda.gov/wic/contacts/

EBT makes it easier to use food benefits.

In most WIC State agencies, participants receive paper checks or vouchers to purchase food, while a few distribute food through centralized warehouses or deliver the foods to participants' homes. However, all WIC State agencies have been mandated to implement WIC electronic benefit transfer (EBT) statewide by October 1, 2020. EBT uses a magnetic stripe or smart card, similar to a credit card, that participants use in the check-out lane to redeem their food benefits. EBT provides a safer, easier, and more efficient grocery experience and provides greater flexibility in the way WIC participants can shop. Find out more and check if your State supports EBT:
http://www.fns.usda.gov/wic/wic-electronic-benefits-transfer-ebt

Focus on breastfeeding.

Even though breast milk is the most nutritious and complete source of food for infants, nationally less than 30% of infants are breastfed at 1 year of age. A major goal of the WIC Program is to improve the nutritional status of infants; therefore, WIC mothers are encouraged to breastfeed their infants, unless medically contraindicated. Pregnant women and new WIC mothers are provided breastfeeding educational materials and support through counseling and guidance. Explore the benefits of breastfeeding and find helpful resources here:
http://www.fns.usda.gov/wic/breastfeeding-promotion-and-support-wic

WIC Facts

- If you participate in another assistance program you may be automatically income-eligible for WIC.
- Breastfeeding mothers are eligible to participate in WIC longer than non-breastfeeding mothers.
- More than half of the infants in the U.S. participate in WIC.
- WIC participants support the local economy through their purchases.
- WIC works with farmers markets to help increase participant access to provide fresh, locally grown fruits and vegetables. Find out more here:
  http://www.fns.usda.gov/fmnp/wic-farmers-market-nutrition-program-fmnp

Where can I learn more?

Information on FNS programs is available at
www.fns.usda.gov/fns/

SPECIAL DIET FORM

This center/facility participates in in the Child and Adult Care Food Program (CACFP) and any meals, snacks, or milk claimed for reimbursement must meet program requirements. Food accommodations must be made when the food accommodation is due to a disability (a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment). Reasonable food accommodations may be made for children/participants without disabilities who may have special medical or dietary needs. Food accommodations are to be supported by a statement signed by a recognized state medical authority which is defined as a state licensed health care professional who is authorized to write medical prescriptions under state law.

To be completed by parent, guardian or authorized representative		
Child/Participant Name:		Birth Date:
Parent/Guardian/Authorized Representative Name:		
Email:		
Home Phone:	Work Phone:	Cell Phone:
Address:		
City:	State:	Zip:

To be completed by recognized state medical authority

Check and complete appropriate information. For the safety of the child, please be as specific as possible.

☐ **Yes, this child/participant has a disability that requires food accommodation?**

Describe disability:

What major life activity is affected?

How does the disability restrict the diet?

☐ **Child/Participant has no disability but requires a special diet**

Describe the medical or other special dietary need that restricts diet:

List food/type of food to be omitted.

List food/type of food to be substituted for omitted food(s). Please be specific regarding any needed food texture changes or detailed menu to be followed.

Signature of Recognized State Medical Authority:	**Date:**
Printed Name:	Phone:

Yellow Springs Community Children's Center
Assessment Permission Form

Each year the teaching staff of the Community Children's Center performs developmental assessments and observations in the Fall, Winter and Spring. We utilize the Creative Curriculum, Developmental Screenings (ASQ & ASQ SE) and maintain individual portfolios to help teachers plan for each child's educational journey.

Parent teacher conferences are scheduled in the Fall and Spring to discuss observations, share work and create educational goals for your child.

Please sign permission for our teachers to conduct observations and do assessments on your child.

I give my permission for the Yellow Springs Community Children's Center to assess my child using a variety of assessment tools (as described above) to help set educational goals for my child while they are enrolled in the Yellow Springs Community Children's Center.

Parent signature: _____

Date: _____

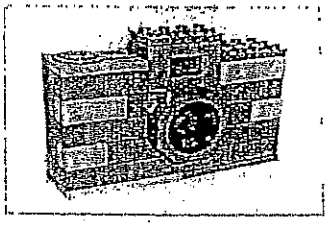
Director's Signature: _____

Ohio Department of Job and Family Services

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information	
Routine Trip Destination(s)	
Date of Permission *(valid for one year)*	
Mode of Transportation (*walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*	
During this trip children will have access to water that is 18 inches or more in depth. ☐ Yes ☐ No Are water activities planned in water that is 18 inches or more in depth? ☐ Yes ☐ No (if yes, a swimming permission slip is required)	
Child's Information	
Child's Name	
My child is ☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 8 years and/or over 4' 9"	
Signature	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date

Photo and video/Audio recording release



For my child's participation in activities to be conducted by the Yellow Springs Community Children's Center, I hereby give me permission and consent, now and for all time, to YSCCC and collaborating third parties to make, produce, edit broadcast any video, film, footage, sound track recordings and photo reproductions of me/my child for marketing purposes via print, social media, television, radio and/or sound track recordings.

I Do give Permission:

Parent/ Guardian Signature: _____

Date: _____

Participant Printed Name: _____

I DO NOT give Permission:

Parent/ Guardian Signature: _____

Date: _____

Participant Printed Name: _____

Ohio Department of Education - Office of Integrated Student Supports

CHILD AND ADULT CARE FOOD PROGRAM

ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside School Hours, Youth Development & After School at Risk

Instructions to Complete

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME		
CHILD'S NAME (please print)	AGE	BIRTHDATE ___/___/___ month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		List hours child normally in care				Check (✓) meals child normally receives while in care					
		Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

☐ **Yes, the schedule listed above may frequently vary due to changes in parents/guardians schedule.**

SIGNATURE OF PARENT/GUARDIAN	DATE	DAY PHONE NUMBER
MAILING ADDRESS: STREET /APT.	CITY	ZIP CODE

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email:program.intake@usda.gov.

This institution is an equal opportunity provider.

INCOME ELIGIBILITY APPLICATION FOR FREE AND REDUCED-PRICE MEALS Fiscal Year 2020-2021

INSTRUCTIONS: To apply for free and reduced-price meals, read the household Letter and Instructions on backside of this form. Complete application ar return to the center. In accordance with the NSLA, information on this application may be disclosed to other Child Nutrition Programs or applicable enforcement agencies. Parents/guardians are not required to consent to this disclosure. *Part 1* is to be completed by all households. *Part 2* is to be used for a child living in a household receiving food assistance (SNAP) or Ohio Works First (OWF) benefits. *Part 3* is only for children NOT receiving Food Assistance or OWF benefits. *Part 4* an adult household member must sign and date form; the last 4 digits of social security number must be listed if Part 3 completed. *Part 5* is optional. * Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

CENTER NAME

PART 1 – PRINT INFORMATION FOR ALL CHILDREN ENROLLED AT CENTER

* NAME OF ENROLLED CHILD(REN)	AGE	BIRTH DATE	CHECK IF A FOSTER CHILD (The legal responsibility of a welfare agency or court)
1.			☐
2.			☐
3.			☐
4.			☐

PART 2 – LIST EACH CHILD'S FOOD ASSISTANCE (SNAP) OR OWF CASE NUMBER (IF ANY). A VALID CASE NUMBER CONTAINS 7 DIGITS.

Check type of benefit: ☐ FOOD ASSISTANCE (SNAP) or ☐ OHIO WORKS FIRST (OWF)

CASE NO. _ _ _ _ _ _ _

CASE NO. _ _ _ _ _ _ _

CASE NO. _ _ _ _ _ _ _

CASE NO. _ _ _ _ _ _ _

PART 3 – TOTAL HOUSEHOLD SIZE, TOTAL HOUSEHOLD GROSS INCOME AND HOW OFTEN IT WAS RECEIVED: List names of all household members. List all gross income: list how much and how often. If Part 2 is completed, skip to Part 4.

a. LIST NAMES OF ALL HOUSEHOLD MEMBERS INCLUDING CHILDREN LISTED ABOVE IN PART 1	b. CHECK IF NO/ZERO INCOME	c. GROSS INCOME during the last month (amount earned before taxes & other deductions) and HOW OFTEN IT WAS RECEIVED: Weekly, Every 2 Weeks, Twice Per Month, Monthly, Annua			
		1. Earnings from work before deductions	2. Welfare payments, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA	4. All Other Income
EXAMPLE: JANE SMITH	☐	$ amount / how often	$ amount / how often	$ amount / how often	$ amount / how o
1.	☐	$ /	$ /	$ /	$ /
2.	☐	$ /	$ /	$ /	$ /
3.	☐	$ /	$ /	$ /	$ /
4.	☐	$ /	$ /	$ /	$ /
5.	☐	$ /	$ /	$ /	$ /
6.	☐	$ /	$ /	$ /	$ /

PART 4 – SIGNATURE & LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: Adult household member must sign/date form. If Part 3 is completed the adult signing the form must also list last 4 digits of his/her Social Security Number or check the "I do not have a Social Security Number" bo

I certify that all information on this form is true and correct and that all income is reported. I understand that the center will get Federal Funds based on th information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

* SIGNATURE OF ADULT HOUSEHOLD MEMBER	* DATE	* If Part 3 is completed, insert last 4 digits of Social Security Number ☐☐☐☐
		☐ (Check if applicable) I do not have a Social Security Number
Print Name:	Daytime Phone Number:	Work Phone Number:
Street / Apt:	City / State / Zip:	County:

PART 5: RACIAL/ETHNIC IDENTITY (Optional): Please check appropriate boxes to identify the race and ethnicity of enrolled child(ren).

☐	American Indian or Alaska Native	☐	Asian	☐	Black or African American
☐	Native Hawaiian or Other Pacific Islander	☐	White	☐	Other

Please mark one ethnic identity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Tempo Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible free or reduced-price meals, and for administration and enforcement of the Program.

State Distribution: 7/1/2020

THIS SECTION TO BE COMPLETED BY CENTER. Note: All information above this section is to be filled in by the parent or guardian.

Complete information below only if qualifying child(ren) by household income from Part 3.

Per the total household size, compare total household income to the USDA Income Eligibility Guidelines to determine correct categorization. When income is listed in different frequencies of pay in Part 3, you must convert all income to annual income before determination. Use the following Annual Income Conversion :
Weekly x 52, Every 2 Weeks (biweekly) x 26, Twice per Month (semi-monthly) x 24, Monthly x 12

Application Certified/Categorized as:

☐ **FREE**, based on ☐ Food Assistance/OWF Case N ☐ Household size and Income ☐ Foster Child

☐ **REDUCED**, based on Household size and Income

☐ **PAID**, based on ☐ Income too high ☐ Incomplete ☐ Invalid case number or inform

Total Household Size: _____

Total Household Income: $_____

Per: ☐ week ☐ every two weeks ☐ twice per month ☐ month ☐ year

Signature of Sponsor / Center Representative

Date Sponsor Certified/Categorized Form

Note: Effective date is determined by parent or sponsor signature date as selected on CRRS application. If date of parent signature is not within month of certification or immediately preceding month, effective date must be date of sponsor certification.

Effective Date (From the first of month of date signed)

Expiration Date (Valid until last day of month I form was signed one year ear

Dear Parent/ Guardian,

Welcome to the Yellow Springs Community Children's Center! We are delighted to have your child/ren in our care and would like for him/her to be kept safe and comfortable here. Please read through the Parent Handbook and coming to us with any questions you might have.

I have read the Parent Handbook and agree to abide by the policies stated within. If I have any questions or do not understand something, I will ask. I understand that interpretation of policies ultimately falls with the director and I will seek his/her assistance as needed.

Signature of Parent/Guardian **Child's Name** **Date**

YELLOW SPRINGS
Community
Children's Center

Dear Yellow Springs Community Children's Center Parents/ Guardians,

As you know, it is our top priority to keep your children safe while in our care. We want each child to feel safe and enjoy their time here at the Children's Center. In order to support this, Yellow Springs Community Children's Center will not tolerate excessive disrespect towards faculty or other students, bullying or violence of any kind, or disregard of the rules put in place to insure the safety of children. If your child participates in any of these behaviors, he or she will be subject to suspension or expulsion from YSCCC.

Staff and parent collaboration is vital for a child's success when navigating through emotional and behavioral challenges. If we do not receive equal support/ participation in helping children through these challenges **(utilizing referrals, screenings, testing, therapies, adjusting home practices to support specifics challenges at school and home)** we have the right to disenroll the child from the center for safety purposes and to ensure we can provide an optimal learning environment for all children.

The following protocol is in place to prevent these events:

Incident #1: The parent will be called and the child will be asked to go home immediately with a one-day suspension the following day. An individualized behavior plan will be put into place, if necessary, noting specific strategies to help the child self- regulate.

Incident #2: The parent will be called and the child will be asked to go home immediately with a two-day suspension.

Incident #3: The parent will be called and the child will be asked to go home immediately and the child will not be allowed to return to the center.

Child name: _____

By signing this form, I acknowledge this behavior policy.

X _____ _____ _____

Parent Signature Print name Date

X _____

Allie Turner , Executive Director