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
terry@daytonymca.org

- Fairborn YMCA
  Contact: Diane Roman
  Phone: 937-754-9622
droman@daytonymca.org

- South YMCA
  Contact: Arielle Evans
  Phone: 937-434-1964
eaevans@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
  sgudgen@daytonymca.org

- Xenia YMCA
  Contact: Samantha Bates
  Phone: 937-376-9622
  sbates@daytonymca.org
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

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Child’s Date of Birth</th>
<th>Parent’s Name</th>
</tr>
</thead>
</table>

Name and Address of Pandemic Child Care Center

Is Your Child Receiving Publicly Funded Child Care?
☐ Yes
☐ No

If Yes: List the Provider’s Name and Address

Description of Parent’s Employment Providing Health and Safety Services as defined by the Ohio Department of Job and Family Services (ODJFS). Please attach verification.

Find Your Family Size in the Chart. Is Your Income Below These Annual or Monthly Limits?
☐ Yes
☐ No

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

Signature of Parent

Date
CHILD CARE PAYMENT AUTHORIZATION

*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
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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.

EFT:

□ Checking Account
□ Savings Account
Routing #: ___________ Account #: ___________ □ Voided Check/Deposit Slip Attached
Draft Date: □ Weekly on ________ □ Monthly on ________

*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 ________ □ Monthly on ________

Payment Terms & Conditions

(Day of Week) (Date of Month)

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.

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Date of Birth</th>
<th>First Day at Program/Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Zip Code</td>
<td>Home Telephone Number</td>
</tr>
<tr>
<td>Parent/Guardian Name</td>
<td>Relationship to Child</td>
<td></td>
</tr>
<tr>
<td>Home Address</td>
<td></td>
<td>Home Telephone Number</td>
</tr>
<tr>
<td>City</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email Address (if applicable)</td>
<td>Cell Phone</td>
<td></td>
</tr>
<tr>
<td>Parent's Work/School Telephone Number</td>
<td>Parent's Work/School Name</td>
<td></td>
</tr>
<tr>
<td>Parent's Work/School Address</td>
<td>City</td>
<td></td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td>Home Telephone Number</td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>Email Address (if applicable)</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>Parent's Work/School Telephone Number</td>
<td>Parent's Work/School Name</td>
</tr>
<tr>
<td>Parent's Work/School Address</td>
<td>City</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Name</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number</td>
<td>Relationship to Child</td>
<td></td>
</tr>
<tr>
<td>Other numbers where emergency contact can be reached (if applicable)</td>
<td>Other numbers where emergency contact can be reached (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Name of Physician or Clinic/Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>
**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

<table>
<thead>
<tr>
<th>Give Permission to Transport</th>
<th>Do Not Give Permission to Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program or Home Name</td>
<td>Program or Home Name</td>
</tr>
<tr>
<td><strong>has permission</strong> 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.</td>
<td><strong>does not have permission</strong> 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:</td>
</tr>
</tbody>
</table>

Parent's Signature  Date

OR

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.

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