EXCEL AFTER THE BELL

Y-CLUB AFTERSCHOOL PROGRAM
for children 5-12

ENROLL TODAY!

Y-Club is for children ages 5-12 enrolled in St.Mary's school system. Children receive homework help, along with an afternoon snack and participate in a fun variety of activities in a safe, nurturing environment. We have spots to fill for the 2025-2026 school year!

DATES
School days starting August 19, 2025

TIME
Mon–Fri; End of school day until 5:30 pm

COST

Full Time (4-5 Days/Week)
$40/week for Y Members
$60/week for Community Members

Part Time (1-3 Days/Week)
$30/week for Y Members
$45/week for Community Members

$20 nonrefundable registration fee. Continuous enrollment, auto draft weekly

20% sibling discount

FINANCIAL ASSISTANCE
No child will be turned away due to inability to pay. Financial assistance is available.
DCF childcare subsidy accepted.-DCF Code: C151105.

LOCATION
St. Mary's- Pittsburg, KS

REQUIREMENTS
New health history paperwork and current copy of child's immunization records are required to attend.

REGISTRATION
Turn in a required documents and completed packet to Pittsburg Family YMCA.

QUESTIONS?
Contact our Youth Development Director, Kristina Kinslow at kkinslow@pfymca.org or call 620-231-1100.

PITTSBURG FAMILY YMCA
1100 N. Miles Pittsburg, KS 66762 | 620-231-1100 | www.pittsburgymca.com

the YMCA

From crafts to crazy fun, Y-Club is the place to be after 3!

Y-CLUB Afterschool parents/guardians,

We are thrilled to continue our Y-Club After School Program for the 2025-2026 school year! We're equally excited about welcoming Kristina Kinslow, our new Youth Development Director, to the team. Kristina will oversee all childcare programs, including our after-school offerings. She brings extensive experience and training in the field of childcare and is eager to connect with our families.

You can reach Kristina directly at **kkinslow@pfymca.org** or by calling **620-231-1100 (YMCA)**. She will serve as your primary contact for communication moving forward.

Important Information to Return with Packets:

1. Parent/guardian primary email address:_____
2. Circle one: Full-Time or Part-Time
3. DCF Code for Frontenac: C151087
4. DCF Code for St. Mary's: C151105
5. Are you planning on using DCF Subsidy for this school year? Y or N
6. Anything about your child we should know?

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Rev. 5/2020

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

Kansas
Department of Health and Environment

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.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

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.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			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?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

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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/ChildCareLicensing

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.

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Kansas Department of Health and Environment

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.

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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.