Hello Parents:

Please complete the following forms to enroll your child in the LionKIND 21st Century Community Learning Center After School Program located at Emmet Belknap Intermediate School or North Park Junior High School.

Once the forms have been completed you can either drop them off in the Main Office of the school your child attends (Emmet Belknap or North Park), alternatively you can mail them to, or drop them off at, the YWCA located at 32 Cottage Street, Lockport, NY 14094.

If you have any questions or require further information please contact me at 478-4827. Thank you.

Sincerely,

Holly Dickinson
Director of Grants & District/Community Programs

HD:klw

cc: File
**ENROLLMENT DATE** (m/d/year) ________________  
**SCHOOL**  
**YWCA OF THE NIAGARA FRONTIER**  
**SCHOOL AGE CHILDCARE PROGRAM ENROLLMENT FORM**

Start Date. ________________

<table>
<thead>
<tr>
<th>Days enrolled per week:</th>
<th>a.m.</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
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<tbody>
<tr>
<td>Before School Program</td>
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<tr>
<td>Days enrolled per week:</td>
<td>p.m.</td>
<td>Mon</td>
<td>Tues</td>
<td>Wed</td>
<td>Thurs</td>
<td>Fri</td>
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<td>After School Program</td>
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</table>

Child’s Name ___________________________  Age _____  Birth Date ________________

Gender  M/F  Grade _____  Teacher Name & Room # ________________________________

Address ___________________________________________  City, State, Zip ______

Parent/Guardian Name _________________________  Ph. # (Home) ________________

Parent/Guardian Address ____________________________________________

Parent/Guardian Address ____________________________________________

Email Address: (Please Print) ____________________________________________

**WARNING!**  Emergency Contact Numbers may not be changed without written consent.

Parent/Guardian Name _________________________  Ph. # (Home) ________________

Parent/Guardian Address ____________________________________________

Parent/Guardian Address ____________________________________________

Email Address: (Please Print): ____________________________________________

**CAN CHILD BE PICKED UP BY BOTH PARENTS?**  □ YES  □ NO  
*(If not, provide written documentation)*

Child lives with  □ both parent’s  □ mother  □ father  □ other ________________

Custody Restrictions? Please elaborate. ____________________________________________

<table>
<thead>
<tr>
<th>Emergency Contact Names/Addresses</th>
<th>Authorized to pick up</th>
<th>Primary Phone</th>
<th>Other phone number/email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Contact:</td>
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**NEWFANE SCHOOLS ONLY**  
WILL YOUR CHILD BE COMING TO SCHOOL BY BUS?  
MORNING BUS........... BUS #.............

**LOCKPORT SCHOOLS ONLY**  
CHILD CARE AVAILABLE  
HALF-DAY: SEPTEMBER 2nd  
YES......... NO.........
Health History Form

Child’s Name __________________________ Date of Birth: ________________
Child’s Primary Care Physician’s Name/Group __________________________ Phone #: __________________
Preferred Hospital: __________________________ Phone #: __________________
Child’s Dental Care __________________________ Phone #: __________________

In case of an emergency, and the YWCA of Niagara is unable to reach the parent/guardian, the following individual(s) have permission to make decisions regarding the care of my child/me, including permission to pick up my child/me from the YWCA in case of an emergency or dismissal from the YWCA of the Niagara Frontier.

Name __________________________ Relationship to child/staff __________________________
Address __________________________ City/State/Zip __________________________
Home Phone (_____) __________________________ Cell Phone (_____) __________________________

HEALTH HISTORY – Indicate and explain as necessary.

<table>
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<tr>
<th>ALLERGIES:</th>
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<tbody>
<tr>
<td>Autism</td>
<td>Seizures</td>
<td>ADD/ADHD</td>
<td>Bee Sting</td>
<td>Dairy</td>
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<tr>
<td>Asperger’s</td>
<td>Hearing</td>
<td>Lactose Intolerant</td>
<td>Wheat</td>
<td></td>
</tr>
<tr>
<td>ODD</td>
<td>Vision</td>
<td>Peanut</td>
<td>Insect Bites</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Motor Delays</td>
<td>Tree Nuts</td>
<td>Penicillin</td>
<td></td>
</tr>
</tbody>
</table>

Child has any special needs/services: Early Intervention/Special Education Occupational Therapy Speech/Language Physical Therapy

Learning Disability __________________________________________________________
Other diseases or details of above ____________________________________________
Dates of operations or serious injuries/illness _________________________________
Chronic or recurring illness _________________________________________________

Is the child/staff currently taking any prescribed medications? ______ yes _____ no. Please be sure to consult with your physician about bringing these medications to the YWCA of the Niagara Frontier along with the MEDICATION CONSENT FORM.

ARE YOU COVERED BY ANY HOSPITALIZATION/MEDICAL CARE POLICY?  YES ________ NO ________

Name of Primary Insurance Company __________________________ Phone # (_____) __________________________
Address __________________________________________________________
Policyholder’s Name __________________________ Policyholder’s Birthdate __________________________
Policy # (including 3 letters): __________________________ Is policy through employer? ______ yes ______ no

PARENT/GUARDIAN AUTHORIZATION: To the best of my knowledge, this health history is correct and the designated child may engage in all YWCA activities (except where noted by the examining physician or myself).
I authorize the YWCA staff to supervise self-administration of sunscreen products by my child. In an emergency, I authorize the YWCA SACC Director to act for me/my child according to her/his best judgement where medical or surgical treatment is required.
I accept responsibility for all medical bills resulting from the illness or injury while my child is in the care of the YWCA.

Please initial:
- I consent to emergency medical treatment for my child ______
- I provided information on my child’s special needs to the program to assist in caring for my child ______
- I agree to review and update this information whenever a change occurs and at least once every year ______
- A current copy of my child’s physical and immunization records has been provided to the program. ______

PARENT/GUARDIAN SIGNATURE __________________________________________ DATE ________
Before entering a child care program, employees, volunteers, parents, children and essential visitors must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time. Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers "Yes" to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:
Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer daily. If any of the answers to the below questions are "Yes," individuals cannot enter the program. If the answers are "No" to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer "No" to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing ANY of the following symptoms?
   - Cough (new or worsening)
   - Shortness of breath (new or worsening)
   - Trouble breathing (new or worsening)
   - Fever
   - Chills
   - Muscle pain (new or worsening)
   - Headache (new or worsening)
   - Sore throat (new or worsening)
   - New loss of taste
   - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered "NO" to all questions, you have passed and may enter the program.

If you have answered "YES" to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

---

Signature

Date

Signature

Date

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.
21st Century Community Learning Center
LionKIND After School Program

TRANSPORTATION PERMISSION SLIP

As part of the funding provided to the Lockport City School District through the 21st Century Grant, bussing will be provided to all program children with the following stipulations:

- All children who are transportation eligible will be placed on the bus after the program on the day they attend (Monday, Tuesday, Thursday, and Friday), UNLESS the Program Director receives direct contact from a parent or guardian. Direct contact may only include a phone call to the site cell phone or a note from the parent, signed and dated stating the effective date of the transportation change,

- Bussing is not available on Wednesdays on this is not a program day this year.

- Only children currently enrolled and actively attending the program are permitted on the bus.

- All busses will be cleaned and sanitized daily and all individuals on the buss are required to wear a face mask and practice social distancing. Students will only be seated one student per seat unless they are siblings living in the same household, in which case they may share a seat.

- Transportation by the school district bus is a privilege not a right, the consequences of poor choices and behavior while on the bus WILL result in the loss of bussing privileges. At which point it will become the parent’s responsibility to provide transportation.

I hereby give permission for ________________________________ to be transported by school district bussing from my child’s home school to an assigned drop off point. I accept responsibility for my child from the drop of location until their return home. I understand that my child is responsible for behaving appropriately while on the bus and is subject to removal from the bussing program should it be deemed necessary. I accept responsibility for notifying the YWCA program in advance should any schedule or location changes become necessary.

Parent/ Guardian Signature: _______________________________________________

Date: _______________ Phone number I can be reached at: ___________________________