Family Acknowledgement Sheet

All centers must maintain a licensing notebook which includes all licensing inspection reports, special investigations and all related action plans.

This Program maintains a licensing notebook and is available to families during business hours and is located near the front entrance.

Licensing inspection and special investigation reports from the past two years are available on the Department of Licensing and Regulatory Affairs (LARA) website at: **http://www.michigan.gov/lara/0,4601,7-154-63294_5529---,00.html**

We the family of _____ _____
(1. Family member) (2. Family member)

acknowledge that we have read the entire Family handbook and agree to the policies and procedures written within.

We also acknowledge that payments are due at a minimum of two weeks before care is needed for the time the child or children are in the program. I acknowledge that if I do not follow the policies and procedures care could be terminated.

I agree to pick up my child after work as soon as I can do so safely. _____ (Initials)

I/we are also aware of the licensing handbook for State Licensing Rules for Childcare Centers in the parent area.

Signed _____ Date _____

Signed _____ Date _____

I hereby give YMCA of Barry County the right and permission to copyright and/or publish or use pictures of my child made through any media for art, advertising, digital communication or any other lawful purpose whatsoever.

____ Yes, I grant full permission

____ Yes, I grant full permission for Internal use ONLY

____ No, I do not grant permission

TURN THIS PAGE INTO THE CENTER

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:	Date of Admission	Date of Discharge

Name of Child (Last, First, Middle Initial)				Child's Date of Birth
Address (Number and Street, Building/Apartment Number)		City	State	Zip Code
Parent/Legal Guardian's Name	Primary Phone ( )	Parent/Legal Guardian's Name (Optional)		Primary Phone ( )
Home Address (if not child's address)	2nd Phone (if applicable) ( )	Home Address (if not child's address)		2nd Phone (if applicable) ( )
City / State	Zip Code	City / State		Zip Code
Email Address (optional)		Email Address (optional)		
Employer Name	Work Phone ( )	Employer Name		Work Phone ( )
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ( )		
Hospital Preferred for Emergency Treatment (optional)				
Allergies, Special Needs and/or Special Instructions? Yes ☐ No ☐ If yes, explain: (Attach additional sheets, if necessary.)				

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	( )	( )
2.	( )	( )
3.	( )	( )

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	( )	**2.**	( )
3.	( )	**4.**	( )

Parent/Legal Guardian Initials: _____

_____ I give permission to Y Time/YMCA of BC, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian — Date Signed

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

CCL-3731 (Rev. 3/17/2022) Previous editions 7-18 & 4-21 may be used

ENROLLMENT/PAYMENT AGREEMENT

Program: School Age or 2.5-5 year old Preschool **START DATE** _____

Child Name_____Gender_____Date of Birth_____ Age_____

Child Name_____Gender_____Date of Birth_____Age_____

Child Name_____Gender_____Date of Birth_____Age_____

Address_____City_____Zip _____

Allergies _____Restrictions_____

Parent/Guardian: Mother_____ Father: _____

Mother: home phone _____ Cell Phone _____

Father: home phone _____ Cell Phone _____

Step Parents_____

Child living with _____

Mother email _____ Father email _____

Emergency contact name and phone number (not a parent) _____

WEEKLY SCHEDULE Please fill in the days/times. Start & End needed.

	Monday	Tuesday	Wednesday	Thursday	Friday
AM					
PM					

MONTHLY/WEEKLY TUITION RATE– SECOND CHILD DISCOUNT 10% OFF OF FULL TIME ONLY

Child One $ _____

Child Two $ _____ **Child Three $** _____ **TOTAL TUITION DUE $** _____

I agree:

1. I have received a copy of the Parent Handbook. I have read and agree to all of the policies and procedures outlined in the Parent Handbook.
2. I understand that this agreement may be changed or cancelled with 2 full weeks written notice.
3. I understand that tuition rates may change with 2 full weeks written notice.
4. I agree to pay $ _____ weekly/monthly.
5. I am aware that the center maintains a licensing notebook that contains reports from all licensing inspections, renewal inspections, special investigations, and corrective actions plans and I may review this material at any time.
6. I am the parent or legal guardian of the child/ren I am enrolling and understand that it is my responsibility to keep all information, authorization, required forms, and health records pertaining to my child/ren, current and up to date.

Parent/Guardian's Name (please print) _____

Parent/Guardian's Signature _____Date _____

Health, Activity, Permission and Acknowledgement Form
YMCA of Barry County Y Time Child Care

Child's First and Last Name _____

Parent / Guardian Medical Authorization

_____ 1. I hereby give permission to the YMCA of Barry County/Y Time Childcare to provide routine health care, administer prescribed medications, and seek emergency medical care including ordering x-rays and routine tests in the event that I am not available.

I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

I give permission to the YMCA of Barry County/Y Time Childcare to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the YMCA of Barry County/Y Time Childcare to secure and administer treatment, including hospitalization for the person named above.

_____ 2. My child is healthy and his/her immunizations are up to date. He/She has permission to participate in all activities except as noted.

List any allergies, conditions, or heath concerns: _____

Activity Restrictions:

_____

Reason for Restriction:

_____

Is your child on any medication? Yes___ No ___ if yes, what: _____

_____ 3. I agree to call Y Time and let staff know if my child will not be attending on a scheduled day. If my child becomes ill while at the program, I know I will be called to take my child home.

Outdoor play and topical medication

_____ 4. Above stated child has my permission to participate in play on the playground where the program is located or closest park.

_____ 5. I give my permission for topical nonprescription medications to be administered as needed, such as sunscreen and bug repellent.

_____ 6. Above stated child has my permission to participate in the YMCA of Barry County Y Time Child Care **field trips** and get to the destination using the Barry County Transit Bus.

_____ 7. I agree to provide a healthy lunch on days my child may not eat the provided lunch.

Health, Activity, Permission and Acknowledgement Form
YMCA of Barry County Y Time Child Care

_____ 8 I agree my child's account must be paid in full by the end of the month for the year and weekly for the Summer Club program. A late fee of $10 may be assessed if payments are late. Credit card payments or checks that are declined may also receive a $10 fee.

_____9. I the parent/guardian of the above name child acknowledge that I have read the entire YMCA/Y Time Child Care Family Handbook and agree to the policies and procedures, including the no electronics' brought to the program section.

_____ 10. I/we are also aware of the licensing handbook for State Licensing Rules for Child Care Centers in the Family area.

_____ 11. I understand that the Director reserves the right to cancel the enrollment of a child for one or more of the following reasons:

a. The program is not contributing to the child's emotional or physical development.
b. A parent/guardian fails to observe the policies set forth by the YMCA and Y Time, including but not limited to, the following reasons:

1. Non-payment or persistent late payment of child care fees.
2. Failure to submit all enrollment forms.
3. Failure to comply with the procedures for arrival and departure of the child.
4. Physical or verbal abuse of children or staff by the parent/guardian.

c. If the Y should have to close its services, the Y would:
1. Notify parents of closing with as much advance notice as possible.
2. Any unused fees paid would be refunded.

Signature of Parent/Guardian: _____

Printed Name: _____ Date: _____

Updated 7/2022

Special Diet Statement

Why am I being asked to fill out this form?

Institutions or organizations who sponsor and operate a federally funded Child Nutrition Program must make reasonable substitutions to meals and/or snacks on a case-by-case basis for participants who are considered to have a disability that restricts their diet.* According to the ADA Amendments Act, most physical and mental impairments that substantially limit or affect one or more major life activities or bodily functions will constitute a disability.

Sponsors are not required to accommodate special dietary requests that are not a disability. This includes requests related to religious or moral convictions or personal preference. **If these requests are accommodated, sponsors must ensure that all USDA meal pattern and nutrient requirements are met.**

This form must be completed by a licensed physician, physician assistant, or an advanced practice registered nurse, such as a certified nurse practitioner. **Updates to this form are required only when a participant's needs change.**

Note to Districts/Schools: Parents/Guardians may provide a written request for lactose-free milk without a physician's signature. Lactose-free milk served must meet meal pattern requirements for the program.

Submit this completed special diet statement to: _____

Participant Information:

Participant's Full Name: _____ Today's Date: _____

Date of Birth: _____

Name of School/Center/Site Attended: _____

Parent/Guardian Name: _____

Home Phone Number: _____ Work Phone Number: _____

Required Information: Dietary Accommodation

1. List the food to be avoided:

   _____

2. Briefly explain how exposure to this food affects the participant:

   _____

3. List foods to be omitted and substituted. Attach a sheet with additional instructions as needed.

Foods to be Omitted	Foods to be Substituted

Additional Information

☐ Texture Modification: ☐ Pureed ☐ Ground ☐ Bite-Sized Pieces ☐ Other: _____

☐ Tube Feeding Formula Name: _____

Administering Instructions: _____

Oral Feeding: ☐ No ☐ Yes If yes, specify foods: _____

☐ Other Dietary Modification or Additional Instructions (Describe): _____

*School Nutrition Program –7 CFR 210.10(m), Child and Adult Care Food Program – 7 CFR 226.20 (g), Summer Food Service Program – 7 CFR 225.16(f)(4).

Required Signature

This form must be signed by a licensed physician, physician assistant, or advanced practice registered nurse such as a certified nurse practitioner. The medical person signing it should keep a copy of this document in his/her records.

Prescribing Authority Credentials (print):_____Date:_____

Signature:_____Clinic/Hospital:_____

Phone Number:_____Fax Number: _____

Voluntary Authorization

Note to Parent(s)/Guardian(s)/Participant: You may allow the director of the school/center/site to talk with the medical person about this Special Diet Statement by signing the Voluntary Authorization section:

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Family Educational Rights and Privacy Act I hereby authorize _____ **(physician/medical authority name)** to release such protected health information as is necessary for the specific purpose of Special Diet information to_____**(program name)** and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning me, with the program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for me. I understand that permission to release this information may be rescinded at any time except when the information has already been released. **Optional**: My permission to release this information will expire on_____**(date)**. This information is to be released for the specific purpose of Special Diet information. The undersigned certifies that he/she is the parent, guardian, or authorized representative of the participant listed on this document and has the legal authority to sign on behalf of that participant.

Parent/Guardian:_____Date: _____

OR Participant's Signature (Adult Day Care ONLY): _____

Non-Discrimination Statement

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 (https://www.ocio.usda.gov/sites/default/files/docs/2012/Complain_combined_6_8_12.pdf), (AD-3027) found online at: How to File a Complaint (https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint), and at any USDA office, or write a letter addresse d 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 of 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.