

YWCA of the Niagara Frontier, Inc.
Preschool and Playroom Plus Program

February 24, 2020

Dear Parents and Guardians:

Beginning Monday, March 9, 2020, registration for all YWCA of the Niagara Frontier, Inc. Preschool and Playroom Plus Programs will be accepted on a first come first served basis. In order to secure a spot for your child or children, the first month's tuition and onetime registration fee of \$75 must accompany the registration packet.

- **Preschool- Three Year Old Children; Monday, Wednesday, and Friday; am or pm; cost \$120/month**
- **Playroom Plus- Two Year Old Children; Tuesday & Thursday am only; cost \$100/month**

Our enrollment forms for 2020-2021 continue to request the same information as required in previous years. Classes fill quickly, so please register now to avoid disappointment. **We do not save placements.** When returning all required enrollment forms, the onetime registration fee of \$75 (non-refundable) and first month's tuition must be paid at this time.

If you have questions or concerns please contact our School Secretary, Sheila Hanczarowski, at (716) 478-4751.

Sincerely,

Sylvia Baptiste
Interim Early Childhood Director
YWCA of the Niagara Frontier Inc.

OVER

YWCA of the Niagara Frontier, Inc.
Preschool and Playroom Plus

JOHN POUND EARLY CHILDHOOD CENTER

REQUIRED DOCUMENTS

RETURN TO JOHN POUND EARLY CHILDHOOD SCHOOL OFFICE:

- THE REGISTRATION PACKET
- PLEASE BRING:
 1. The Child's Original Birth Certificate
 2. Custody/Legal Documentation, if applicable
 3. Child's Up to Date Immunization Record
 4. Child's Current Physical Information From His/Her Physician
 5. One Time Registration Fee \$75 and First Month's Tuition.

WHEN ALL FORMS AND PAYMENT COMPLETED, PLEASE RETURN TO SCHOOL SECRETARY. ALL REGISTRATIONS WILL BE DONE AT JOHN POUND EARLY CHILDHOOD CENTER.

YWCA of the Niagara Frontier at John Pound Early Childhood Center Registration Form

Registration Date: _____

- YWCA Pre School 3 Year Old AM
- YWCA Pre School 3 Year Old PM
- Playroom Plus 2 Year Old AM Only

STUDENT INFORMATION: (Please print. Complete all the information requested and place a check in the appropriate areas.)

Last Name: _____ First Name: _____ Middle: _____

Address: _____
City State Zip Home Phone: _____ Cell Phone: _____

Mailing Address: _____
City State Zip

Email Address: _____ Birthdate: ____/____/____ Place of Birth: _____
City State

Ethnic Origin: ___White ___Black ___Hispanic ___Asian ___Native American ___Multi-racial (check 2 from list) ___Male ___Female

Is English the primary language spoken in your home? ___yes ___no If not what language: _____

Does your child have a hand preference? ___Left ___Right

Name of Primary Insurance _____ Policy Holder Name/D.O.B _____

Policy Number _____ Group Number/I.D Number _____

In the event of an accident or serious illness requiring immediate medical intervention, every effort will be made to contact the parent/guardian. If the YWCA of the Niagara Frontier is unable to contact the parent/guardian or person indicated on emergency contact list, I authorize the YWCA of the Niagara Frontier to transport my child. **Please Note:** Local rescue will transport only to the nearest emergency facility, Eastern Niagara Hospital. I accept responsibility for all medical bills resulting from the illness or injury while my child is in the care of the YWCA of the Niagara Frontier, Inc.

Signature of Parent/Guardian _____

Date _____

FAMILY BACKGROUND

Student Lives with: Both Parents Father Mother Other _____ relationship _____

Legal Custody: Both Parents Father Mother Other _____ relationship _____

Legal Documentation of Custody? yes no (copies attached) Explain: _____

Father: _____ / _____ / _____
 Last Name First Middle Occupation

Address (if different from student) City State Zip U.S. Citizen: yes no Deceased: yes no

Name and Address of Father's Employer Employer's Telephone Number

Mother: _____ / _____ / _____
 Last Name First Middle Occupation

Address (if different from student) City State Zip U.S. Citizen: yes no Deceased: yes no

Name and Address of Mother's Employer Employer's Telephone Number

Extended Family

Stepfather's Last Name / First Name / Middle Address Telephone

Stepmother's Last Name / First Name / Middle Address Telephone

Guardian's Last Name / First Name / Middle Address Telephone

Other Children in the home Name	Age	Birth date	School, if applicable
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Front Desk Information & Payment Information – Preschool 2020-21

Student Name: _____

Circle one: 3 Year AM 3 Year PM 2 Year Playroom Plus

Parent/Guardian Information:

Full Name: _____

Address: _____ city / state / zip _____

Home phone: _____ cell phone: _____

Email Address: _____

Full Name: _____

Address: _____ city / state / zip _____

Home phone: _____ cell phone: _____

Email Address: _____

For automatic payment from your credit card, please provide the information below:

I, _____, authorize the YWCA of the Niagara Frontier to charge my account automatically each month during the School Age Child Care program.

Amount: _____

Account No.: _____

Expiration Date: _____ Security Code (on back of the card): _____

Signature: _____ **OVER PLEASE**

Month	Payment	Date	Receipt#	Month	Payment	Date	Receipt#
September	_____	_____	_____	February	_____	_____	_____
October	_____	_____	_____	March	_____	_____	_____
November	_____	_____	_____	April	_____	_____	_____
December	_____	_____	_____	May	_____	_____	_____
January	_____	_____	_____	June	_____	_____	_____

To be completed by YWCA Staff:

\$ _____ YWCA Registration Fee	YWCA registration expiration date _____
\$ _____ First Month Payment	Month starting: _____
\$ _____ Total Due at Registration	Receipt number: _____
\$ _____ Monthly Payment Thereafter	Date of Registration: _____ Initials _____

YWCA OF NIAGARA AT JOHN POUND EARLY CHILDHOOD CENTER
PARENT/GUARDIAN FINANCIAL RESPONSIBILITIES

Child's Name _____

Parent/Guardian Name _____

Program: Circle One

YWCA Preschool (3 Year Old)

YWCA Playroom Plus (2 Year Old)

Parent/Guardian Financial Information

- The YWCA of the Niagara Frontier, Inc. reserves the right to suspend children from the YWCA programs listed above due to non-payment of tuition.
All forms, tuition and registration fee needs to be completed in full before child is registered Forms and payment need to be made at John Pound Early Childhood Center, 51 High Street, Lockport.
Additional monthly payments can be mailed to The YWCA of the Niagara Frontier, Inc. 32 Cottage Street, Lockport, NY 14094
- Monthly tuition payments can _____
Parent/Guardian Signature _____
- Monthly tuition payments may be made at John Pound Early Childhood's main office; only if you pay by check or cash (exact amount, please).
- No Credit or Debit Card data can be transacted at John Pound Early Childhood Center.
- YWCA registrations are non-refundable.
- Only fees for programs cancelled by the YWCA of the Niagara Frontier are refundable.
- Dismissal or withdrawal from the YWCA of Niagara Frontier programs listed above does not reduce your cost. Absence from the YWCA of the Niagara Frontier programs listed above does not reduce your cost.
- Refunds will NOT be given for absences, weather related or emergency closings.

Parent/Guardian Consent & Acknowledgement

Parent/Guardian Responsibility Acknowledgement for YWCA Preschool Programs at John Pound Early Childhood Center: I Understand, that in order to begin or continue in each of the programs listed above, the child's registration packet must be completed, including signed, documents, **the \$75 registration fee and the monthly tuition payments.**

Parent/Guardian Responsibility Acknowledgement for YWCA Preschool Programs at John Pound Early Childhood Center: I understand that I am responsible to notify the YWCA Program Director in writing or direct phone call (478-4151) of any changes in my child's School attendance. Sample: My Child is withdrawing from the YWCA Preschool or Playroom Plus because of moving out of the area.

- **Parent/Guardian Communication Acknowledgement for YWCA Preschool Programs at John Pound Early Childhood Center:** The school main office number is 478-4751. Please contact the school secretary to report an *emergency home situation or to request to speak with the classroom teacher. ***In case of an emergency speak to the school secretary. Please do not leave a message.**

I have read and understand the policies stated above.

Parent/Guardian Signature _____ Date: _____

JOHN POUND EARLY CHILDHOOD CENTER
EMERGENCY CONTACT & PERMISSION TO PICK UP CHILD
(Please print)

Teacher _____

Classroom Number _____

Child's Name _____

Date of Birth _____

Mother's Name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Father's Name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Guardian's Name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Who does the child live with? _____

If I am not available to pick up my child from school or in the event of an emergency, the following people have my permission to do so for me and are at least 18 years of age: **They will be called in number order for emergencies and pick up.***

1. Name _____ Phones: _____

Relationship to my child _____

2. Name _____ Phones: _____

Relationship to my child _____

3. Name _____ Phones: _____

Relationship to my child _____

4. Name _____ Phones: _____

Relationship to my child _____

5. Name _____ Phones: _____

Relationship to my child _____

6. Name _____ Phones: _____

Relationship to my child _____

7. Name _____ Phones: _____

Relationship to my child _____

*I hereby authorize the above person(s) to pick up my child from school. If a person comes to pick up my child from school that is not on the list, I understand that he/she will need written permission and a picture ID will need to be provided or my child will not be released to that person. *In certain situations, verbal permission may be approved.*

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____

JOHN POUND EARLY CHILDHOOD CENTER
PERMISSION FORM

* PLEASE PRINT *

CHILD'S NAME _____ Date of Birth _____
Last First

Parent/Guardian Name _____ Today's Date _____

Please read each section below, circle your answer to each section, and sign at the bottom.

PHOTOGRAPHY / PHOTOS, VIDEO OR FACEBOOK PERMISSION

YES NO

I give permission for my child to be photographed or filmed in the John Pound Early Childhood Programs for use in local newspapers, in slides or videos or photo displays in conjunction with activities related to education. My child's name may also be used for these purposes.

PHOTOGRAPHY / YEARBOOK

YES NO

I give permission for my child to be photographed and his/her photo to be included in the John Pound Early Childhood Programs class picture and/or year book.

FIELD TRIP PERMISSION

YES NO

I give permission for my child to participate in and travel on field trips under the supervision of John Pound Early Childhood Programs Staff. I will be notified of each trip in advance.

OUTDOOR ACTIVITIES PERMISSION

YES NO

I give permission for my child to participate in walks and outdoor activities under the supervision of John Pound Early Childhood Programs Staff.

COMPUTER USE

YES NO

I give permission for my child to use classroom computers for educational purposes as they pertain to the John Pound Early Childhood Programs curriculum.

Parent/Guardian Signature _____

YWCA OF THE NIAGARA FRONTIER AT JOHN POUND EARLY CHILDHOOD CENTER - HEALTH HISTORY FORM

State law requires that all new entrants produce proof of sufficient vaccine status. **THEREFORE: A COPY OF IMMUNIZATIONS FROM A DOCTOR OR CLINIC IS REQUIRED – PLEASE ATTACH TO THIS FORM.**

I understand that the information contained on this form will be kept confidential and may be shared with school and transportation personnel if needed to protect the student's health and safety while at school.

STUDENT'S NAME: _____ BIRTHDATE: _____

(First) (Initial) (Last)

ADDRESS _____ PHONE: _____

BIRTHPLACE: _____ SEX: () Female () Male

(City) (State) (Country)

NAME OF PHYSICIAN: _____ NAME OF DENTIST: _____

HEALTH CONDITIONS PLEASE CHECK ANY THAT APPLY TO YOUR CHILD

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal spinal curvature (scoliosis, etc.)
<input type="checkbox"/> Asthma or wheezing
<input type="checkbox"/> Depressed immune system
<input type="checkbox"/> Sickle cell disease/Blood disorder
<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Broken bones _____
<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> Any Surgeries: _____ | <input type="checkbox"/> Ear infections (more than 3 in one year)
<input type="checkbox"/> Tubes in ears: Left ____ Right ____
<input type="checkbox"/> Wears hearing aid
<input type="checkbox"/> Wears glasses/contacts
<input type="checkbox"/> Other visual impairment _____
<input type="checkbox"/> Orthopedic impairment _____
<input type="checkbox"/> Heart Condition/murmur _____

<input type="checkbox"/> Any Restrictions: _____ | <input type="checkbox"/> Head injury or loss of consciousness
<input type="checkbox"/> Frequent headaches
<input type="checkbox"/> Frequent nosebleeds
<input type="checkbox"/> Fainting or blacking out
<input type="checkbox"/> Concern about relationship with siblings or friends
<input type="checkbox"/> Behavioral / Emotional problems
<input type="checkbox"/> Substance abuse: ____ Drugs ____ Alcohol
<input type="checkbox"/> Depression
<input type="checkbox"/> Suicide attempt |
|--|---|---|

*** Please describe/explain the health conditions noted above, along with any other concerns which you feel the school should be aware of on the back of this form:

ALLERGIES: (Please list and describe reactions): _____

SEVERE ILLNESSES OR INJURIES: _____

DAILY MEDICATIONS AND DOSAGE: (please list and explain associated medical condition) _____

OTHER: _____

(Print name of person completing this form)

(Signature of person completing this form)

(Relationship to student)

(Date completed)

Explanation of health conditions from other side:

Other concerns or comments:

John Pound Early Childhood Center

Dear Parent/Guardian:

The YWCA of the Niagara Frontier's Preschool or Playroom Plus Programs at John Pound Early Childhood Center is requesting your child have a physical examination.

Please contact your physician to make an appointment. If your child has had a physical examination within the past 12 months, the physician may simply document that examination.

A Health Appraisal Form has been included or your physician may provide you with his or her own printed version. Either document is acceptable.

Additionally, please make sure your child's Immunization records are up to date.

Please return the completed Health Appraisal Form included or your child's physician's Health Appraisal Form, and the Immunization Record to the John Pound Early Childhood Center as soon as possible.

Your physician may also fax the forms to John Pound Early Childhood Center at 201-4637. Please indicate that the child will attend the YWCA of the Niagara Frontier's Preschool or Playroom Plus Programs. Please send to the attention of Sheila, the school secretary.

YWCA of the Niagara Frontier at John Pound Early Childhood Center Health Appraisal Form

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal:

Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: Positive Negative Not done Date: _____
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: See attached: _____

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Date of Exam: _____

Height: _____ Weight: _____ Blood Pressure: _____ Heart rate: _____

Body Mass Index: _____ BMI Chart on reverse side Weight Status Category (BMI Percentile) <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - without glasses/contact lenses			<i>Referral</i>	
		R	L		
	Vision - with glasses/contact lenses		R	L	
	Vision - Near Point		R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:		R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No
 Note: Nurse will also assess self-direction for the school setting. Parents are advised to send in additional medication in the event that emergency sheltering is necessary at school.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
 ___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: _____ None
 Known or suspected disability: _____ Please monitor
 Restrictions: _____ Please monitor
 Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)
 Provider's Name/Address: _____ Date: _____
 Parent Signature: _____ Date: _____

John Pound Early Childhood Programs Bathroom Form

The mission of the John Pound Early Childhood Programs is to make your child successful in early readiness skills and self-help skills. We would like to have consistency between home and school during bathroom times. During bathroom times at school, there will be supervision at the bathrooms at all times according to your child's needs. Typical supervision includes an adult standing outside the bathroom doors.

Please check the appropriate boxes below that relate to your child's self-help in the bathroom.

- My child is independent in the bathroom. He/She can use the bathroom on his/her own with no assistance.
- My child is potty trained.
- My child is not independent in the bathroom. He/She is still in the process of being potty trained.

Please check the appropriate boxes below that relate to what your child wears to school.

- My child wears underwear.
- My child wears pull-ups.
- My child wears diapers.

Please leave additional information and comments regarding your child's bathroom tendencies below. Any further information would be helpful to insure consistency between home and school. Also, if your child is in the process of potty training or not potty trained at all, please make sure to send in additional underwear, pull-ups, diapers and clothes.

Student's Name _____

Parent/Guardian's Signature _____ Date _____

YWCA OF THE NIAGARA FRONTIER CHILD PROFILE PARENT QUESTIONNAIRE

Child's Name _____ Entering: (circle one) YWCA 3 Year Program

YWCA 2 Year Playroom Plus

You know your child better than anyone else in the world! You have observed your child's growth on a day to day basis, and you are uniquely qualified to share that with us. Please take a moment to complete this profile about your child. This information will help us know your child better and meet his or her individual needs.

PLEASE CHECK HOLIDAYS CELEBRATED:

<input type="checkbox"/> Halloween	<input type="checkbox"/> Thanksgiving	<input type="checkbox"/> Passover	<input type="checkbox"/> Christmas
<input type="checkbox"/> Valentine's Day	<input type="checkbox"/> Cinco de Mayo	<input type="checkbox"/> Hanukkah	<input type="checkbox"/> Mother's Day
<input type="checkbox"/> Father's Day	<input type="checkbox"/> Easter	<input type="checkbox"/> Kwanzaa	<input type="checkbox"/> Other

Interests:

What would you like your child to experience with us? _____

What is your child's favorite activity? _____

What is your child curious about? _____

What are your child's favorite toys? _____

Personal Habits:

Does your child play with other children? _____

Does your child have any particular fears? _____

Do you consider your child shy or outgoing? _____

What words are spoken in your home for toileting? _____

Does your child take naps? _____ How long? _____ How many hours of sleep per night does your child receive? _____

Does your child need a special item (such as a blanket) for a nap? _____ If so, does your child have a name for it? _____

How do you reward positive behavior (ex: hugs, movies, etc...)? _____

How would you like us to reward positive behavior? _____

Family:

What things do you do as a family? _____

Parents, do you have special training or talents that you would like to share (art, music, cooking)? _____

What language is spoken in the home? _____

Do you have family pets? Please name them. _____

Are you available to help us with special events and/or field trips? _____

Is there any other helpful information we should know? _____