



YELLOW SPRINGS  
**Community**  
Children's Center

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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)
- \_\_\_\_\_ Health Assessment (2 pages)
- \_\_\_\_\_ Special Diet Form \*Must be signed by parent (Optional)
- \_\_\_\_\_ Family information for Step Up to Quality for School Age Students (3 pages)
- \_\_\_\_\_ Assessment Permission
- \_\_\_\_\_ Behavioral Policy Acknowledgement
- \_\_\_\_\_ Routine Trip Permission
- \_\_\_\_\_ Swim Permission
- \_\_\_\_\_ Photo/Video/ Audio Release statement
- \_\_\_\_\_ Handbook Acknowledgement

Yellow Springs Community Children's Center

Center hours of operation 6:30 a – 6:00p

Before Care hours are 6:30 – 7:40/ After care hours of operation 2:45 – 6:00

Holidays, school closings, Snow days are an additional \$50.00 per day

5% discount for 3 months advance pay

10% Sibling discount

15% Military discount (Please bring ID)

Infant Program (6weeks-17months)

Toddler Program (18 months-3 years)

<u>Attendance</u>	<u>Monthly</u>	<u>Attendance</u>	<u>Monthly</u>
5 full days	\$1095.50	5 full days	\$920.00
5 Mornings or Afternoon	\$916.00	5 Mornings or Afternoon	\$718.00
4 Full Days	\$1061.00	4 Full Days	\$883.00
4 Morning or Afternoon	\$819.50	4 Morning or Afternoon	\$620.50
3 Full Days	\$950.00	3 Full Days	\$815.00
3 Morning or afternoon	\$765.00	3 Morning or afternoon	\$525.50

Preschool Program (3 years – 5 years)

<u>Attendance</u>	<u>Monthly</u>
5 Full days	\$750.00
5 Mornings or Afternoons	\$546.00
4 Full Days	\$685.00
4 Mornings or Afternoons	\$478.00
3 Full Days	\$597.00
3 Mornings or Afternoons	\$420.00

Approved by YSCCC Board on 5/1/21

Yellow Springs Community Children's Center

After School ONLY school Age Program

Before School ONLY School Age Program

\*Includes snack and developmentally appropriate activities

5 Days per week	\$400.00	5 Days per week	\$300.00
4 Days per week	\$390.00	4 Days per week	\$280.00
3 Days per week	\$320.00	3 Days per week	\$215.00

\*Before and After Care School Age Program

Summer Program

\*Includes snack in the afternoon, School Closings,  
Snow Days and Holidays.

\*Additional onetime \$130.00 activity fee  
which covers field trips and classroom materials  
\* Includes Breakfast, Lunch, Snack

\*Includes developmentally appropriate activities and lesson plans

5 Days per week	\$675.00	5 Days per week	\$680.00
4 Days per week	\$660.00	4 days per week	\$650.00
3 Days per week	\$600.00	3 days per week	620.00

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 5<sup>th</sup>.

\* 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.

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**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 5<sup>th</sup> 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 it is 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			Relationship to Child	
Home Address			Home Telephone Number	
City			State	Zip
Email Address (if applicable)		Cell Phone		
Parent's Work/School Telephone Number		Parent's Work/School Name		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email Where can you be reached while your child is in this program/home?				
Parent/Guardian Name			Relationship to Child	
Home Address			Home Telephone Number	
City			State	Zip
Email Address (if applicable)		Cell Phone		
Parent's Work/School Telephone Number		Parent's Work/School Name		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email Where can you be reached while your child is in this program/home?				
<b>Emergency Contacts:</b> Parents <u>cannot be listed</u> 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 within one hour of the center/home, 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

**Allergies, Special Health or Medical Conditions, and Food Supplements**

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? *(check all that apply)*

☐ No

☐ Yes - check all that apply

☐ Food

☐ Medication

☐ Environmental

Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? *(check one)*

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? *(check one)*

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? *(check one)*

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? *(check one)*

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? *(check one)*

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

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.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

#### Diapering Statement

Is your child toilet trained? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> No (If no, fill out the following)	
The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:	
<input type="checkbox"/> I agree with the program's schedule	<input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

#### Emergency Transportation Authorization

Give <u>Permission</u> to Transport	OR	Do Not Give <u>Permission</u> to Transport
Program or Home Name		Program or Home Name
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.	OR Do not sign both	does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature		Parent's Signature
Date		Date

#### Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No (check one)
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This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.	
Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.			
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.



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](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](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

Revised 10/2019

**INSTRUCTIONS:** To apply for free and reduced-price meals, read the household letter and instructions on backside of this form. Complete application and 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 only 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* is completed, *Part 5* is optional. \* Asterisks indicate info that must be completed. Form must be completed annually and valid for only 12 months.

**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.

**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" box. 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 the information. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, I may be prosecuted.

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

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, we 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 the 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), Temporary 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 you 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 for free or reduced-price meals, and for administration and enforcement of the Program.

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

Signature of Sponsor / Center Representative	Date Sponsor Certified/Categorized Form	Effective Date	Expiration Date
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.		(From the first of month of date signed)	(Valid until last day of month in which form was signed one year earlier)

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)

## Yellow Springs Community Children's Center Health Assessment

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:

## Family Information (School-Age)

Child's Name (Last)	First	Nickname (if any)
<p>By providing complete information about your child, you will be assisting the 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 who care for your child.</p>		
Members of child's immediate family		
Who lives at home with your child?		
Languages spoken in your home/Primary language		
Are there any special family arrangements, such as shared parenting or custody specifications, etc?		
Changes or transitions that your child recently experienced or is experiencing? (ie. new home, birth of sibling, divorce, school issues, death of family member, friend, pet)		
Any cultural or religious practices of your family of which we should be aware? (dietary restrictions, head coverings, clothing, language, etc)		
Do you have any pets at home? If so, type of pet and pet's name		
What are your child's favorite foods?		

What are the foods your child dislikes?
Are there any foods your child should not be fed? (Child Care Licensing requires a form to be completed for children with food allergies or dietary restrictions)
What time does your child normally wake up and go to bed at night on a school night? Wake Up _____ Go to Bed _____
What is your child's favorite subject (s) in school/what subject (s) is a challenge? Favorite: Challenge:
What causes your child to feel angry or frustrated?
What actions or items do you use to comfort your child when upset?
What methods do you use to respond to your child's negative behavior?
How do you reward your child's good behavior or accomplishments?
What are some of your child's interests?
Is your child taking any lessons or participating in organized clubs/teams? (ie. swim, dance, piano, scouts, soccer, youth group, etc)
Average number of hours per day your child watches TV/DVDs during the school week? ____ Less than 1 hour      ____ 1-3 hours      ____ 4 or more hours
Average number of hours per day your child has access to the items listed below: ____ Computer/Ipad      ____ Cell phone      ____ Video Games

Please circle all of the words that best describe your child's personality and general behavior:

active adventurous affectionate anxious bossy calm cautious cheerful content creative  
curious emotional energetic excitable friendly happy insecure likes structure/routine loud  
loving outgoing quiet prefers adult attention sensitive serious stubborn talkative

What makes your child laugh?

Is there anything that is making your child excited about starting in this program?

Is there anything that is making you or your child anxious about starting in this program?

Please rank from 1-10 (10 most important) the importance of After-School activities:

Snack\_\_\_\_ Art&Drama\_\_\_\_ Physical Activity\_\_\_\_ Structured Play\_\_\_\_ Friends\_\_\_\_  
Rest\_\_\_\_ Homework\_\_\_\_ Free Play\_\_\_\_ Safe Environment\_\_\_\_ Learning Activities\_\_\_\_

Has your child had a previous care arrangement? If so, what type (center based, in-home, with family, summer camp, youth program)

What are your expectations of this program?

Any other information that would be helpful for the staff caring for your child to know?

Does your child have an I.E.P (Individualized Care Plan) or an IFSP (Individualized Family Service Plan)

Yes

No

If yes, would you be willing to provide the program a copy, so the teachers can support your child and family.

Yes

No

Do you or anyone in your family have a hobby, skill, or area of expertise you would be interested in sharing with school age youth?

Parent/Guardian Signature

Date

Ohio Department of Job and Family Services  
**ROUTINE TRIP PERMISSION FOR CHILD CARE**

<b>Routine Trip Information</b>	
Routine Trip Destination(s) Bike Path, John Bryan Park, Antloch, Downtown YS, YS library, Toddler Park, Police/Fire Station, Mills Lawn	
Date of Permission ( <i>valid for one year</i> )	
Mode of Transportation ( <i>walking, school bus, public transportation, parent vehicles, provider vehicle and driver</i> ) Walking	
During this trip children will have access to water that is 18 inches or more in depth. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? (if yes, a swimming permission slip is required) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>Child's Information</b>	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 8 years and/or over 4' 9"	
<b>Signature</b>	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date



Ohio Department of Job and Family Services  
**PERMISSION TO PARTICIPATE IN SWIMMING ACTIVITIES  
FOR CHILD CARE**

Written parental permission is required for the water activities your child will be engaging in (check all that apply for this activity)	
<input type="checkbox"/> Child swimming in water 18 inches or more in depth	
<input type="checkbox"/> Child participating in activities near water 18 inches or more in depth (no water activities planned)	
<input type="checkbox"/> Infants and toddlers using wading pools	
I give permission for my child to participate in the following swimming/water activities	
Swim Site	
Date(s)	
Departure/Arrival Times from Center	
Mode of Transportation (parent's driving, provider vehicle, public transportation, school bus, etc.)	
Child's Name	Child's Date of Birth
My child is a <input type="checkbox"/> Swimmer <input type="checkbox"/> Non swimmer	
Parent's Signature	Date

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.

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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: \_\_\_\_\_

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

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. To support this, Yellow Springs Community Children's Center will not tolerate excessive disrespect toward faculty or students, bullying or violence of any kind of disregard of the rules put into place to ensure the safety of children. If you child participates in any of these behaviors, he or she will be subject to suspension or expulsion from YSCCC.

*The following protocol is in place to prevent these events:*

**Incident #1:** The parent will be called and the child will receive a warning with the expectation that the behaviors will not continue.

**Incident #2:** The parent will be called and the child will be asked to go home immediately. An individualized behavior plan will be put into place, if necessary, noting specific strategies to help the child self-regulate.

**Incident #3:** The parent will be called and the child will be asked to go home immediately with a two day suspension.

**Incident #4:** 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.

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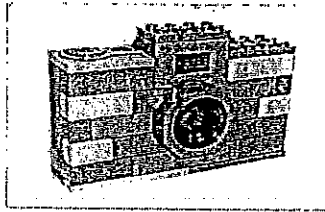
Child's Name: \_\_\_\_\_

By signing this form, I acknowledge this behavior policy and will follow it as needed.

Parent signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Executive Director: \_\_\_\_\_

# 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: \_\_\_\_\_

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.

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Signature of Parent/Guardian	Child’s Name	Date
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Child's Name : \_\_\_\_\_

Birthdate : \_\_\_\_\_

Mailbox # : \_\_\_\_\_ Enrollment Date : \_\_\_\_\_

Allergies : \_\_\_\_\_

Address : \_\_\_\_\_

Home phone : \_\_\_\_\_

\_\_\_\_\_

Email : \_\_\_\_\_

Parent's/Guardian's name : \_\_\_\_\_

Cell phone : \_\_\_\_\_

Parent's/Guardian's workplace : \_\_\_\_\_

Work phone: \_\_\_\_\_

Parent's/Guardian's name : \_\_\_\_\_

Cell phone : \_\_\_\_\_

Parent's/Guardian's workplace : \_\_\_\_\_

Work phone: \_\_\_\_\_

Doctor : \_\_\_\_\_

Doctor's phone : \_\_\_\_\_

Emergency contacts : \_\_\_\_\_

phone : \_\_\_\_\_

\_\_\_\_\_

phone : \_\_\_\_\_

Pick-up people : \_\_\_\_\_

phone : \_\_\_\_\_

\_\_\_\_\_

phone : \_\_\_\_\_

Medical Information : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Special Needs : \_\_\_\_\_

\_\_\_\_\_

Photographs of Child : Yes \_\_\_\_\_ No \_\_\_\_\_

Include in Parent Roster : Yes \_\_\_\_\_ No \_\_\_\_\_

Emergency transport : Yes \_\_\_\_\_ No \_\_\_\_\_

Hospital \_\_\_\_\_

Parent / Guardian signature(s) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_