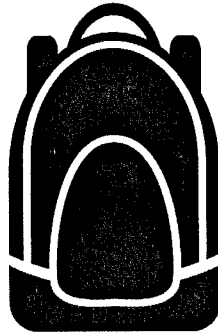
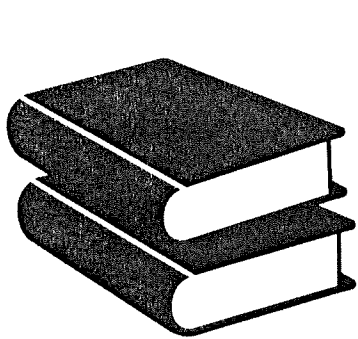


FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# ENROLLMENT PACKET 2025-2026 SCHOOL YEAR

**Before School, After School, United Way Sites,  
Fundays, Holiday and Spring Break Camps!**



**YMCA Childcare Programs offer:**

A safe, productive environment

Homework tutoring

Swimming

Lunch and snacks

Arts and Crafts

Character Development

Convenient hours

Scholarship opportunities

Caring, experienced staff

Age-appropriate activities

Physical and Education activities



*We are licensed by the State of Kansas and are proud to be a United Way Agency. We accept SRS, TFI Family Services and St. Francis contracts.*

The following packet outlines the details for the 2025-2026 school year. For more information, please contact Krystal Richardson, Chief Administrator at 620-275-1199 ext. 209 or [krichardson@ymcaswkansas.org](mailto:krichardson@ymcaswkansas.org)

## Registration Form

*The following information **MUST BE COMPLETELY FILLED OUT.***

Child's Name \_\_\_\_\_

School Attending \_\_\_\_\_

Grade \_\_\_\_\_ Teacher's Name \_\_\_\_\_

Does your child currently have a YMCA membership?      Yes    No

*(Please note that your child must have a membership to receive the member rates. This excludes United Way funded sites)*

**\*Please circle all Childcare programs your child will be attending:**

*(Fees will automatically be applied to your account and scheduled to draft when circled and child attends)*

Before School

After School

Fundays

Holiday/Spring Break Camp

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### *Prices and Times for Programs*

*Please note that these are the MEMBER rates. If your child does NOT have a membership, your prices will double.*

### ***HELPING HANDS SCHOLARSHIPS ARE AVAILABLE!***

#### **Before School @ the YMCA**

\$30 equipment fee

\$20/week – EFT Auto draft

(Opening at 6:30 to school drop off)

#### **After School @ the YMCA**

\$50 equipment fee

\$40/week – EFT Auto Draft

(Opened from 3:50 to 6:00 pm)

#### **After School Enrichment Sites**

*(Florence Wilson and St. Dominic's)*

\$30 equipment fee

\$20/week – EFT Auto draft

(FW hours are 3:50-5:50 M-F)

#### **United Way After School Enrichment Sites**

*(Buffalo Jones, Victor Ornelas, Alta Brown, Abe Hubert, Georgia Matthews)*

\$20 equipment fee/\$10 per week

(Hours are from 3:50-5:50 M-F)

#### **Fundays**

\$30/day

(Open 6:30 am to 6:00 pm)

#### **Holiday/Spring Break Camp**

\$120/week

(Open 6:30 am to 6:00 pm)

(Close early on Dec. 24/CLOSED Christmas & New Year's Day)

*All equipment fees, first week of payment and paperwork must be completed and turned in prior to the child attending. Payments are due on the scheduled draft day or the week before for the following week. Pay arrangements are available and must be set up with Krystal Richardson, Chief Administrator.*



# YMCA Childcare

## Child/Program Information

*To help us better serve your child we would like to know the specific times your child will be attending our program. We would also like to make sure that your child is picked up and dropped off in a timely manner. Please give us any details that will help us in providing the best daily routine possible.*

Approximate time(s) your child will arrive at the YMCA or Site: \_\_\_\_\_

Approximate time your child will be picked up from the YMCA or Site: \_\_\_\_\_

Days your child will attend the YMCA program: M\_\_\_\_T\_\_\_\_W\_\_\_\_TH\_\_\_\_F\_\_\_\_

Time your child's school begins: \_\_\_\_\_

Time your child's school ends: \_\_\_\_\_

Will your child require transportation: Yes No

Times of needed transportation: \_\_\_\_\_

Place(s) of transportation \_\_\_\_\_

Is there anything else we need to know about your child's daily schedule?

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Cell Phone Number \_\_\_\_\_ Cell Provider \_\_\_\_\_

Email Address \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# YMCA Childcare Authorization and Agreement

Please read the following statements, initial by each one, and sign and date at the bottom.

1. \_\_\_\_ My child has my permission to use all the play equipment and participate in all the activities while attending and participating in any YMCA program.
2. \_\_\_\_ My child has my permission to swim in the Garden City Family YMCA's swimming pool during childcare program activities.
3. \_\_\_\_ I understand weekly payments will be automatically drafted from a checking/savings or credit card account. I understand that if payments are not paid on time, my child will lose his/her spot in the program and my balance due will be sent to collections.
4. \_\_\_\_ All enrollment procedures will be completed before my child may enter the program.
5. \_\_\_\_ I understand if my child is fevered, sick, throwing up or considered contagious they may not attend the program for 48 hours. In addition, if they develop a fever, get sick or throw up while attending, they MUST go home and cannot return for 48 hours.
6. \_\_\_\_ I understand that there are inherent risks in participating in any activity and I will not hold the Garden City Family YMCA responsible for any accident or injury that may occur during program hours.
7. \_\_\_\_ YMCA Before & After School hours are 6:30a.m. to school starting & 3:50-6:00p.m.
8. \_\_\_\_ United Way After School Enrichment Site hours are 3:50-5:50 p.m.  
Florence Wilson's hours are 3:50-5:50p.m.
9. \_\_\_\_ I understand that a late fee will be applied to my account if I am late picking up my child. Each late fee will be \$10 for every five minutes I am late.
10. \_\_\_\_ I give my permission for my child to ride USD #457 buses and Garden City Family YMCA vehicles to and from their schools.
11. \_\_\_\_ I understand that NO transportation will be provided from YMCA vehicles on ½ days of school. I will transport, or they will be transported to the YMCA via USD #457 buses.
12. \_\_\_\_ I understand that if my child has been suspended from school at ANY time during the day, they will also be suspended from YMCA programs during the suspension period.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Child Information

Does your child have any specific food or medicine allergies that we need to be aware of?

Please explain. \_\_\_\_\_  
\_\_\_\_\_

Does your child have any specific fears, problems, or dislikes that we need to be aware of?

Please explain. \_\_\_\_\_  
\_\_\_\_\_

Does your child have any chronic or special needs that we need to be aware of or monitor?

Please explain. \_\_\_\_\_  
\_\_\_\_\_

Does your child require any daily medications? Please explain and state the time and days medication is needed. You will also need to fill out a Medication Authorization Form.

\_\_\_\_\_

How would you rate your child's ability to swim? Has he/she participated in progressive swim lessons? \_\_\_\_\_

\_\_\_\_\_

Please list all other services provided within the community for your child? (Example: TFI Family Services, Inc., St. Francis, Compass Behavioral Health, Boy Scouts, Girl Scouts, Salvation Army, Big Brothers/Big Sisters, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Names of individuals specifically <u>UNAUTHORIZED</u> to visit or pick up children:				
Name	Relation	Restraining Order:	Yes	No
Name	Relation	Restraining Order:	Yes	No
Name	Relation	Restraining Order:	Yes	No
Name	Relation	Restraining Order:	Yes	No

### **BANK DRAFT & CREDIT CARD DRAFT POLICY**

1. I authorize the Garden City Family YMCA to withdraw my childcare dues from the account provided below each week or monthly.
2. To cancel my childcare, I need to fill out the YMCA's cancellation form two weeks prior to the date of draft. If not, I understand my childcare dues will be drafted from my account once more before being cancelled\_\_\_\_\_. (Initial here)
3. To make any account changes towards childcare dues, I understand that I must notify the Childcare Coordinator at least two weeks prior to my next draft date.
4. The Garden City Family YMCA charges \$30 service fee on all insufficient drafts. If my draft is returned unpaid, the YMCA will automatically redraft it and the \$30 service charge as many times as deemed necessary until all monies are collected. If my draft is returned two consecutive times and the first draft has yet to be collected, your child will no longer be allowed to attend YMCA childcare program. If my childcare draft is denied because of a stop payment or a closed account, the YMCA may cancel my childcare, but I will still owe the dues plus \$30 service charge.
5. Childcare rates are based on the programs that you are enrolled in. We do not prorate if your child does not attend. Childcare rates are based on the type of membership and the school that the child attends. If your enrollment type changes for any reason, you will be notified via telephone or e-mail, and your draft amount will automatically be adjusted to the appropriate childcare rate
6. Bank drafts and credit card drafts can be deducted from an account in the following ways: (please circle)

- One Time Payment on \_\_\_\_\_
- Monthly Payments on Day \_\_\_\_\_
- Weekly Payments on M TU W TH FRI (circle one)
- Semimonthly Payments on Day \_\_\_\_\_ & \_\_\_\_\_

7. Garden City Family YMCA reserves the right to cancel childcare services at any time for any behavior that goes against the YMCA mission. Our MISSION is: **To put Christian principles into practice through programs that build healthy spirit, mind and body for all.**
8. The YMCA does not give cash refunds. All refund requests must go through the Finance Committee and all decisions made by the committee are final.

**\*By signing below, you are giving the Garden City Family YMCA authorization to draft your monthly childcare dues directly from your bank or credit card account, in accordance to the terms and conditions listed above.**

Date: \_\_\_\_\_ Name of Financial Institution: \_\_\_\_\_

Account# or Credit Card: \_\_\_\_\_ Checking Savings Credit Card

Routing # or Expiration Date: \_\_\_\_\_

Account Holder's name (Please Print): \_\_\_\_\_

Account Holder's signature: \_\_\_\_\_

#### ***Office Use Only***

Child Care Service: \_\_\_\_\_ Rate according to time of draft: \_\_\_\_\_



### HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by 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.

**Complete one form for each child or youth attending the School Age Program.**

<b>First and Last Name of the Child or Youth</b>	<b>Gender (M or F)</b>	<b>Date of Birth (MM/DD/YYYY)</b>	<b>First day at this program: (MM/DD/YYYY)</b>
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<b>First and Last Name of the Child's or Youth's Mother or Guardian</b>
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<b>Mother/Guardian's Home Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Home Phone # (     )</b>
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<b>Mother/Guardian's Work Place Name &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Work Phone # (     )</b>
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<b>First and Last Name of the Child's or Youth's Father or Guardian</b>
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<b>Father/Guardian's Home Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Home Phone # (     )</b>
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<b>Father/Guardian's Work Place Name &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Work Phone # (     )</b>
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<b>Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)</b>
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<b>Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.</b>	<b>City</b>	<b>Zip Code</b>	<b>Phone Number (during program hours):</b>
1.			
2.			
3.			

<b>First and Last Name of Physician &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Phone Number (     )</b>
--	-------------	-----------------	---------------------------------

<b>Name of Hospital Preference in case of emergency.</b>
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Yes	No	N/A	<b>Complete the following information about medications for this child or youth.</b>
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

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



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 Garden City Family YMCA SAP	License # 188
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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

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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.



# ENROLLMENT/INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

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.)

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

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					
<p>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 <i>Privacy Act Statement on the back of this page</i>.</p> <p>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.</p> <p>"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."</p>					
Signature of Adult _____  X _____	<table style="width: 100%;"> <tr> <td style="width: 50%;">Today's Date _____</td> <td style="width: 50%;">Print Name of Adult Signing _____</td> </tr> <tr> <td colspan="2">           Social Security Number (SSN) (last four digits)            XXX-XX- _____ <input type="checkbox"/> Check if no SSN         </td> </tr> </table>	Today's Date _____	Print Name of Adult Signing _____	Social Security Number (SSN) (last four digits) XXX-XX- _____ <input type="checkbox"/> Check if no SSN	
Today's Date _____	Print Name of Adult Signing _____				
Social Security Number (SSN) (last four digits) XXX-XX- _____ <input type="checkbox"/> Check if no SSN					
Address _____ City/State/Zip Code _____	Daytime Phone _____				

**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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**  
U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410; or
2. **fax:**  
(833) 256-1665 or (202) 690-7442; or
3. **email:**  
[program.intake@usda.gov](mailto:program.intake@usda.gov)

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.