YMCA OF THE IOWA MISSISSIPPI VALLEY
CHILD CARE & FAMILY SERVICES
KIDS CLUB – 2021-2022 SCHOOL YEAR

Child's Name: ____ Birthdate:_____________

Payment Type: ☐ Weekly Bank Draft ☐ Child Care Assistance

For Billing questions, contact: Amanda Dang, Administrative services Director
563.323.5730 cc-admin@ymcaimv.org

We need: ☐ Before school care ☐ After school care ☐ Before & After School Care

	Before school care	After school care	Before & After School Care
Member:	$70/week	$70/week	$86/week
Non-Mbr:	$75/week	$75/week	$95/week

School Site: (Choose one)

☐ Bridgeview ☐ Cody ☐ Forrest Grove ☐ Grant Wood
☐ Herbert Hoover ☐ Hopewell ☐ Paul Norton ☐ Pleasant View
☐ Riverdale Hgts ☐ North Y ☐ West Y

Includes all snow days. Separate registration required for scheduled no school days, including winter and spring break. Doesn't include holidays, including Labor Day, Thanksgiving, Friday after Thanksgiving, Christmas Eve, Christmas Day, Year's Eve Day, New Year's Day and Memorial Day.

YMCA of Iowa Mississippi Valley Authorization to weekly Bank Draft of Program Fees:

My weekly draft will beginning on the 2nd Monday of the starting program, 2 weeks of program fees will be drafted with the first draft (for weeks 1 and 2).

from: ☐Checking or ☐Savings Account (choose one)

ENTER BANK ACCOUNT INFORMATION BELOW **PLEASE PRINT CLEARLY**

BANK ROUTING # ☐☐☐☐☐☐☐☐☐ (ROUTING # MUST BE 9 DIGITS)

BANK ACCOUNT#____

I attest that I have the authority to authorize recurring payments from this account.

ACCOUNT HOLDER'S INITIALS:_________

- Bank draft will occur weekly, and it will continue unless the YMCA of the Iowa Mississippi Valley is **NOTIFIED THE WEDNESDAY PRIOR TO THE NEXT DRAFT.** **ACCOUNT HOLDER'S INITIALS:_________**
- Program rates are subject to change; you will be notified in writing prior to any rate adjustments. Program fees are non-refundable.
- Program fees are collected Monday for each week's services and may **NOT** be carried over to future weeks or transfer to another week or participant. (1st draft will be on 2nd Monday for 1st 2 weeks of program fees)
- I will notify the YMCA of the Iowa Mississippi Valley of change in my bank account, phone number, email or home address.
- I understand that, should any bank draft not be honored by my bank for any reason, I am responsible for that payment, PLUS any service fee assessed by the YMCA of the Iowa Mississippi Valley. This is in addition to any service fees assessed by my bank.

Account Holder's Signature:

____Date:_______________

(Parent/Guardian if minor under 18) **Signature required for all registrations**

I understand that by typing my name above, I am electronically signing.

YMCA OF THE IOWA MISSISSIPPI VALLEY
CHILD CARE & FAMILY SERVICES
KIDS CLUB – 2021-2022 SCHOOL YEAR

Thank you for choosing the YMCA Childcare, we are delighted to have you and your family as a member of our YMCA family. Please note we have a Child Care & Family Services Handbook to assist you with any questions you might have. All of our childcare programs are based on our mission to put Judeo-Christian principles into practice through the programs that build healthy spirit, mind, and body for all.

Child's Home School: ____ Start Date: _____________
Funding Source: ☐ Parent Pay ☐ State Pay

Child's Name: ____ Nickname (if any): ____________________

Address: _________________________________ City: __________________ State: ____ Zip: ________

Home Ph: ________________________ Cell Ph: _______________________ BirthDate: _______________

Email: ____ Age: ______ Grade: ______ Sex: M ☐ F ☐

The following information is required by the Child & Adult Care Food Program the Y participates in.
My child's usual days and times of attendance will be:

	Monday	Tuesday	Wednesday	Thursday	Friday
Arriving at:	___________	___________	___________	___________	___________
Leaving at:	___________	___________	___________	___________	___________

My child's anticipated meal participation will be: ☐ Breakfast PM Snack

Hispanic or Latino	Non-Hispanic or Latino	American Indian	Alaskan Native	Asian	Caucasian	Black or African American	Pacific Islander or Native Hawaiian
☐	☐	☐	☐	☐	☐	☐	☐

In Case of Emergency / Authorized Pick Up Persons

Name:_________________________________Relationship:______________Phone:________________

Name:_________________________________Relationship:______________Phone:________________

Name:_________________________________Relationship:______________Phone:________________

If there are any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child(ren) while in care at the center, please list the names of the person(s). If there is a custody or restraining order in place, we will need a copy of the document for the file.

Parental Emergency Medical Consent

This form must be presented upon admission for treatment

Child's Name: ____ Birth Date:_______________ Age:_____

Parents/Guardians/Custodians with whom the child resides:

Name:____ Relationship to Child:___________________________

Address:_______________________________________ Employer:_____________________________________

City:_________________State:_____Zip:__________ Dept:________________Work Hours:_____________

Home:____________________ Cell:________________ Work: _________________

Name:____ Relationship to Child:___________________________

Address:_______________________________________ Employer:_____________________________________

City:_________________State:_____Zip:__________ Dept:________________Work Hours:_____________

Home:____________________ Cell:________________ Work: _________________

This form allows parents and guardians to authorize the provision of emergency treatment for the above named child in the event that the child becomes ill or injured while under program authority when parents/guardians cannot be reached. In the event reasonable attempts to contact me at the above listed numbers are not successful, I hereby give consent for the administration of any treatment deemed necessary by:

Physician and Dentist Information

Physician	Dentist
Physician Name:______________________________	Dentist Name:_______________________________
Address:____________________________________	Address:____________________________________
City:________________________State:___________	City:________________________State:___________
Phone:______________________________________	Phone:______________________________________

In the event that the designated practitioners are not available, then by another licensed physician or dentist and the transfer of the child to __________________________(SPECIFIC HOSPITAL OF PREFERENCE)

Date of Last Tetanus:_________________________________ Known Allergies:_________________________

Present Medications:__________________________________

Insurance Company:__________________________________ Policy Holder's ID:_______________________

This consent will be in effect for one year beginning_______________________.

Signature of Parent or Guardian:____ Date:________________

I understand that by typing my name above, I am electronically signing.

Signature of Parent or Guardian:____ Date:________________

I understand that by typing my name above, I am electronically signing.

Child's Name: ____ Birth Date:________________ Age:_____

Waiver of Liability

I understand that I am able and am speaking on behalf of myself and other individuals listed on this application. In consideration of my/our participation in the YMCA of the Iowa Mississippi Valley ChildCare program(s) I/we do hereby agree to hold free from any and all liability the YMCA and it's respective officers, employees, and forever discharge any and all rights and claims for damages that I/we may hereafter accrue to me/us arising from, or connected with myself/ourselves to be physically sound having medical approval to participate in the childcare program of the YMCA.

Transportation and Activity Authorizations

I give permission for my child to participate in trips, tours, walks, and special events under the supervision of YMCA staff. Notifications of any activity will be given in advance of said activity. Please note that all Y activity classes that a child has signed up for will be considered a field trip from the center. The Y staff involved in teaching the class is/are not considered a member of the childcare staff. I further understand the childcare staff will be responsible for preparing each child for lessons including assisting with changing clothes if the class requires special clothing (swim suits, gymnastics outfits, etc.). Children will be supervised at all times and no child will be allowed to go to or from any activity class without the supervision of a staff person from the childcare department.

Parent Payment Agreement

Tuition for all programs is due in advance each Friday for the next week of service. Kids Club programs are billed according to the school schedule. However, there will be no deductions for snow days. We do not offer part time care in any of our programs. Parents are required to pay an annual registration fee of $25.00. Families will be charged a late pick up fee of $5.00 per every fifteen minutes after 6:00 pm. There will be an additional fee in the event of a returned check. In case of withdrawal of my child from the program, I agree to give the center a two week notice.

Photography Consent

I ☐ DO or ☐ DO NOT give consent to let my child be photographed for use by the YMCA in newspapers or other media for the purpose of advertisement or publicity.

First Aid Consent

I give my permission for staff to give first aid or apply antiseptic ointment if it is deemed necessary.

Permission to Apply Sunscreen to Child

As the parent/guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at the YMCA of the Iowa Mississippi Valley to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he/she will be playing outside during the months of March through October and between the daily times of 10 am and 4 pm. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of ears, nose, and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

☐ I do not know of any allergies my child has to sunscreen.

☐ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.

☐ I have provided the following brand/type of sunscreen for use on my child:__________________________

☐ My child is allergic to some sunscreens. Please only use the following brand(s) and type(s) of sunscreen:

____

☐ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

____

Parent/Guardian full legal name (print):____

Parent/Guardian signature:____ **Date:**______________

I understand that by typing my name above, I am electronically signing.

School-Age Child Health From/Parent Statement of Health

Parent/Guardian please complete

Child's Name:	Child's Birth date:	Name of School: Grade: School Phone:
Parent/Guardian Name (#1):	Parent/Guardian Name (#2):	
Child's Home Address (#1):	Child's Home Address (#2):	Phone (#1): Phone (#2):
Parent/Guardian (#1) Place of Employment:	Work Address (#1):	Work Phone (#1): Email:
Parent/Guardian (#2) Place of Employment:	Work Address (#2):	Work Phone (#2): Email:

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care facility is unable to immediately make contact with the parent/guardian. ☐ **Yes** ☐ **No**

During an emergency, the child care provider is authorized to contact the following person when the parent or guardian cannot be reached.

Parent/Guardian Signature:______________________ **Date:**________________
I understand that by typing my name above, I am electronically signing.

Alternate Emergency contact person's name:_____________________________ **Phone:**_________________

Relationship to Child:_____________________________________ **Additional Phone:**_____________________

Child's **Doctor's** Name:	Doctor's Phone:	Hospital of choice:
Doctor's address:	After hours telephone:	Does your child have health insurance? ☐ Yes ☐ No Company: ID #:
Child's **Dentist's** Name:	Dentist's Phone:	Does your child have dental insurance? ☐ Yes ☐ No Company: ID #:
Dentist's address:	After hours telephone:	☐ Help us find a family doctor or dentist ☐ Help us find health or dental insurance
Other health care/mental health specialist name:		Phone:

YMCA of Iowa Mississippi Valley
Child Care & Family Services
School Age Child Care Program

Code of Conduct

Child's Name: ______________________________ School/Site:________________

1. Check in to the YMCA Kids Club immediately after school each day.
2. Keep my personal belongings in the storage area during YMCA Kids Club.
3. Remain seated and quiet during roll call and announcements. Answer only for myself.
4. Follow all YMCA Kids Club rules during self-directed play, snack, and activity time.
5. Follow all instructions given by the YMCA Kids Club staff.
6. Tell the YMCA Kids Club staff if I am sick or hurt.
7. Follow the "Time-Out" instructions of the YMCA Kids Club.
    a. For each Code of Conduct violation there may be a 5-15 minute Time-Out (up to 3 per day.)
8. Respect all other children and the YMCA Kids Club staff at all times.
9. Respect all YMCA Kids Club supplies, equipment, and property.
10. Respect all personal belongings of the other children.
11. Help in cleaning up after myself in all activities.
12. Never leave the YMCA Kids Club site without permission from a staff member.

A disciplinary problem is defined as one in which a child is hampering the smooth flow of the program by wither requiring constant or one-on-one attention; is inflicting physical or emotional harm on themselves or other children; is physically and/or verbally abusing staff or is otherwise unable to conform to the rules and guidelines of the program. We reserve the right to dismiss your child for the day if they are exhibiting behaviors that cannot be controlled and/or are putting other children at risk.

Physical violence is NOT tolerated at Kids Club. Any physical violence taking place will result in an immediate write-up, and possible dismissal for the day at the Site Director's discretion.

____

Child Signature Date

____

Parent Signature Date

____

Staff Signature Date

I understand that by typing my name above, I am electronically signing.

School-Age Child Health Form/Parent Statement of Health

PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **Child's Name:** ______________________

Please use an **X** in the box ☐ for statements that apply to your child.

Date of child's last physical exam: ____________
Date of last dental appointment: ____________

☐ **Growth** - I am concerned about child's growth.

☐ **Appetite** - I am concerned about child's eating habits.

☐ **Rest** - My child needs to rest after school.

☐ **Illness/Surgery/Injury** - My child had a serious illness, surgery, or injury. Please describe:

☐ **Physical Activity** - My child must restrict physical activity or needs special equipment to be active. Please describe:

Play with friends - My child
- ☐ Plays well in groups with other children.
- ☐ Will play only with one or two other children.
- ☐ Prefers to play alone.
- ☐ Fights with other children.
- ☐ I am concerned about my child's play activity with other children. Please describe:

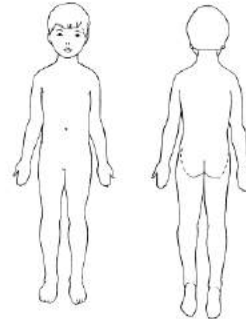
School and Learning - My child
- ☐ Is doing well at school.
- ☐ Is having difficulty in some classes.
- ☐ Does not want to go to school.
- ☐ Frequently misses or is late for school.
- ☐ I am concerned about how my child is doing in school. Please describe:

☐ **Allergy** - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.). List allergies:

☐ **Special Needs Care Plan** - My child has a special need and a care plan for child care. Please discuss with your health care provider.

☐ **Body Health** - My child has problems with skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below.



- ☐ Eyes/vision, glasses or contact lenses
- ☐ Ears/hearing, hearing assistive aides or device, earache, tubes in ears
- ☐ Nose problems, nosebleeds
- ☐ Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
- ☐ Breathing problems, asthma, cough
- ☐ Heart problems or heart murmur
- ☐ Stomach aches or upset stomach
- ☐ Trouble using toilet or accidents
- ☐ Hard stools, constipation, diarrhea, watery stools
- ☐ Bones, muscles, movement, pain when moving
- ☐ Mobility, child uses assistive equipment
- ☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
- ☐ Females – difficult monthly periods
- ☐ Other special needs. Please describe:

☐ **Medication**[2] - My child takes medication.

Medication Name	Time Given	Reason for giving medication

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at www.idph.iowa.gov/hcci/products

Parent/Guardian Signature (required): ______________________ **Date:** __________

[2] Please review the child care program's policies about the use of medication at child care.

Iowa Eligibility Application

FFY 21-22

Complete one application per household. Fiscal Year 2021-2022

Part 1. Check all applicable boxes:
☐ school meals
☐ special milk (restrictions apply)
☐ children in child care center
☐ Tier I home provider (HP)
☐ Head Start/Even Start
☐ children in child care home (HP)
Provider name:

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 3. FIP or SNAP Eligible: Enter the FIP or SNAP Case Number for ANY household member as listed in the Notice of Decision (10 digits, include zeros). NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5.
Name of household member with Case Number __________________________ List Case Number ___-___-___-___-___-___-___-___-___-___

Part 4. Children enrolled: REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Ethnicity: H=Hispanic or Latino N=Not Hispanic or Latino
Race: A = Asian B = Black or African American I = American Indian or Alaska Native W=White
If ethnicity & race are not completed, the form will be completed based on visual observation

Last Name	First Name	Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL ETHNICITY	OPTIONAL RACE	Name of School/Head Start/ Child Care Center/Home
1.			☐					
2.			☐					
3.			☐					
4.			☐					
5.			☐					

Part 5. Total Household Gross Income: DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR SNAP NUMBER IN PART 3.
Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self-employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.

Last Name	First Name	Age	Check if NO Income	Gross Income: Report income by how often the household member is paid. Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Other Monthly Payments or Income Received. Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.			☐							
2.			☐							
3.			☐							
4.			☐							
5.			☐							

Last four digits of my Social Security Number: **X XX - X X -** ___ ___ ___ ___ ☐ I do **not** have a Social Security Number.
If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.
I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form____

Signature of Adult Completing Form | Printed Name of Adult Completing Form | Date Signed

Address of Adult Completing Form | Town | ZIP Code | Work Phone | Home Phone | Cell Phone

Part 7. TO BE COMPLTED BY CENTER STAFF.
Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12
Household Income: $ ___________ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size _______

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/SNAP
☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway (Schools only)

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk
Application Denied: ☐ Incomplete ☐ Over income limits

CACFP HP ONLY:
☐ Tier 1 Area (Provider's own children)
☐ Tier 1 Income (All children)
☐ Tier 1 Child (Tier 2 mixed)

Determining Official Signature **Effective Date**

Self-Employment Income Worksheet: This worksheet will help you calculate the amount to report if you farm, are self employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for meal benefits. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this Application, it is not possible to have a negative income. The **least self-employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for Tier 1 meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced-price eligibility. Wages paid to a spouse or other family or household member in the operation of a farm or private business must be shown as household income in Part 5 of this Application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return – Form 1040 or 1040-SR including Schedule 1 (Additional Income and Adjustments to Income). Complete the identified lines from Form 1040 or Form 1040-SR and Schedule 1.

Capital gain or (loss): Form 1040 or 1040-SR, Line 7 $ ______________________

Business income or (loss): Schedule 1 Part 1, Line 3 $ ______________________

Other gains or (losses): Schedule 1 Part 1, Line 4 $ ______________________

Rental real estate, royalties, partnerships, S corporations, trusts, etc.:
Schedule 1 Part 1, Line 5 $ ______________________

Farm income or (loss): Schedule 1 Part 1, Line 6 $ ______________________

*Total = $ ______________________

*The least income possible is zero (a negative number cannot be reported).
*Enter amount in the "**All other Income**" column in Part 5 on the front of this Application.