

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

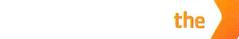
New health history paperwork and current copy of child's immunization records are required to attend.

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.







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:

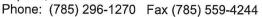
- Parent/guardian primary email address:______
- 2. Circle one: Full-Time or Part-Time
- 3. DCF Code for Frontenac: C151087
- 4. DCF Code for St. Mary's: C151105
- 5. Are you planning on using DCF Subsidy for this school year? Y or N
- 6. Anything about your child we should know?

CCL. 358 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

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



Website: www.kdheks.gov/kidsnet



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.

First	and La	st Name	e 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 La	st Name	e of the Child's or Youth's Mother or G	Guardian				
Moth	er/Gua	rdian's l	Home Street Address	City		Zip Code	Home Phone #	
Moth	Mother/Guardian's Work Place Name & Street Address			City		Zip Code	Work Phone #	
First	and La	st Name	of the Child's or Youth's Father or G	uardian				
Father/Guardian's Home Street Address			lome Street Address	City	City		Home Phone #	
Father/Guardian's Work Place Name & Street Address				City		Zip Code	Work Phone #	
Name	es and a	ages of	other children in the Child or Youth's	Family (Attao	ch additiona	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.			Include first and last name and	City		Zip Code	Phone Number (during program hours):	
2.								
3.	-							
First and Last Name of Physician & Street Address				City Zip Code		Zip Code	Phone Number	
Name	of Hos	spital Pr	eference in case of emergency.					
Yes	No	N/A	Complete the following information	about medic	cations for th	nis child or youtl	n.	
			Will this child or youth need to take an program?		tion or presci	ription medication	during their time at the	
			If yes above, is there signed permission	on on file?				

Skin Problems Asthma Headaches	Diabetes
10. 110	
Vision Speech/Communication Hearing	Emotion/Behavior
Other: Please describe.	

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.

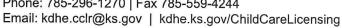
	-				A STATE OF THE STA	
		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	1.1	1 1	1.1	1 1
	POLIO	1 1	1 1	1 1	1 1	
	MMR	1 1	1 1			ı
Single	RUBEOLA (MEASLES)	1 1	1 1			
Dose						
Only						
	MUMPS	1 1	1 1			
	RUBELLA (GERMAN MEASLES)	1 1	1 1			
	HIB (Hemophilus Influ. B) *RECOMMENDED	1 1	1 1	1 1	1 1	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	1 1	1.1,	1 1		H
	VAR (Varicella-Chicken Pox) *RECOMMENDED	1 1				

Print the First and Last Name of the Person Completing this Health History form	Relationship to Child/Youth	o the 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 p	erson's relationship to h?
Lattast under nonalty of porium, that to the heat of my knowledge the information w	navidad au Alaia	forms to two sections
I attest, under penalty of perjury, that to the best of my knowledge, the information p	rovided on this	form is true and correct.
Signature of person completing this form	1	Date Signed

CCL.010 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





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 licens	se	License #
I authorize		(caregiver/staff) who
is/are representative(s) of the above-named facility	y to give consent for any and	
care for my child or youth	(0	hild'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 emergency:	t the medical conditions of this	s child or youth pertinent in case of
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.026 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/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	Medication #2
First and Last Name of Child/Youth Date of Birth	First and Last Name of Child/Youth Date of Birth
Name of Medication	Name of Medication
Reason for Medication	Reason for Medication
Dose Time to be Given Stop Date	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.	Name of Licensed Physician/PA/APRN prescribing the medication I allow the above medication to be given to my child/youth by the decimated passes.
Parent's Signature Date	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 I	Designated Person Administering Medication	Initialing as				
*Signature of I	Designated Person Administering Medication	Initialing as				
*Signature of I	Designated Person Administering Medication	Initialing as				
*Signature of I	Designated Person Administering Medication	Initialing as				
	Note Form					
Date	Additional comments about the incident or other related incid about the child's/youth's appearance and/or condition.	ents, including comments or remarks				
		3,000				

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 Las	t Name of Child or Youth		
Name of Med	lication (only one medication per authoriz	zation)	
Reason for M	edication		
Dose	Time to be Given	Start Date	Stop Date**
Print the Name	of licensed Physician or Nurse Practitioner p	prescribing the medication	Phone# of Health Care Provider
I authorize the	e self-administration of the above medica	ation by my child or youth unde	er staff supervision.
Signature of	Parent or Responsible Adult		Date Signed
I authorize the	e self-administration of the above medica	ation by the child or youth liste	d above under staff supervision.
Licensed Ph	ysician or Nurse practitioner Signatur	e	Date Signed

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.

^{**}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.

*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 o	Initialing as					
	Note Form					
Date	e Additional comments about the incident or other related incidents, including comments or remarks about the child's or youth's appearance and/or condition.					
	4					
						