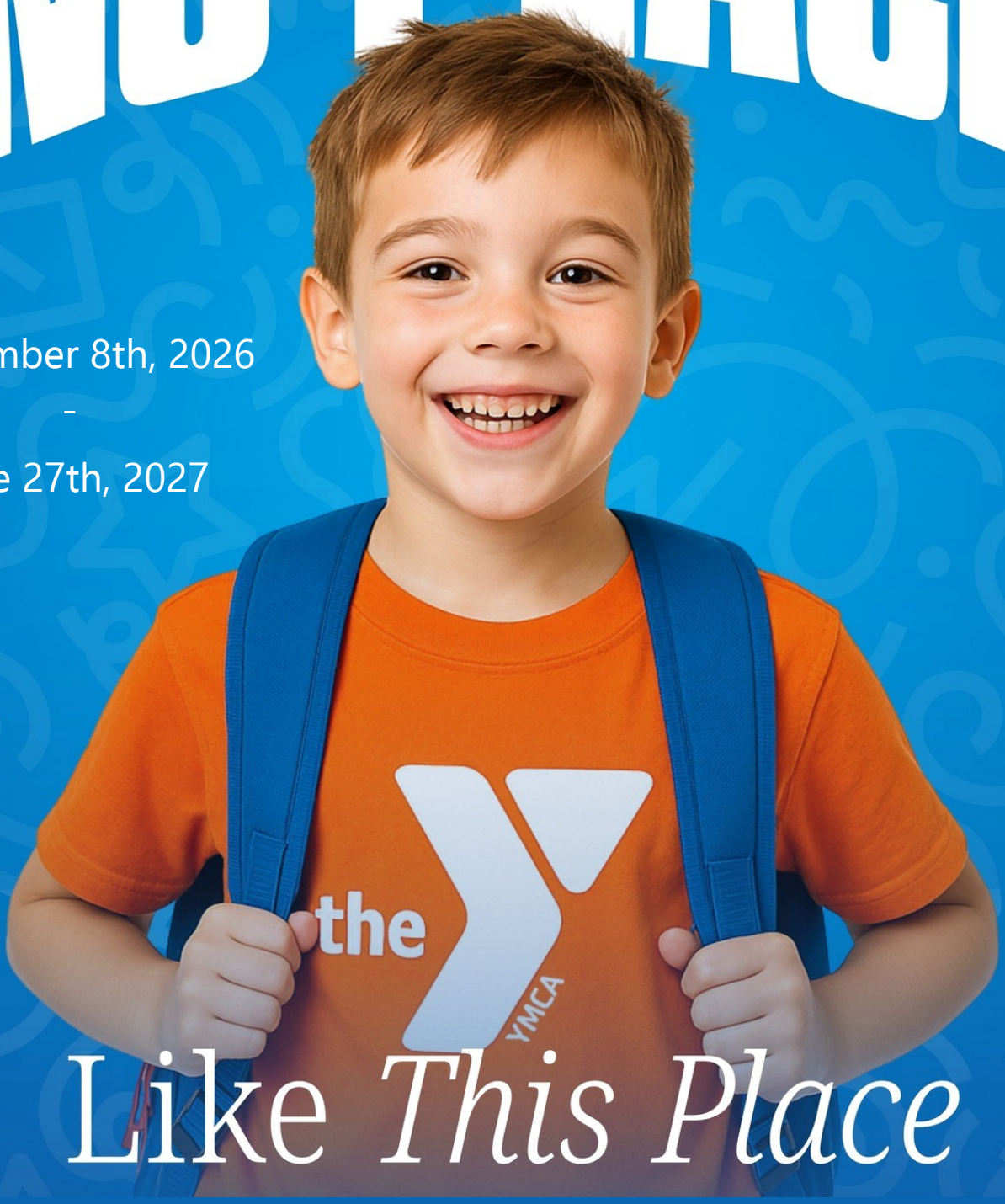
# NO PLACE

September 8th, 2026

-

June 27th, 2027




# Like *This Place*

## 2026-27 After School Care

## REGISTRATION & PAYMENT

Payment is required in advance; you may pay monthly, or bi-weekly. A non-refundable registration fee ($20/child or $30/family) is due at registration.

Monthly payments are due by the 1st.

Bi-weekly payments are due on the 1st and 15th. We can store credit card details and automate your payments upon request.

## FINANCIAL ASSISTANCE

If you need help paying for childcare, please ask for a Financial Assistance Application at the Front Desk.

Complete the document and return it with the required documentation to be considered for assistance.

## PARENT HANDBOOK

Our Parent Handbook is available at GenevaFamilyYMCA.org, under the Youth + Teens tab, among the "Helpful Documents"

## TYPICAL DAILY SCHEDULE

The program day ends at 6:00pm.

Parents should contact the YMCA by phone at 315-789-1616 if they will be delayed (please no texting, emailing or social media messaging). Please note that youth in program after 6:00pm may incur a late fee.

Care is available on normal school days and most school holidays.

After-school care may include table games, gym, swimming, and outdoor games, seasonal crafts, and a healthy snack.

For questions about child care and other programs for school age youth, please contact us at 315-789-1616. You can also check us out online at www.Genevafamilyymca.org.

# YMCA Emergency Information Sheet

| Child's Full Name:<br>Nickname: | Date of Birth:<br>/ / | Gender: |
|---|---|---|
| Child's Home Address: | | |
| Name of Person Enrolling Child: | Relationship to Child:<br>☐ Parent ☐ Guardian ☐ Caretaker<br>☐ Relative _____ ☐ Other _____ | |
| Phone Number(s) of Person Enrolling Child:<br>( ) - | Address of Person Enrolling Child: | |
| Email Address: | | |

| EMERGENCY CONTACT NAMES /ADDRESSES | Authorized to Pick | PRIMARY PHONE NUMBER | OTHER PHONE NUMBER/ EMAIL |
|---|---|---|---|
| Primary Contact | ☐ Yes ☐ No | ( ) - | ( ) - |
| | ☐ Yes ☐ No | ( ) - | ( ) - |
| | ☐ Yes ☐ No | ( ) - | ( ) - |

**Check boxes below to indicate if your child has any special needs/services:** ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/ Language ☐ Physical Therapy

☐ Allergies (list) _____

☐ Other _____

| Child's Primary Care Physician's Name/ Group: | Phone Number:<br>( ) - |
|---|---|
| Preferred Hospital: | Phone Number:<br>( ) - |
| Child's Dentist: | Phone Number:<br>( ) - |

**Child health insurance information is available by calling toll-free 1-800-698-4543 or The NYS Health Marketplace website: https://nystateofhealth.ny.gov/**

## AGREEMENTS

| | | |
|---|---|---|
| I consent to emergency medical treatment for my child | ☐ Yes | ☐ No |
| • I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision | ☐ Yes | ☐ No |
| • I understand the program may need additional permission for situations such as transportation, medication, release of information, and field trips | ☐ Yes | ☐ No |
| • I've provided information on my child's special needs to the program to assist in caring for my child | ☐ Yes | ☐ No |
| • I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation | ☐ Yes | ☐ No |
| • I agree to review and update this information whenever a change occurs or at least once a year | ☐ Yes | ☐ No |

| SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE: | DATE:<br>/ / |
|---|---|

# YMCA Parent Authorizations

## Over-the-Counter Medication

I authorize the YMCA ASP staff to administer over-the-counter topical ointments such as sunscreen, first aid ointments, itch reliever and topically applied insect repellent to my child when needed.

_____
Parent Initial

## Emergency Transportation

I authorize the Geneva Family YMCA to contact 911 to have my child transported in the unlikely event of an accident or illness. I understand and acknowledge that my child may be injured while participating in the YMCA ASP. I will not hold the YMCA ASP or representatives responsible for any injury my child may sustain while participating in this program. I further agree to be legally and financially responsible. My health and accident insurance will cover my child.

_____
Parent Initial

## Financial Agreement

If paying monthly, payments will be due on the 1st of each month. If paying bi-weekly, payments will be due by the 1st & 15th each month. Parents whose payments are two weeks late will be asked to withdraw their child from the program, unless other arrangements have been made with the Child Care Director.

_____
Parent Initial

## Promotion Agreement

The YMCA staff may take photos and videos during program and post them on the organization's social media sites or use them in brochures or other YMCA material. I authorize the YMCA staff to take and post photos or use videos of my child for the use of this program.

_____
Parent Initial

| SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE: | DATE: / / |
|---|---|

*For Program Use Only*
*Date of Enrollment:* / / *Date of Disenrollment:* / /

*Program Enrolled in :* _____

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# CHILD IN CARE MEDICAL STATEMENT

## To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

| Name of Child: | Date of Birth: / / | Date of Examination: / / |
|---|---|---|
| | | |

**Immunizations required for entry into day care**

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

| | | | | | |
|---|---|---|---|---|---|
| Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date / / | 5th Date / / |
| Polio (IPV or OPV) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date / / | |
| Haemophilus influenzae type B (Hib) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date **OR** 1st Date (if given on or after 15 months of age) / / | |
| Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08) | 1st Date / / | 2nd Date / / | 3rd Date / / | 4th Date / / | |
| Hepatitis B | 1st Date / / | 2nd Date / / | 3rd Date / / | | |
| Measles, Mumps and Rubella (MMR) | 1st Date / / | 2nd Date / / | | | |
| Varicella (also known as Chicken Pox) | 1st Date / / | 2nd Date / / | | | |

## Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

| | | | |
|---|---|---|---|
| Type of Immunization: | Date: / / | Type of Immunization: | Date: / / |
| Type of Immunization: | Date: / / | Type of Immunization: | Date: / / |
| Type of Immunization: | Date: / / | Type of Immunization: | Date: / / |

## Tests

Tuberculin Test Date: / / _____ Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / / _____

Attach lead level statement

**Lead Screening (Include All Dates and Results)**

1 year / / _____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / _____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

**Most recent date of lead screening (if different from above):**

/ / _____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

**Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.** If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

*(Continued on reverse side)*

# CHILD IN CARE MEDICAL STATEMENT *(continued)*

| Health Specifics | | Comments |
|---|---|---|
| Are there allergies? (Specify) | ☐ Yes ☐ No | |
| Is medication regularly taken? (Specify drug and condition) | ☐ Yes ☐ No | |
| Is a special diet required? (Specify diet and condition) | ☐ Yes ☐ No | |
| Are there any hearing, visual or dental conditions requiring special attention? | ☐ Yes ☐ No | |
| Are there any medical or developmental conditions requiring special attention? | ☐ Yes ☐ No | |

## Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) -

Phone

/ /

Date

# FEE SCHEDULE

Payments will be due by the 5th of each month. If paying bi-weekly, payments will be due by the 1st & 15th of each month. Attached to the back of this packet is the billing form. Everyone needs to fill the form out and sign at the bottom. Forms of payment: Cash, Check, Debit/Credit cards are welcome. If you have any questions let us know.

## COST (PER MONTH)

***30% DISOUNT FOR MEMBERS OR HIGHER INCOME FINANCIAL ASSISTANCE**

**+10% DISCOUNT FOR LOWER INCOME FINANCIAL ASSISTANCE OR MULTIPLE SIB-YOUNGEST SIBLING(S) WILL RECEIVE DISCOUNT.**

**LOCATION INFORMATION (PLEASE CHECK ALL THAT APPLY)** **Start Date_____/_____/_____**

**AFTER SCHOOL PROGRAM** **$400/Mo** ☐

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

Program is year long broken out into 10 months. Some months have more days, some have less days, however the rate is the same.

**Fun Club Days (When school is closed)*** **$50 Per Day** ☐

*Please reference school calendar for designated days off of school. Not all school closing dates are Fun Club Days.*

# SACC BILLING FORM

the YMCA
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

**2026-2027**

***BILLING PARTY INFORMATION*** (PLEASE PRINT CLEARLY) YMCA Member: Yes ☐ No ☐ Financial Support Needed?: Yes ☐ No ☐

Child's Name _____

Primary Sponsor Name _____ Secondary Sponsor Name _____

Sponsor share _____% Sponsor share _____%

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Home/cell (_____) _____ Home/cell (_____) _____

**LOCATION INFORMATION (PLEASE CHECK ALL THAT APPLY)** **Start Date_____/_____/_____**

**AFTER SCHOOL PROGRAM** ☐ **$400/Mo**

**KIDS CLUB (Schools Out Day)** ☐ **$50/Day**

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

**BILLING METHOD** **Draft date: ☐ 1st of the month ☐ 15th of the month**

☐ Cash
☐ Check
☐ Master Card
☐ Visa Card
☐ **Please draft the account # below**

Expiration Date: _____/_____

Account #: _____ - _____ - _____ - _____

CID: _____ (3 digit code)

Account Holder's Name: _____ Date: _____

Signature: _____

PARENT/GUARDIAN AGREEMENT (I understand:)

- Only combination before & after school full-time participants will have fee waived for half days of school.
- Vacation Fun Club days are a separate fee.
- Payments are due by the 1st or 15th of each month attending.
- Should a non business day or holiday fall on the 1st or 15th, the account will be drafted on the next full business day.
- Payments not received on due date are subject to a $25 late fee.
- The YMCA requires 2 weeks notice for termination of care. I am responsible for full payment of these 2 weeks of care.
- If payment is not received the YMCA will send me to a collection agency for further action.
- All changes to my child's schedule of care must be made in writing (**ASK ABOUT OUR BLUE CHANGE FORM**) 48 hours in advance.

**MY SIGNATURE ACKNOWLEDGES MY UNDERSTANDING OF AND AGREEMENT TO THE ABOVE**

_____ _____

**Parent/Guardian Signature** **Date**