Application Checklist

- Program Application
- Emergency Contact form (NO BLANKS)
- Parental Agreement Form
- Payment Policy
- ACH authorization form (if applicable)
- Child Health Report (physical) and immunizations
- Proof of income(Tax Return Only)
- Payment of $50.00 registration fee

Any questions please call 412-441-5405 or email jnash@macac-inc.org

Mount Ararat Community Activity Center
Youth Programs Registration Form
____Camp Harambee ____Mentoring __B . R . I . D . G . E . S . After school
___Learning Hub(Please select the program you are applying for)

Please Print Legible Child's Last Name:		Child's First Name:	Male ☐ Female ☐
Street Address:		City, State Zip:	
Date of Birth:	/ /	Age:	Phone: ( )
Allergies or Other Medical Concerns:		School: Grade:	

Siblings Attending	Name	Age

Parent/GuardianName:	Date of Birth:	Cell Phone:	Email Address:
Parent/GuardianName:	Date of Birth:	Cell Phone:	Email Address:

Photo Release and Consent: I give my permission for my son/daughter to be photographed and/or videotaped by Mount Ararat's Summer Camp Program to be used on promotional materials. Yes No	**Payment Method (Staff Completes)** __ ELRC $_____Weekly Co-pay amount __ Private Pay__ Other_____(Indicate type)
T-Shirt Size (Youth): ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ Other (Adult size) _____	**Weeks your child will be attending camp.** ____ June 21st – August 12th (Entire Camp) _____Other (indicate weeks)
Please indicate any special talent, skills or interest your child may have. _____	My Child/ren have permission to walk home: Yes ☐ No ☐

AUTHORIZATION

I authorize M.A.C.A.C. to seek medical attention for my child in case of emergency. Yes ☐ No ☐ Health Insurance Carrier_____Policy#_____		
Parent/Guardian Signature:		Date:

Complete entire registration unless otherwise indicated

Mount Ararat Community Activity Center
Youth Programs Registration Form
____Camp Harambee ____Mentoring __B . R . I . D . G . E . S . After school
___Learning Hub(Please select the program you are applying for)

Mount Ararat Community Activity Center

Early Childhood Development Center and Youth Programs

PAYMENT POLICY

The MACAC Early Childhood Development Center (ECDC) & Youth Programs provides children with a safe and nurturing learning environment. For ECDC & Youth Programs to provide quality services and maintain an environment conducive to the growth of children it serves, it is imperative that ECDC collect fees for services rendered in a timely manner.

- All tuition fees are to be paid via ACH auto debit deduction. No exceptions.
- There will be a $50 application processing fee
- Two-week notice is required for withdrawals. Tuition will be charged if notice is not given.
- Tuition will not be adjusted if a student is absent.
- There is a $50/week fee to hold a space for a medical leave up to 4 weeks with a doctor's excuse.
- Parents may make payments weekly, bi-weekly, or monthly in advance for childcare/program services that are received.
- All payments are due on Friday of each week prior to services being rendered.
- If payments are not received, families will be notified, and services will be suspended until payment is received.
- All payments returned from the bank NSF will be assessed a $36.00 fee. All declined payments will need to be paid by the next business day for services to continue.
- If payments are declined more than three times per year services may terminated.
- There is a $1.00 per minute per child late fee when a child is picked up after 6:00pm the late fee must be paid by the next business day.

MACAC reserves the right to use a collection agency to collect fees owed and to report payment history to the credit bureaus.

Please contact the Early Childhood Director or Youth Programs Director at 412-441-186 or 412-441-5405 with questions, concerns, or comments.

I have received a copy of the ECDC payment policy and agree to the terms outlined.

Signature _____ Date_____

Complete entire registration unless otherwise indicated

EMERGENCY CONTACT PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b), 3270.181 & 182, 3280.124(a)(b), 3280.181 & 182, 3290.124(a)(b), 3290.181 & 182

CHILD'S NAME	BIRTH DATE
ADDRESS	

MOTHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

FATHER'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	MOBILE TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	

EMERGENCY CONTACT PERSON(S)	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED	NAME	ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTIONS)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENTS SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	**ADMIN. OF MINOR FIRST - AID PROCEDURES**
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY-WEEK week	DAY PAYMENT TO BE MADE Fridays

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

MACAC- will transport during the school year from the following schools: Dilworth, Faison, Fulton, Liberty, Linden, Obama, Sterrett, Sunnyside, Urban Academy and Westinghouse.

MACAC- will provide transportation to field trips during summer camp

MACAC- will provide meals.

Must be picked up no later than 4:00pm during (Summer Camp) and 6:00pm during (After School)

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
Summer: 8:00 am/School: 2:30 pm	Summer: 4:00 pm/School: 6:00 pm	See Emergency contact form
LATE FEE $ 1.00	PER MIN-HR per minute	

Extra services to be provided at an additional fee if applicable

- Extended day care when schools are closed (additional fees for private pay families)
- Summer Day Camp Services available (additional fee and registration)

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

SIGNATURE-OPERATOR DATE SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN DATE

MACAC ACH / Debit Card Authorization Form

I,_____hereby authorize Mount Ararat Community Activity Center (MACAC) to charge my account in the amount of $_____beginning on date_____for _____ and ending on date_____.

(Child/Children)

My account will be billed in this amount *(check one:)* Weekly___Bi-Weekly_____Monthly ___

(Note Monthly Payers: Months with 5 Mondays will be charged on the 5th Monday for the week.)

ACH Debits: PLEASE ATTACH A VOIDED CHECK FOR VERIFICATION

Bank Name: _____
Bank Routing Number: _____
Bank Account Number: _____
Please check: Checking:_____ or Savings: _____

OR

Debit Card Authorization:

Card Number: _____ Expiration Date: _____ 3 Digit Code: _____

Name and Address as appears on the account:

Name: _____
Street: _____
City: _____ State: _____ Zip Code: _____

Telephone: ( )_____- _____

Changes:

New Amount	Effective Date	Cardholder Initials	Director Initials

Please allow 3-5 Business days for changes to occur.

Check if canceling account/card ☐ Purpose of Cancellation: _____

Your completion of this authorization form helps us to protect you from credit card fraud.
MACAC will keep all information entered on this form strictly confidential. Payment is due by the Monday of each week. All declined payments will be assessed a $36.00 fee.

_____ _____/_____/_____
Cardholder's Signature Date

Effective: 6/12/20

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.