EXCEL AFTER THE BELL

Y Club Afterschool Care for Grades K–5.

ENROLL TODAY!

Our Y Club afterschool care program includes a variety of activities to keep your child engaged, healthy, and happy after the school day is done. From free play and physical activity to healthy snacks and homework help, we provide a safe and supportive environment where kids can learn, grow, and have fun with their peers.

OUR STAFF

All Y Club staff are trained, qualified and have cleared a background check. They also complete annual childcare training, child abuse prevention training, mandated reporter training, and CPR/First Aid/AED certification, so you can be confident that your child is receiving safe, quality, and supportive care after school each day.

PROGRAM HOURS

Our Afterschool Programs operate on regular school attendance days from school dismissal until 5:30pm. Early dismissal care may be available on designated school early-release days.

LOCATIONS (Frontenac/Pittsburg)

- Frank Layden
- George Nettels
- Lakeside
- Meadowlark
- Westside
- St. Mary's Colgan

WEEKLY FEES

Save with your YMCA Membership!
At $52/month, family membership pays for itself with the Afterschool Member discount. Plus, you get member discounts on swim lessons, youth sports and Kids Night Out, and member access to all the Y has to offer!

Part-Time (1-3 days):
- YMCA Members: $30/week
- Community Members: $45/week

Full-Time (4-5 days):
- YMCA Members: $40/week
- Community Members: $60/week

Registration Fee: A fee of $25 per child is due before enrollment in the afterschool program and is nonrefundable.

FINANCIAL ASSISTANCE

Financial assistance is available to all participants. To request financial assistance, you must first apply for Kansas Department for Children and Families (DCF) Child Care Assistance through the DCF Child Care Subsidy Program. Learn more at pfymca.org/afterschool

REGISTRATION

All completed Afterschool Care Documents can be turned into the Welcome Center at the Pittsburg Family YMCA (1100 N Miles Ave, Pittsburg, KS), or emailed to the smccullough@pfymca.org.

PITTSBURG FAMILY YMCA

1100 N Miles Ave, Pittsburg, KS 66762 | 620-231-1100 | www.pfymca.org/afterschool

PITTSBURG FAMILY YMCA
AFTER SCHOOL REGISTRATION FORM

CHILD'S INFORMATION

First Name	Middle	*Last
*Date of Birth (Month/Day/Year)		Gender ☐ Male ☐ Female
Children live with		

AFTER SCHOOL LOCATION

☐ Frank Layden ☐ St Mary's ☐ George Nettels ☐ Lakeside ☐ Meadowlark ☐ Westside

PARENT/GUARDIAN INFORMATION

Name (Title–Mr., Ms,. Mrs.)	*First	Middle	*Last	Suffix (Sr., Jr., II, III)
*Home Street Address / PO Box	Apt. #	*City	*State	*Zip
(Include Area Codes) Home Phone ( )		*Cell Phone ( )		
*Preferred Email Address	*Date of Birth (Month/Day/Year)		Gender ☐ Male ☐ Female	
Employer Name				

EMERGENCY CONTACT

Name (First, MI, Last)		Relationship
(Include Area Codes) Home Phone ( )	Home Phone ( )	Cell Phone ( )

PAYMENT INFORMATION

Will you be using DCF payments for the Afterschool Program? ☐ Yes ☐ No

***Financial Assistance Policy:** Families seeking financial assistance for childcare are required to first apply for childcare assistance through the Kansas Department for Children and Families (DCF). To begin the process, families must submit an inquiry to DCF through the Kansas Department of Health and Environment (KDHE).

Once DCF has made its determination, families must provide the YMCA with their DCF notice of determination along with the YMCA Financial Assistance Worksheet. If DCF assistance does not provide enough support to make childcare affordable for the family, the family may then apply for YMCA Financial Assistance for consideration.

As part of the YMCA Financial Assistance application process, families are required to submit a copy of their DCF notice of determination. Applications for YMCA Financial Assistance will not be considered without this documentation.

DRAFT INFORMATION

Name of Bank Customer/Credit Card Holder as it appears on the card				
First Name	Middle	Last		Suffix (Sr., Jr., II, III)
Billing Address (if different than mailing address)				PO Box or Apt. #
City	State	Zip	Phone	
Draft Amount	Draft Date: ☐ Fridays Begin Date: _____	Billing Method ☐ Credit Card ☐ EFT		
Electronic Fund Transfer Info (use voided check)	Routing Number	Account Number	☐ Checking ☐ Savings	
Credit Card Information	Card Number	Expiration Date		
I would like to make a monthly gift to the Annual Campaign in the amount of: ☐ $5.00 ☐ $10.00 ☐ $25.00 ☐ Other: _____				

PARTICIPATION RELEASE

I release the Pittsburg Family YMCA from all claims of injury which may be sustained by the participant while participating in any Y-sponsored activity, whether caused by negligence of the Y or otherwise. If medical attention is required, I give my permission for such medical care. I also agree to follow the Pittsburg Family YMCA's standards and guidelines while participating in any Y-program. Pittsburg Family YMCA asks that only the items requested by staff be brought to camp and to keep all other personal items be left at home. By signing below, I give the Y permission to use photographs or videos of the named participant in its promotional/education materials.

Participant Parent/Guardian Signature: _____ Date: _____

CCL. 358
Rev. 02/2026

Kansas Department of Health and Environment
Curtis State Office Building
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/280/Child-Care-Licensing

Child Health History
School Age Programs

In accordance with K.A.R. 28-4-590(d)(1), each school age program operator shall obtain a health history for each child or youth. Each health history shall be maintained in the child's or youth's file on the premises.

Child's First Day in Child Care_____ Name of Child Care Facility_____

Child's Name_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____ Name _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Child's Physician Name & Phone Number_____

Physician Address _____

Hospital Preference (for emergencies):_____

List any allergies or medical conditions of child:

_____

List any non-prescription or prescription medication the child will take during their time at the program:

_____

Provide additional information that will help staff meet the needs of the child (attach additional page if needed):

_____

Parent/Guardian Signature: _____ Date: _____

Child Health History (continued)
Immunizations

Child's Name:_____Date of Birth: _____
First Last MM/DD/YYYY

K.A.R. 28-4-590(d)(2), Each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.
K.A.R. 28-4-590(d)(4) Children or youth who are currently attending or who attended in the preceding school year a public or accredited non-public school in Kansas, Missouri, or Oklahoma shall not be required to provide documentation of current immunizations or exemptions from immunizations.

Do not provide immunization or exemption information if the child or youth is currently attending, or was attending during the previous school year at, a public or accredited non-public school.

Vaccine	Record the date (MM/DD/YY) each dose of vaccine was received				
	1st	2nd	3rd	4th	5th
Diphtheria, Tetanus, Pertussis (DTaP)					
Haemophilus influenzae type b (Hib)					
Hepatitis A (Hep A)					
Hepatitis B (Hep B)					
Measles, Mumps, Rubella (MMR)					
Pneumococcal disease (PCV15, PCV20)					
Poliomyelitis (IPV)					
Varicella (VAR)					
Respiratory syncytial virus (RSV) – Recommended, not required					
Rotavirus (RV) – Recommended, not required					
Influenza – Recommended, not required					

I attest that to the best of my knowledge the immunization information entered is true and correct.

Parent/Guardian Signature: _____ Date: _____

If your child is exempted from the law requiring immunizations, K.S.A. 65-508(g), check either (A) or (B) below and complete as required.

☐ (A) Certification from licensed physician stating that immunization would endanger the child's life. Child is exempt from the following immunizations:

_____DTaP _____Hib ____Hep A ____Hep B ____MMR ____PCV15/PCV20 ____IPV ____VAR

Physician's Signature (required): _____Date: _____

☐ (B) My child is exempt under the law from immunizations. As the parent or legal guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.

Parent/Guardian Signature: _____ Date: _____

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Rev. 07/2024

Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

AD ASTRA PER ASPERA
Kansas
Department of Health
and Environment

Authorization for Emergency Medical Care

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license	**License #**

I authorize ____(*caregiver/staff*) who is/are representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth__________________________________ (*child's first and last name)* while child or youth is in the facility's custody between ______________ and ___________________.
MM/DD/YYYY MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

____

____

____

Signature of Parent or Guardian	**Date Signed**

- -

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is off premised from the facility.

CCL.359
Rev. 3/2017

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200 Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

Authorization for Self-Administration of Medication (Children/Youth in School Age Programs)

According to K.A.R. 28-4-590(e)(5)(A) any operator may permit a child or youth with a **chronic illness, condition requiring prescription medication on a regular basis, or a condition requiring the use of an inhaler** to administer the medication under staff supervision. The operator shall obtain written permission for the child or youth to self-administer medication from the child's or youth's parent or other adult responsible for the child or youth, and from the licensed physician or nurse practitioner treating the condition of the child or youth. Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. A record of administration must be kept.

_____

First and Last Name of Child or Youth

_____

Name of Medication (only one medication per authorization)

_____

Reason for Medication

_____

Dose Time to be Given **Start Date** **Stop Date****

_____

Print the Name of licensed Physician or Nurse Practitioner prescribing the medication Phone# of Health Care Provider

I authorize the self-administration of the above medication by my child or youth under staff supervision.

_____

Signature of Parent or Responsible Adult **Date Signed**

I authorize the self-administration of the above medication by the child or youth listed above under staff supervision.

_____

Licensed Physician or Nurse practitioner Signature **Date Signed**

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature and the licensed physician or nurse practitioner signature is required only once per year.**

THIS FORM IS TO BE USED TO DOCUMENT SELF ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member supervising the self-administration of medication to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

*Signature of Person Supervising Self-Administration of Medication _____Initialing as_____

*Signature of Person Supervising Self-Administration of Medication _____Initialing as _____

*Signature of Person Supervising Self-Administration of Medication _____Initialing as _____

*Signature of Person Supervising Self-Administration of Medication _____Initialing as _____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's or youth's appearance and/or condition.

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Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/Childcare Licensing

Authorization for Administering Medications to Children and Youth
Short-Term Medications (Prescription and Non-Prescription)

Prescription medication must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child or youth designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

Medication #1

_____
First and Last Name of Child/Youth Date of Birth

_____
Name of Medication

_____
Reason for Medication

_____
Dose Time to be Given Stop Date

_____
Name of Licensed Physician/PA/APRN prescribing the medication

I allow the above medication to be given to my child/youth by the designated person.

_____
Parent's Signature **Date**

Medication #2

_____
First and Last Name of Child/Youth Date of Birth

_____
Name of Medication

_____
Reason for Medication

_____
Dose Time to be Given Stop Date

_____
Name of Licensed Physician/PA/APRN prescribing the medication

I allow the above medication to be given to my child/youth by the designated person.

_____
Parent's Signature **Date**

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE.
Designated Person to note any comments or remarks about the child's/youth's appearance below on this form.
*Each designated person administering medication is to sign below on this form and identify initials used.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.

CCL.027
Rev. 07/2024

Curtis State Office Building
Kansas Department of Health and Environment
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Kansas Department of Health and Environment

Authorization for Administering Medications to Children and Youth
Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

First and Last Name of Child/Youth **Date of Birth**

Name of Medication (only one medication per authorization **Prescription OR Non-Prescription**

Reason for Medication

Dose **Time to be Given** **Start Date** **Stop Date****

Name of Licensed Physician, PA or APRN prescribing the medication

I allow the above medication to be given to my child/youth by the designated person.

Parent's Signature **Date Signed**

**Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.

This form is to be used to document administration of only the medication(s) identified above. Designated Person to note any comments or remarks about the child's/youth's appearance on the back of this form.
*Each designated person administering medication is to sign on the back side of this form and identify initials used.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

FINANCIAL ASSISTANCE APPLICATION

Name: _____Address:_____

City: _____State:_____ Zip Code:_____

Home Phone:_____ Cell:_____ Email:_____

Household members (Including Self) First Middle Initial Last	Relationship	DOB	Check if claimed on form 1040 as dependent

Income/Expense Worksheet

Income	Amount	Expense	Amount
Gross Monthly Income (Before Taxes)	$	Rent/Mortgage	$
Spouse's Gross Monthly Income	$	Car/Insurance	$
Child Support	$	Fuel	$
Aid to Dependent Children	$	Groceries	$
Social Security Compensation	$	Utilities	$
Unemployment Compensation	$	Phone	$
Food Stamps	$	Child Support	$
Tanf/Cash Benefits	$	Medical	$
Retirement Funds	$	Childcare	$
Other (Please Explain)	$	Alimony	$
Other (Please Explain)	$	Other (Please Explain)	$
Other (Please Explain)	$		
Total Monthly Income	**$**	**Total Monthly Income**	**$**

Please provide the following documents to the Y when applying for financial assistance:

* Current W-2's *1099, *Current 1040 Income tax forms *Proof of government assistance

I am requesting assistance from the Y because of my personal circumstances. I verify that all information submitted is complete and accurate. If I submit false or Inaccurate information or fail to notify the Y of a change within 30 days, I may be terminated from the financial assistance program. I understand that as a participant in the Y's financial assistance program, I will be asked to provide proof of income annually. If I do not verify information annually, my membership rate is subject to increase and/or terminated.

Applicant Signature: _____ Date: _____