



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Primetime YMCA OF TOPEKA

2022-2023

Primetime -The Y's before and after school program employs mission oriented team members who are active, engaging and responsible to work with your children. Based in area elementary schools, students in grades K-6 are nurtured in a comfortable, thought-provoking child care environment.

Primetime—Sites are open before school at 7am and after school until 6pm.

Lowman Hill

Berryton

Shawnee Heights Elementary

AM—\$10.00 /day

PM—\$15.00 /day

AM and PM—\$25.00/day

Terry Jones—785-435-8651

TerryJ@ymcatopeka.org

Extended Camp - This program offers daily childcare options for elementary aged students during school days out such as teacher in-service days. Based at the Southwest YMCA (students grades K—6th) student's needs are balanced with learning, physical activities and social skills.

Enroll for the days you need! Forms at www.ymcatopeka.org

7:00 am—5:30 pm at the Southwest YMCA (K—6th grade)

Members: \$27.00/day

Non-members: \$30.00/day





School Age Program

**YMCA PRIME TIME-BEFORE & AFTER SCHOOL CARE
2022-2023 Enrollment Forms (Please Print)**

Account #

SCHOOL (Please Circle One):

**Lowman Hill
Berryton**

Shawnee Heights Elementary

Start Date: ___/___/___

Primetime ONLY:

Please circle session attending: AM - PM - Both

Days of Week: M T W Th F

Child's Name:	Date of Birth: ___/___/___ Male or Female	Age:	Grade in Fall of 2020:
Child's Address:	City/State/Zip:		

Primary Parent/Guardian Contact Information Mother Father Other: _____

Primary Parent/Guardian Name:	Date of Birth: ___/___/___ Male or Female	Cell# Home# Work#
Home Address (if different from child):	City/State/Zip:	

Custodial Parent: Yes No May the Y release to non custodial Parent? Yes No

Ethnicity: Caucasian African American Hispanic Asian/Pacific Islander Other _____

Email:	Preferred Method of Communication: <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> All
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Primary Parent/Guardian Contact Information Mother Father Other: _____

Primary Parent/Guardian Name:	Date of Birth: ___/___/___ Male or Female	Cell# Home# Work#
Home Address (if different from child):	City/State/Zip:	

Custodial Parent: Yes No May the Y release to non custodial Parent? Yes No

Ethnicity: Caucasian African American Hispanic Asian/Pacific Islander Other _____

Email:	Preferred Method of Communication: <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> All
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Emergency Contact/Authorized Pick Up (other than parents):

Name:	Home Address:	City/State/Zip:
Relationship to Child:	Phone #:	Driver's License:

Additional Authorized Pick Up (other than parents):

Name:	Address:	Phone #:
Name:	Address:	Phone #:
Name:	Address:	Phone #:

Participant Health History and Information

Hospital preference (circle one): St. Francis Stormont Vail Other _____

Child's Doctor: _____ Address: _____ Phone #: _____

Is your child covered by insurance? Yes No If yes please complete the following:

Health Insurance/Medical Assistance Name _____ Policy/Card number _____

Military Medical Care I.D. Number _____

Check any conditions that your child has experienced:

Asthma Autism Diabetes Heart/Lung Conditions ADD/ADHD Cerebral Palsy/Other Motor Disorder

Cognitive or Learning Disabilities Status of Vision, Hearing, Speech to Note _____

Non-Food Allergies (list) _____

Food/Milk Allergies (list) _____

If your child has food allergies or dietary restrictions, attach a statement from a medical professional. (REQUIRED)

My child carries an epi-pen, inhaler or other medication. (additional medication form is required)

Other conditions to note: _____

Please provide symptoms and/or special instructions for any condition marked above. (Additional form is required and notes may be attached) _____

Check any of the following that relate to your child:

Fears we should be aware of: _____

An event in your child's life that may have been particularly upsetting: _____

Social or emotional characteristic you would like to note: _____

Other conditions requiring special care or additional information you feel would be helpful. (additional pages or notes may be attached) _____

Please answer yes/no to each of the following:

My child attended a public/accredited non-public school in Kansas, Missouri, or Oklahoma the previous year.

I have provided a copy of immunization records for my kindergarten child along with this form.

My child is current on his/her immunizations.

Is your child currently taking any medication during prime time? Yes No If yes, what kind and why (unless confidential by law)? _____ If any

medication (prescription or over the counter) is required during Y program time, a medication form **MUST** be completed.

The YMCA of Topeka has my permission to: (initial each line)

Involve my child in swimming

Involve my child in field trips

Involve my child in photographs or video taken for Y publicity purposes

Transport my child, provided that the Y and the driver have the legally required insurance in force, the driver has a valid Kansas driver's license and there is a current Kansas tag on the vehicle.

Statement of understanding: (your signature confirms your agreement with the following terms)

- I will notify the staff of any changes in the registration information.
- I understand it is my responsibility to sign my child in upon arrival to the program and out before leaving each day.
- I understand there is \$1/minute late pick up fee charged for each child picked up after 6pm. If the child is not picked up by 7:00pm 911 will be called.
- I understand that the Y has a no outside contact policy between Staff and Children. This includes but is not limited to: babysitting, sleepovers, transportation or other non-Y events.
- I understand that state law mandates the Y to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- **In the event that I cannot be reached to make arrangements for emergency medical attention at the time of illness or accident, I hereby authorize the Y to take my child to the nearest facility for medical attention.**
- I consent to my child's participation in the Y program and assume the risks involved. I attest and verify that I have knowledge of the risks involved in program activities and I give my child authorization to participate in such activities.
- By signature and of free will I do hereby agree to indemnify and hold harmless the Y for any and all claims or demands, cost of expense arising out of any injury or damage sustained by me or any party I am responsible for.
- I understand that even when every reasonable precaution is taken, accidents can sometimes happen. Therefore, in exchange for allowing my child to participate in Y programs, I understand and expressly acknowledge that I, for myself and for anyone entitled to act on my behalf, waive and release the Y, sponsors, representatives and successors from all claims or liabilities of any kind arising out of my child's participation in activities at or sponsored by the Y. I further agree to indemnify and save harmless the Y from any claims or demands arising out of such injuries or losses. I understand that this release includes any claims based on negligence, action or inaction of the YMCA of Topeka, its staff, directors, members and guests.

Print Name _____ Relationship to child _____ Sign Name _____ Date _____

If the health history form was completed by a person other than a Parent/Guardian, What is that person's relationship to _____

Child and Adult Care Food Program ENROLLMENT/INCOME ELIGIBILITY FORM

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.						
Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received		
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast P.M. Snack	A.M. Snack Supper	Lunch Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast P.M. Snack	A.M. Snack Supper	Lunch Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast P.M. Snack	A.M. Snack Supper	Lunch Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast P.M. Snack	A.M. Snack Supper	Lunch Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

- A family member in our household receives benefits from Food Assistance (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)
- One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)
- My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)
- My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR— Any household member receiving benefits can establish eligibility for all children in the household.	Case Number or Identification Number
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PART 3 – FOSTER CHILDREN— List the names of any children listed in Part 1 who are foster children.	

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.															
List names (First and Last) of everyone in your household, including foster children	Tell us how much and how often. If no income, write "0". Use net income if self-employed.														
	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED	
The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. See Privacy Act Statement on the back of this page.	
If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.	
"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."	

Signature of Adult	Today's Date	Print Name of Adult Signing
X _____	_____	Social Security Number (SSN) (last four digits) XXX-XX- <input type="checkbox"/> Check if no SSN
Address		Daytime Phone
City/State/Zip Code		

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): Hispanic or Latino Not Hispanic or Latino

Race (check one or more): American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or Pacific Islander White

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Food Assistance (FA), Temporary Assistance for Families (TAF) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue SW
Washington, D.C. 20250-9410

FAX: 202-690-7442
EMAIL: program.intake@usda.gov

*Only use this address if you are filing a complaint of discrimination.

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

- Child(ren) are categorically free based on FA/TAF/FDPIR.
 Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.
 Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

- Child(ren) on this form who are not categorically eligible qualify as follows:

Check one: Free
 Reduced Price
 Paid

Household Size: _____

Total Income: \$ _____
 Annual Monthly Twice Per Month
 Every Two Weeks Weekly

X _____
Signature of Determining Official

Today's Date

X _____
Signature of Confirming Official

Today's Date

NOT VALID WITHOUT SIGNATURE AND DATE.

E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective date.



FOR YOUTH DEVELOPMENT
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PrimeTime

Berryton
Lowman Hill
Shawnee Heights Elementary

Letter of Cancellation or Termination

Form Must Be Turned In @ YMCA Front Desk or Emailed to tonic@ymcatopeka.org

Attn: Billing

Effective _____ **(Date)** I would like to cancel the following week or weeks of Prime Time.

Child's Name: _____

Parent/Guardian Name: _____

School: _____

Week/Weeks: _____

Pursuant to the agreement between the YMCA and _____,
(Parent/Guardian)

either party may cancel or terminate the contract with a two weeks' notice.

Date: _____

Parent Signature: _____

(Office use only)

Acct: _____

Date form Recd _____

Date Completed: _____

YMCA OF TOPEKA

3635 SW Chelsea, Topeka, Kansas 66614 - 785-271-7979