YMCA OF GREATER DAYTON
MEETING OUR COMMUNITY'S NEEDS

the YMCA

Child Care for Health Care Personnel Program

Ages Infant-12
Call for pricing. Participants will participate in a variety of developmentally appropriate activities provided by YMCA staff so that you are able to assist our community at this critical time with peace of mind. Open to families that are actively providing essential duties to the Dayton community.

Hours
6am–6pm

Pricing (Infant, Toddlers & Preschool)
Infants - $232 / Toddlers - $206 /
Preschool - $181

Pricing (K-12)
$4/hour / $35/day / $165/week

*Partial scholarships or subsides may be available, check with the local branch for details.
*Meals - Breakfast, Lunch & PM Snack will be provided. Families with allergies & special preferences may provide food themselves. NO NUTS.

Registration
Call or visit your local YMCA that is offering this program option during our enrollment hours, 5pm–8pm, Monday–Friday. Space is limited, registrations will be first come, first serve. Proof of employment must be provided upon first check-in.

Families will sign a letter of understanding and an ODJFS Health Form. Additional ODJFS forms will be needed for children with any special accomodations or medication to be administered.

LOCATIONS AVAILABLE:

- **Coffman YMCA**
  Contact: Teresa Perry
  Phone Number: 937-886-9622
  tperry@daytonymca.org
- **Fairborn YMCA**
  Contact: Diane Roman
  Phone: 937-754-9622
  droman@daytonymca.org
- **South YMCA**
  Contact: Arielle Evans
  Phone: 937-434-1964
  aevans@daytonymca.org
- **Huber Heights YMCA**
  Contact: Kimberly Bond
  Phone: 937-236-9622
  kbond@daytonymca.org
- **Kleptz YMCA**
  Contact: Samantha Lopez
  Phone: 937-836-9622
  slopez@daytonymca.org
- **Preble YMCA**
  Contact: Cathy Bulach
  Phone: 937-472-2010
  cbulach@daytonymca.org
- **Grace UMC**
  Contact: Annette Rohaly
  Phone: 937-278-4636
  arohaly@daytonymca.org
- **St. Anthony**
  Contact: Mary Loper
  Phone: 937-673-2935
  mloper@daytonymca.org
- **West Carrollton**
  Contact: Samantha Grudgen
  Phone: 937-866-9622
  ssementilli@daytonymca.org
- **Xenia YMCA**
  Contact: Samantha Bates
  Phone: 937-376-9622
  sbates@daytonymca.org

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

I understand that the YMCA of Greater Dayton is offering critical childcare to persons deemed essential during the COVID 19 pandemic.

I am a Healthcare Provider, or a _____. I am considered essential in the community; therefore, I need childcare for my child(ren).

Typical hours of care needed are _____ to _____. The YMCA is currently open 600am-6pm

I understand that I need to keep my contact information up to date.

Cell phone:_____ Email:_____

Cell phone:_____ Email:_____

I understand that I will complete the ODJFS Health Form jfs 01234 for each child. Note: If any of my children require any medication to be administered while in your care or if they have special food accommodations I will need to fill out a request to provide medication form jfs 01217 and/or a health care plan form jfs 01236. I will remind the on-site YMCA staff every day of these needs.

I understand that the YMCA will provide breakfast, lunch and a snack and that if I prefer I may provide these especially if my child has special food accommodations or allergies. No nuts.

I understand that my fees will be $_____ per week. I will provide the financial details to the branch to ensure my fees are paid. _____I intend to pay via credit card or ___bank draft. ___I may also need help with some scholarship funds and will turn in additional paperwork for that.

I will be enrolling Print Name & age of Child(ren):

_____, _____, _____, _____

Signature: _____ Date: _____

Ohio Department of Job and Family Services

PANDEMIC CHILD CARE CENTER CHILD ENROLLMENT ADDENDUM

Child's Name	Parent's Name

Description of Parent's Employment Providing Health and Safety Services as defined by the Ohio Department of Job and Family Services (ODJFS)

Find Your Family Size in the Chart. Is Your Income Below These Annual or Monthly Limits?

☐ Yes ☐ No

Family Size	Annual Income	Monthly Income
1	$24,980	$2,082
2	$33,820	$2,819
3	$42,660	$3,555
4	$51,500	$4,292
5	$60,340	$5,029
6	$69,180	$5,765
7	$78,020	$6,502
8	$86,860	$7,239
9	$95,700	$7,975
10	$104,540	$8,712
11	$113,380	$9,449
12	$122,220	$10,185

Signature of Parent	Date

CHILD CARE PAYMENT AUTHORIZATION

Staff Accept: _____
Accept Date: _____
Staff Input Date: _____

**10 days' notice is required for all changes*

Agreement made between _____ *and (YMCA of Greater Dayton) on* _____
Parent/Guardian Signature(s) — Today's Date

Current Information:

Parent/Guardian Name (print):_____Parent DOB: ____/____/____

Address:_____City: _____State:_____Zip Code:_____

Phone: (___) ___-_____Email: _____

Child Name (print):_____Child DOB: ____/____/____ □ELC □SACC □DC

Child Name (print):_____Child DOB: ____/____/____ □ELC □SACC □DC

Child Name (print):_____Child DOB: ____/____/____ □ELC □SACC □DC

Child Name (print):_____Child DOB: ____/____/____ □ELC □SACC □DC

Child Name (print):_____Child DOB: ____/____/____ □ELC □SACC □DC

Child Name (print):_____Child DOB: ____/____/____ □ELC □SACC □DC

Receiving Title XX Subsidy? (Check One): ____No ____Yes (I understand that my child(ren) needs to attend as agreed to retain their spot.

Account Information

Payments are due the Friday before the week of care or the Monday after care if you are hourly (at select locations).

EFT:

□ Checking Account □ Savings Account

Routing #:_____ Account #:_____ □ Voided Check/Deposit Slip Attached

Draft Date: □ Weekly on Friday □ Monday after care is provided (ONLY if you are hourly)

**Child is not registered until full account information is provided to director at the time of phone call.*

Credit Card:

□ Visa □ MasterCard □ Discover □ American Express Name on Card: _____

Card #:_____ Exp:____/_____

Billing Address:_____Billing Zip Code: _____

Draft Date is prior to the week of care: □ Weekly on Friday □ Monday after care (ONLY if you are hourly)

Payment Terms & Conditions

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I authorize my bank to honor pre-authorized drafts drawn by the YMCA on my account for child care payments and/or additional care. When the bank or credit card carrier honors the draft by charging my account, such drafts constitute my receipt for the payment. If at any time there is to be a change, deletion or cancellation of my services, it is to be submitted in writing to the branch at least 10 days prior to bank draft date (using approved forms.)

_____ **INITIALS**

All drafts returned "non-sufficient funds" (NSF) will be drafted as soon as funds are available. A fee of $25.00 will be collected by a third party agency for the "NSF" re-draft. If the second draft attempt is returned "NSF" child care services will be terminated.

For each return, the YMCA of Greater Dayton will collect a separate $10 fee to cover bank and administrative costs.

By Signing below, I/we agree to following Childcare Payment terms as outlined in the Parent Handbook. I/we understand that childcare fee amounts may change and I/we will be notified of these changes 30 days in advance.

(X) Primary Member Signature **Date**

**Before your child is registered, all the information on this form must be verified in person or with a Child Care Director at the time of phone call.*

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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) 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		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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) 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 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? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ 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:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			***Do Not Give Permission* to Transport**	
Program or Home Name		**OR**	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.		**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	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

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 Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☐ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication	Exact Dosage

To be administered at the following times	For the following period of time

☐ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Box 3	The following section must be completed by the center, family child care provider or in-home aide for the child listed on page one of this form. All medication must be documented when administered.

Date	Time	Dosage	Signature of Designated Person Administering Medication

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

Child's Name	Date of Birth

Special Health Conditions

Symptoms to watch for and emergency action to be taken if the following symptoms occur

Activities/foods/environmental conditions to avoid, if applicable

Medical procedures to be followed and expected benefit of treatment, if applicable

Are any medications required? ☐ Yes ☐ No *(If yes, complete JFS 01217 "Request for Administration of Medication")*
If yes, what medications?

In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate?
☐ Yes ☐ No

In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child?
☐ Yes ☐ No

Training Instructions *(Trainer must be a parent or certified professional)*

Signature of Trainer	Date

Signature of trained providers, substitutes or child care staff members who have been made aware of the condition.
(There must always be a trained caregiver present when the child is present)

Signature	Date	I have been ☐ Informed	I have been ☐ Trained

(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)

Additional services (educational/therapeutic) child is receiving

Who provides the above services?

Name	Phone Number	May we contact? ☐ Yes ☐ No

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken