FCYFA Child Care
200 Lincoln St.
Johnstown, PA 15901

(814) 539-0164
Owner:
Mr. Oscar Cashaw

This Daycare Service Agreement is made and entered into as of [_____] by and between [Parent/Guardian Name: _____] and [Daycare Provider Name: _____].

Child's Information:

Child's Name (1): _____ Date of Birth: _____

Child's Allergies Or Special Needs: _____

Child's Name (2): _____ Date of Birth: _____

Child's Allergies Or Special Needs: _____

Parent/Guardian Information:

Parent/Guardian (1) Name: _____ Relationship To Child: _____

Parent/Guardian (2) Name: _____ Relationship To Child: _____

Hours of Operation:

The Daycare Provider's hours of operation are as follows:

- Monday to Friday: [Start time _____] - [End Time _____]
- Weekends and holidays: [Non-Applicable]

Fees and Payment:

The Parent/Guardian agrees to pay the Daycare Provider as follows: Fees are based on the date of service start: Self-Pay or Subsidised. Please note that if Subsidised, please contact your county assistance office for eligibility requirements.
Signature: _____ Date: _____

FCYFA Child Care

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814-539-0164
www.FCYFA .com
200 Lincoln St. Johnstown, PA 15901

This Daycare Service Agreement is made and entered into as of [_____], by and between [Parent/Guardian Name: Print-_____] and Sign:_____.
[Daycare Provider Name: _FCYFA Child Care

Child's Information:

Child's Name (1): _____ Date of Birth: _____

Child's Allergies Or Special Needs: _____

Child's Name (2): _____ Date of Birth: _____

Child's Allergies Or Special Needs: _____

Parent/Guardian Information:

Parent/Guardian (1) Name: _____ Relationship To Child: _____

Parent/Guardian (2) Name: _____ Relationship To Child: _____

Hours of Operation:

The Daycare Provider's hours of operation are as follows:

Monday to Friday: Start time: 7:00 am, End time: 7:00 pm
Unless otherwise agreed upon.
Monday, _____, Tuesday,_____, Wednesday,_____, Thursday,_____, Friday,_____. No Holiday hours unless otherwise specified.
Operating hours: Summer hours, June 16th-August 2025, 7 am-4 pm. Fall hours are: August- June 9th, 2 pm -7 pm; Unless otherwise specified.
The Parent/Guardian agrees to pay the Daycare Provider as follows:

- Registration Fee: $ 5:00 (non-refundable, due upon signing)
- Daily Rate: for self-pay, $7.00 per day. Minimum days of service is 3 days per week, and the pricing range for self-pay is $21.00-$35.00 a week. Subsidy Pricing is based on the DHS requirement and agreement that pricing is based on state qualifications. Please contact your caseworker.
- Weekly Rate: $ 35.00 per week, Late payment fee $10.00,
- Late pick-up fee of $10.00 due upon pick-up.
- Payment is due the same day of the week, determined by the enrollment date.
- Check payments made out to FCYFA. No money orders. Cash payments accepted.

FCYFA Child Care Center
Date:14 April 2025

Flood City Youth & Fitness Academy
Child Care

Late Fees and Policies:

Late payment fee $10.00

Late pick-up Fee: $10.00, beginning 30 minutes after the scheduled pick-up time, to be paid at the time of pick-up.

Holidays and Closures:

The Daycare Provider will be closed on the following holidays:

-New Year's Day Memorial Day Christmas Day Easter Break
-Independence Day, Labor Day, Thanksgiving Day, We follow the Greater Johnstown School District holidays and closures. Unless otherwise specified.

Health and Safety Policies:

- The Parent/Guardian must provide current immunization records for the child(ren).
- The Parent/Guardian must notify the Daycare Provider of any allergies or medical conditions.
- Sick children must be kept at home. If a child becomes ill during the day, the Parent or guardian will be contacted to pick up the child as soon as possible.
- Permission to transport your child/children to the Hospital: Sign and date.
  Sign:_____ Date:_____

Termination of Agreement:

- Either party may terminate this Agreement with a [2] -week notice.
- Immediate termination may occur if the terms of this Agreement are violated or if the child's behavior is deemed unsafe for others.
- If agreement is terminated without notice, "YOU are responsible for payment.

Responsibilities of the Parent/Guardian:

- Provide all necessary supplies (e.g., a change of clothes). Medications (The Name must be on all prescription medications, and the date of the medication must be current.
- Permission to supply must be in writing. Print signature: _____ signature:_____ Date:_____.
- Please inform the FCYFA immediately of any changes in contact information:
- Phone numbers(Immediately) and Addresses (Immediately).
- The child(ren) must be dropped off and picked up within the agreed-upon hours. If any changes are made, the designated pick-up person (s) need to be updated in writing.

Responsibilities of the Daycare Provider:

- **Provide a safe and nurturing environment for the child(ren).**
- **Maintain appropriate child-to-staff ratios.**
- **Communicate regularly with the Parent/Guardian regarding the child(ren)'s progress and any issues.**

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK	DAY PAYMENT TO BE MADE

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE $	PER MIN-HR	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION
DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN DATE

Flood City Youth and Fitness Academy Child Care

Emergency Procedures:

In case of an emergency, the Daycare Provider will:

- Contact the Parent/Guardian immediately.
- If the Parent/Guardian cannot be reached, the emergency contact listed below will be notified:

Emergency Contact Name:_____

Relationship to Child: _____

Phone Number: _____

Confidentiality:

All information regarding the child(ren) and the family will be kept confidential and will not be disclosed without written consent, except as required by law.

Designated permission person/s /s release of information:_____

Date signed:_____ Wltness:_____ Date:_____

Amendments:

This Agreement may be amended only in writing and must be signed by both the Parent/Guardian and the Daycare Provider.

Governing Law:

This Agreement shall be governed by and construed in accordance with the laws of the State of Pennsylvania.

Signatures:

By signing below, both parties agree to the terms and conditions outlined in this contract.

Parent/Guardian Signature: _____

Daycare Provider Signature: _____

Date: _____

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124 (a) (b), 3270.181 & 182; 3280.124 (a) (b), 3280.181 & .182; 3290.124 (a) (b), 3290.181 & .182

CHILD'S NAME	DATE OF BIRTH
ADDRESS	

PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER ( )
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S) NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROV IDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL SITUATION
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST-AID PROCEDURES
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

WHITE COPY (Original) YELLOW COPY (Child Care Space) PINK COPY (Excursion)

pennsylvania
OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING

FCYFA: DOCUMENTATION OF EMERGENCY PLAN DELIVERY
Regulations 3270.27(f); 3280.26(f) and 3290.24(f)

Facilities must retain documentation that they submitted their initial emergency plan and any updated plan to their local and county municipalities.

Facility Location/Name
Location Physical Address
Legal Entity/Person responsible for the Legal Entity
Local Municipality (i.e. borough, township, city, district)
Name:
Address:
Phone Number:
Email Address (if available):
Fax Number (if available):
Method Submitted (i.e. mail, fax, email, hand delivered):
Date Submitted:
County Municipality
Name:
Address:
Phone Number:
Email Address (if available):
Fax Number (if available):
Method Submitted (i.e. mail, fax, email, hand delivered):
Date Submitted:
Self-Certification
I hereby swear/affirm that the information provided is true and correct to the best of my knowledge. _____ Signature _____ Title _____ Date

FCYFA: VERBAL REQUEST FOR RELEASE OF CHILD

55 PACODE CHAPTERS 3270.117(c) and 3280.117(c) and 3290.116(c) THIS FORM MUST BE COMPLETED TO DOCUMENT THE VERBALREQUEST BYAPARENT FOR THE RELEASE OF ACHILD TO APERSON(S) NOT INDICATED ON THE AGREEMENT (CHAPTERS 3270.123(a)(5), 3270.124(b)(7); 3280.123(a)(5), 3280.124(b)(7); 3290.123(a)(5), 3290.124(b)(7)).

NAME OF CHILD	DATE	TIME
NAME OF REQUESTING PARENT	TELEPHONE NO. FROM WHICH PARENTIS CALLING	
NAME OF INDIVIDUALTO WHOM THE CHILD IS TO BE RELEASED		
NAME OF STAFF PERSON TAKING THE CALL		

CALLTHE ENROLLING PARENT BACK TO CONFIRM THE INFORMATION IF POSSIBLE

CONFIRMING PARENT	DATE
NAME OF STAFF PERSON CONFIRMING INFORMATION	TIME

NAME OF STAFF PERSON RELEASING CHILD

DATE

Always ask for IDENTIFICATION WHEN THE INDIVIDUALARRIVES TO PICK UPTHE CHILD.

FCYFA 200 Lincoln St. (814)539-0164

Mental Health Assessment

Child's Name:_____

DOB: _____ Age:_____ Gender:_____

	Yes or NO
ADHD	_____
Anxiety	_____
Depression	_____
ODD	_____
Autism	_____
Behavior or Conduct Problems	_____
OCD	_____
PTSD	_____
Mood disorder	_____
Isolation	_____

Please list any disorder that your child may be dealing with below.

_____

_____

Medications and Dosage. Please print

_____ _____ _____ _____

_____ _____ _____ _____

Parent/Guardian signature: (P) _____

(s)

_____ **Date:_____**

Lasha Jeffers, MA, is a professional mental health counselor who offers in-house services through FCYFA for our students.

If you suspect your child may have a mental health issue, it's crucial to seek professional help. Consult your child's health care provider or a qualified mental health specialist for diagnosis and treatment. Early intervention can significantly improve outcomes for children with mental health conditions.

If you would like your child to speak to Lasha Jeffers, MA.

I, parent /guardian, Print: _____

Signature:_____

Date:_____ I give permission for my child to be seen: _____

Name: _____ Date_____

Witness:_____ Date:_____

Disclaimer: **FCYFA does not provide medical advice. Consult with a qualified healthcare professional for any health concerns.**

FCYFA 200 LINCOLN ST. JOHNSTOWN, PA 15906

FCYFA GENERAL PERMISSION SLIP
ACTIVITY CONSENT FORM

NAME OF PARENT:_____

NAME OF CHILD:_____

I GIVE PERMISSION FOR THE FOLLOWING: PLEASE INITIAL AND SIGN:

FIELD TRIPS_____

WALKS_____

WATER PLAY_____

AMUSEMENT PARK_____

SPORTS EVENTS_____

ECT: YOU STILL WILL BE SENT HOME PERMISSION SLIPS FOR ANY EVENT THAT THE CHILDREN ATTEND.

PARENT/GUARDIAN PLEASE SIGN & DATE

PRINT_____

SIGNATURE_____

DATE_____

DISCLAIMER: By signing this form, I acknowledge that I understand the potential risk

pennsylvania
OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING

DOCUMENTATION OF EMERGENCY PLAN DELIVERY
Regulations 3270.27(f); 3280.26(f) and 3290.24(f)

Facilities must retain documentation that they submitted their initial emergency plan and any updated plan to their local and county municipalities.

Facility Location/Name: Flood City Youth and Fitness Academy

Physical Address: 200 Lincoln St. Johnstown, PA 15901

Legal Entity/Person responsible for the Legal Entity: Oscar Z. Cashaw Sr.

Local Municipality: Johnstown, PA, Cambria County.

Name:

Address:

Phone Number:

Email Address (if available):

Fax Number (if available):

Method Submitted (i.e. mail, fax, email, hand delivered):

Date Submitted:

County Municipality

Name:

Address:

Phone Number:

Email Address (if available):

Fax Number (if available):

Method Submitted (i.e. mail, fax, email, hand delivered):

Date Submitted:

Self-Certification

I hereby swear/affirm that the information provided is true and correct to the best of my knowledge.

Signature Title Date

FLOOD CITY YOUTH FITNESS ACADEMY

Sunscreen Usage

Permission to administer or provide for self-administration. please provide permission: Signed:_____

Printed:_____

Date:_____

If you would like to have sunscreen administered, or for your Child to self-apply, you will need to provide the sunscreen product of your choice for use by your child during the summer months. We can not offer sunscreen without parental permission.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.