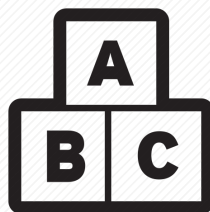


RaritanValleyYMCA.org

2025-26

Early Childhood Learning Center
OPEN ENROLLMENT

6 Weeks Old—Entering Kindergarten
Open Year-Round 7:00am until 6:00pm



Licensed, Accredited, Quality Care
Adventurous Center with Indoor/Outdoor Play Space
Discover Year-Round Enrichment Activities
Open for Older Siblings Most School Closure Days
Caring, Trained, Dependable Year-Round Staff

CALL OR EMAIL
TO REQUEST A TOUR APPOINTMENT
Preeti Srivastava, Associate Executive Director
psrivastava@raritanvalleyymca.org

732.257.4114



Enrollment for the Early Childhood Learning Center is ongoing, pending availability. Two (2) business days' notice is required to review, and process completed registration paperwork. Please register early to ensure we can prepare for your child's safe arrival.

2025-26 Weekly Tuition

Early Childhood Learning registration requires **2 weeks' security deposit** at time of registration. Deposits are credited towards the last two weeks of the school year and are re-applied, when two weeks' written notification of departure from the program is provided, towards those two weeks. **If you place a card on auto draft for weekly tuition at registration; we will only require a 1-week security deposit.**

Full Day Program (7:00am-6:00pm) Cost/Week

	<u>3 Days/Wk</u>	<u>4 Days/Wk</u>	<u>5 Days/Wk</u>
Infants 6 wks-18mths (Sept-Aug)	\$264	\$287	\$327
Toddlers 18-30mths (Sept-Aug)	\$264	\$287	\$327
Preschool 2.5-5yrs (Sept-Aug)	\$208	\$245	\$275

Half Day Program

	<u>3 Days/Wk</u>	<u>5 Days/Wk</u>
Preschool 2.5-5yrs (Sept-Aug., 9:30-12:30)	\$154	\$208

No make-up dates can be arranged for any missed prescheduled program days.

Financial Assistance is available; please see our handbook for more information.

Additional Fees

YMCA Program Membership is required for all program registrations. Facility Memberships are awarded at no cost to two adult parents/guardians of Full Day (5 days only) program participants to support healthy family living.

Parents may choose to add enrichment classes such as swim lessons, youth sports and/or creative arts enrichment programs available evenings and week-ends. Class trips, school year photos, child-focused events, and occasional fundraisers may charge a nominal fee.

Vacation/Snow Day Camp may be available 7:00am-6:00pm for older siblings on most school closure days. Pre-registration is required, pending availability. More details can be found on our website, including trip and activity details.

the Y EARLY CHILDHOOD

Raritan Valley YMCA Early Childhood Learning 2025-26 Registration

Choose One:

- ☐ Full Day Infant (5, 4, or 3 Days)
- ☐ Full Day Toddler (5, 4, or 3 Days)
- ☐ Full Day Preschool (5, 4, or 3 Days)
- ☐ Half Day Preschool (5 or 3 Days)

Child _____ M / F
 Birthdate ____ / ____ / ____ Age ____
 Address _____
 City _____ NJ Zip Code _____
 Enroll Date ____ / ____ / ____ Start Date ____ / ____ / ____

Circle Days Registering: Mon Tue Wed Thu Fri
 Days are permanent unless schedule change request

Parent Contact Information

[Email is our primary method of communicating. However, invoices are ONLY sent to the primary contact.]

Parent/Guardian #1 _____ Birthdate ____ / ____ / ____
 Primary Phone _____ Alternate Phone _____
 Email _____ Employer _____
 Employer Address _____

Parent/Guardian #2 _____ Birthdate ____ / ____ / ____
 Primary Phone _____ Alternate Phone _____
 Email _____ Employer _____
 Employer Address _____

ALTERNATE PICK-UP AUTHORIZATION CONTACT INFORMATION

Emergency Contact #1 _____ Relationship _____
 Primary Phone _____ Alternate Phone _____
 Emergency Contact #2 _____ Relationship _____
 Primary Phone _____ Alternate Phone _____

Who may NOT pick up your child, if any? (Please provide legal documentation if a parent.)

Name _____ Relationship _____
 Reason _____
 Name _____ Relationship _____
 Reason _____

Registrations are not considered active until all forms and fees have been processed.

- ☐ Early Childhood Registration Form
- ☐ Personal History for Caretakers
- ☐ Medical Release Form
- ☐ Parent/ Guardian Agreement Form
- ☐ Late Pick up and Sunscreen Policies
- ☐ Universal Health Record
- ☐ All Registration and Tuition Fee
- ☐ Auto-Draft Payment Form (Optional)

As Needed

- ☐ Alternate Pick-Up Form
- ☐ Permission to Medicate Form

REGISTRATION FEE SUMMARY

\$ _____ Annual Membership dues thru 6/30/2025
 \$ _____ 1 or 2 Weeks Deposit
 \$ _____ 1st Week Tuition (If no Auto-Draft)

Checks to YMCA are processed at registration.

Auto-Draft Forms will charge deposit now and future weeks on Mondays. We accept: Visa, MC, Discover, Amex, or electronic bank drafts.

\$ _____ TOTAL DUE at registration

Staff Reviewing/Accepting Forms _____ Date _____
 Staff Processing Registration/ Auto Draft _____ Date _____



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Personal History for Early Childhood Caretakers

Child Name _____ Birth Date ____/____/____

Name/Ages of Siblings: _____

What is the primary language spoken at home? _____

Is this your child's first educational experience? _____

What are your child's favorite activities to help calm/sooth or redirect behavior, where necessary?

What upsets or frightens your child? _____

What form of discipline does your child best respond to? _____

Please describe your child's current sleeping schedule: _____

Are you breast feeding your child? _____ Is your child using a bottle/cup? _____

Is your child eating baby or table food? _____

Please list all foods your child is currently eating or should be encouraged to try.

Are there any dietary restrictions for your child?

Please describe eating times and amount per feeding? _____

Where does your child spend their awake time (if infants)? _____

Please describe your child's bowel and urination movements / timeliness. _____

Does your child require diaper changes? _____ If so, please describe any needs or suggestions to ensure a healthy and happy experience. _____

Any physical, educational, emotional, medical, or special needs we should be aware of?



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Early Childhood Learning Medical Release Form

Child Name _____ Birth Date ____/____/____

Physician _____ Phone _____

Address _____
Street City State Zip

Insurance Carrier _____ Policy # _____

Chronic Illness / Bloody Nose History? _____

Asthma History? _____ Seizure History? _____

Food Reactions _____ Insect Reactions _____

Medication Allergies _____

Medications Being Taken _____

(The Y does not dispense any medication without a completed Permission to Administer Medication Form provided the medication is in its original container and labeled with the child's full name, doctor, and dosage. All medication dispensing requests must be approved by the Child Care Director.)

This health history is correct as far as I know, and my child is in good health and has permission to engage in all the normal activities of the Early Childhood Learning Center. **I understand I must also complete a Universal Health Record with a doctor's signature to participate in this program.**

In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the medical personnel selected by the Y, to transport, hospitalize, and secure proper treatment, order x-rays, injections, anesthesia, or surgery, and to release any records necessary for insurance purposes for my child as named above.

Parent/Guardian Signature _____ Date ____/____/____

I agree that the YMCA shall not be responsible for any personal injuries or losses sustained by me or my family on any YMCA premises, or as a result of any YMCA sponsored activities. I further agree to indemnify and hold harmless the Y from any claims or demands arising out of any such injuries or losses. The undersigned hereby releases, waives, discharges, and covenants not sue the Y, its directors, officers, employees, and agents from any claims for injury, illness, death, loss or damage that may be suffered as a result of participation in these activities. The undersigned acknowledges that a physician should be consulted prior to participating in any physical activity or program.

Parent/Guardian Signature _____ Date ____/____/____



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Child's Name _____

Early Childhood Learning Parent/Guardian Agreement Form

Please read and retain the Parent Handbook available on our website at www.RaritanValleyYMCA.org under Child Care > Child Care Handbook. Registration is not complete until all completed forms and fees are processed.

I acknowledge the following:

I have received and read the Parent Handbook and I am fully aware of the policies of the Raritan Valley YMCA Child Care programs and any questions have been answered to my satisfaction by the YMCA staff. I also agree to complete additional forms from the website, as necessary, including: Alternate Pick-Up Form and Permission to Administer Medication Form. By signing below, I understand and agree to accept the terms and conditions of the policies in the Parent Handbook (revised July 2024) including:

PLEASE CHECK ALL BOXES

- ☐ Information to Parents Statement prepared by the NJ Bureau of Licensing
- ☐ Policy on the Release of Children
- ☐ Behavior Management, Positive Guidance, Discipline and Expulsion Policy
- ☐ Policy on Methods of Parent Communication
- ☐ Babysitting Policy
- ☐ Health Policy & Communicable Disease Management
- ☐ Absences and Tuition Credits Policy
- ☐ Technology & Social Media Policy
- ☐ YMCA Parent Handbook

Parent/Guardian Signature _____ Date ____/____/____

I understand the following:

- ☐ Enrollment and fees are based on our school calendar year Infants (Sept-Aug), Toddler/Pre-K (Sept-June)
- ☐ I must give 2 weeks' notice, in writing, to cancel my child's enrollment and to apply deposits appropriately.
- ☐ Deposits will be applied to the last two weeks once notice of cancellation has been received, in writing.
- ☐ Membership Fees are non-refundable/transferrable.
- ☐ I must communicate any changes in contact information, emergency contacts, or medical needs, in writing.
- ☐ It is my responsibility to communicate absences due to any potential communicable disease/illness.
- ☐ I will request a Permission to Administer Medication and follow all guidelines, if needed.
- ☐ I must provide all snacks, meals, and utensils to be brought home and sanitized each day.
- ☐ The Y is not responsible for any lost or stolen personal belongings and I should label all belongings.
- ☐ A late pick-up fee of \$15 for each 15-minute interval is charged after your pre-arranged pick up time.

Parent/Guardian Signature _____ Date ____/____/____

I give the Y permission for the following:

- ☐ To have my child to participate in walking trips within the center's neighborhood.
- ☐ To transport my child on occasional trips, with advance communication.
- ☐ To use any media footage of my child for publicity purposes. (Cross off if not authorized.)

Parent/Guardian Signature _____ Date ____/____/____



Child's Name _____

LATE PICK-UP FEE POLICY

The YMCA Childcare Program ends promptly at 6:00pm. We understand that emergencies occur. We kindly ask you to consider your child's well-being and our staff's responsibilities outside of the YMCA. Their time is also valuable, and they may have other obligations.

Please call the center if you anticipate being late on any given day. Calling does not waive the late fees but does allow the YMCA to make arrangements for supervision of the child until the parent /guardian arrives. We also ask that you contact your alternate authorized contacts to arrange to pick-up your child timely to avoid late fees.

Parents/guardians must pay a considerable late fee if the child is picked up after the program ends. A fee of \$15.00 for up to every fifteen (15) minutes is charged and payable before you sign your child in again. (Examples 6:01-6:15pm=\$15.00, 6:16 – 6:30=\$30.00, 6:31-6:45pm=\$45.00 etc)

AFTER 3 LATE PICK UPS, YOUR CHILD MAY BE SUSPENDED FROM THE PROGRAM.

If the parents or persons authorized by parents fail to pick-up a child at the time of the center's daily closing, the procedure shall require:

- The child is supervised at all times.
- Staff attempt to contact the parents or persons authorized by the parents.
- An hour or more after closing time, provided that other arrangements for releasing the child to his/her parents or additional authorized contacts have failed, and staff cannot continue to supervise the child at the center, staff shall call the Division's 24-hour Child Abuse Hotline (1-800-792-8610) to seek assistance in caring for the child until the parents/authorized contact is able to pick up the child.

Parent/Guardian Signature _____ Date ____/____/____

SUNSCREEN POLICY

The childcare participants spend a great deal of time in the outdoors and are thereby exposed to the sun's harmful rays. Since it is our commitment to promote healthy spirits, minds and bodies, we have made the following policies in this regard:

- It is suggested that all children and staff wear sunscreen with an SPF of at least 15 on all exposed skin.
- Parents or legal guardian will be responsible for applying the first layer of sunscreen prior to drop off.
- Parents or legal guardians will be responsible for providing the children with enough sunscreen (in a sealed container) to take with them for later applications. One container per child, please.
- Childcare staff will be responsible for ensuring thorough follow-up applications after one hour in the water, after 2 hours of activity in the sun (due to perspiration), and/or any other time that it is needed. Please note, this will mean your child will have the sunscreen applied for them by the childcare staff. Please explain this to your child before attending.
- For children who have fair skin, freckles, or numerous moles, have blonde, red or light brown hair; have blue, green, or gray eyes; tend to burn easily and tan little or not at all; and have a family history of skin cancer, we recommend an extra t-shirt and hat be brought to wear in the water for extra protection.

I understand the Y reserves the right to disallow anyone to participate in the childcare program at any time for failure to comply with this policy. Please note that these decisions were made to protect your child. Furthermore, our staff members have been trained on this subject and understand their responsibilities and the consequences for failure in observing this policy.

Parent/Guardian Signature _____ Date ____/____/____

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)					
Child's Name (Last) (First)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth / /	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier			
Parent/Guardian Name		Home Telephone Number () -		Work Telephone/Cell Phone Number () -	
Parent/Guardian Name		Home Telephone Number () -		Work Telephone/Cell Phone Number () -	
I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.					
Signature/Date				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Abnormalities Noted:		Weight (must be taken within 30 days for WIC)			
		Height (must be taken within 30 days for WIC)			
		Head Circumference (if <2 Years)			
		Blood Pressure (if ≥3 Years)			
IMMUNIZATIONS		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)

- **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
- **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
- **Head Circumference** - Only enter if the child is less than 2 years.
- **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.

- "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

d. **Special Equipment** - Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

g. **Behavioral/Mental Health issues** - Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.

- For lead screening state if the blood sample was capillary or venous and the value of the test performed.
- For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
- Scoliosis screenings are done biennially in the public schools beginning at age 10.

This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)

- Print the health care provider's name.
- Stamp with health care site's name, address and phone number.