CHILD DEVELOPMENT CENTER

ENROLLMENT GUIDE AND FORMS PACKET

the YMCA®

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

ymcawichita.org/CDC

FOR BEST RESULTS:
Pull forms one at a time from the center of the booklet.

CDC ENROLLMENT

For enrollment consideration you must complete all forms in this packet for each child (one set per child) you wish to enroll.

ENROLLMENT REMINDERS

- Contact the Child Care and Camp Administrative offices or the CDC Location you wish to enroll prior to completion of the forms to discuss space availability.
- Selection for enrollment is based on available space and under priority considerations (see Program Policies and Parent Information, available at ymcawichita.org/cdc).
- CDC staff will directly contact parents/guardians of children selected for enrollment to discuss weekly fees, finalized a required pay agreement, and to formalize the child's participation start date.
- All initial fees (required, $25/child annual enrollment fee and the first week of non-refundable, non-transferable fees) must be paid, in-full, seven-or-more days before a child can begin program participation.
- Only applicants with complete enrollment forms can be considered.

CCL 010
Rev. 5/2020

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

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

Is child covered by health insurance? ☐ Yes ☐ No

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____

Medical Assistance Program _____ Card Number_____

Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____
MM/DD/YYYY

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

_____

CCL. 029a
Rev. 05/2020

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name_____ **Date of Birth**_____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: _____IN/CM %ILE_____		**Weight: _____LB/KG %ILE_____**
Physical Examination	✓ **If Normal**	**If Abnormal - Comments**
Head/Ears/Eyes/Nose/Throat		

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

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

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month. Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo of age; not required						
**Influenza(Flu) ** Recommended annually >6 mo of age; not required						

CCL. 029
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health Facilities
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

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care_____

Child's Name_____
First Last

Name of Child Care Facility_____

Date of Birth_____ Gender_____
MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Employer_____

Work Phone Number_____

Cell Phone Number_____

E-mail Address _____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Employer_____

Work Phone Number_____

Cell Phone Number_____

E-mail Address_____

GREATER WICHITA YMCA CHILD DEVELOPMENT CENTER (CDC)
2022-2023 REGISTRATION/ENROLLMENT FORM (CONT.)

OFFICE USE ONLY

PARTICIPANT'S NAME _____

ID# _____

EMERGENCY PICK-UP / CONTACTS

Adults (18+)—other than parents (pg. 1)—that **ARE** authorized for participant pick up and for urgent response needs.

_____ _____ ( ) -
FIRST EMERGENCY CONTACT FIRST AND LAST NAME | RELATIONSHIP TO PARTICIPANT | PRIMARY PHONE#

_____ ( ) -
STREET ADDRESS, STATE, ZIP CODE | SECONDARY DAYTIME PHONE#

_____ _____ ( ) -
SECOND EMERGENCY CONTACT FIRST AND LAST NAME | RELATIONSHIP TO PARTICIPANT | PRIMARY PHONE#

_____ ( ) -
STREET ADDRESS, STATE, ZIP CODE | SECONDARY DAYTIME PHONE#

_____ _____ ( ) -
THIRD EMERGENCY CONTACT FIRST AND LAST NAME | RELATIONSHIP TO PARTICIPANT | PRIMARY PHONE#

_____ ( ) -
STREET ADDRESS, STATE, ZIP CODE | SECONDARY DAYTIME PHONE#

ADD. PICK-UP

Adults (18+)—other than parents (pg. 1) and emergency contacts (above)—that **ARE** authorized for participant pick-up.

_____ _____ ( ) -
FIRST AND LAST NAME | RELATIONSHIP TO PARTICIPANT | PRIMARY PHONE#

_____ _____ ( ) -
FIRST AND LAST NAME | RELATIONSHIP TO PARTICIPANT | PRIMARY PHONE#

_____ _____ ( ) -
FIRST AND LAST NAME | RELATIONSHIP TO PARTICIPANT | PRIMARY PHONE#

UNAUTHORIZED CONTACTS / PICK-UP

Please list any individuals that **ARE NOT allowed** access to site / participant INCLUDING pick-up. Note that legal documentation may be required for some restrictions. See Site Director for details.

_____
FIRST AND LAST NAME

_____
RELATIONSHIP TO PARTICIPANT

( ) -
PHONE#

_____
FIRST AND LAST NAME

_____
RELATIONSHIP TO PARTICIPANT

( ) -
PHONE#

CDC WEEKLY FEE AUTODRAFT PLAN

The (stated) CDC weekly fee amount indicated above will be automatically deducted (drafted) from/charged to my (check one) as part of an ongoing, continuous payment plan.

☐ **BANK ACCOUNT** (Checking, Savings)
☐ **CARD** (Credit, Debit)

This AutoDraft payment plan is a continuous program.

STATEMENTS OF UNDERSTANDING

I UNDERSTAND THAT:

- If I wish to exit the CDC program and/or discontinue the agreed weekly draft amount before

TERMS OF AGREEMENT

Your signature confirms your agreement with the following:

1. I/We understand that a minimum **$10** late pick-up fee will be charged for each child picked up after the scheduled CDC closing time, and an additional **$1 per minute** fee will be assessed after the *first ten minutes*. All outsanding balances, including late fees, must be paid in full before a participant may return to the CDC. If a child is not picked up by 6PM and no attempt has been made by the parent/guardian to contact CDC program staff, Greater Wichita YMCA (YMCA) policy requires the notification of program site supervisors as well as police and/or child protective services (9-1-1). Chronic late pick-up is grounds for suspension or dismissal from CDC services.

GREATER WICHITA YMCA CHILD DEVELOPMENT CENTER (CDC)
2022-2023 REGISTRATION/ENROLLMENT FORM

IMPORTANT REGISTRATION/ENROLLMENT NOTES

A. **$25 ENROLLMENT FEE**, **FIRST WEEK OF STATED WEEKLY FEES**, and **COMPLETED REGISTRATION FORM** is required no less than seven (7) days prior to anticipated start date.
B. **ALL** enrollment forms, including CACFP (food program) enrollment and Greater Wichita YMCA payment agreement must be complete and submitted to the appropriate CDC Site Director by 5PM Monday *one full week* prior to your desired/anticipated start date. Incomplete forms will not be accepted and will delay consideration/start date. All complete applicants are processed in the order they are received.
C. Families that have been awarded Greater Wichita YMCA Income-Based Financial Assistance (IBFA) must provide a copy of the award letter (email) to the director before discount can be applied.
D. You **MUST** complete this form, separately and in its entirety, for each child you wish to register/enroll.

OFFICE USE ONLY

PARTICIPANT NAME _____

ID# _____

CDC SITE FOR ENROLLMENT

- ☐ EAST H.S.
- ☐ HEIGHTS H.S.
- ☐ NORTH H.S.
- ☐ NORTHWEST H.S.
- ☐ SOUTH H.S.
- ☐ SOUTHEAST H.S.
- ☐ WEST H.S.

INITAL PAYMENT MADE YES NO

☐ Check/Money Order CHECK # _____

☐ **I have been awarded Greater Wichita YMCA C hild Care and Camp Branch Income-Based Financial Assistance (IBFA)*.** Rate Reduction ____ %

PAYMENT DUE AT ENROLLMENT/REGISTRATION	
ANNUAL ENROLLMENT FEE ($25/Child/Year fee is NON-REFUNDABLE and NON-TRANSFERABLE)	**$ 25**
WEEKLY FEE / TUITION (ONGOING Fees Payable by Cash, Check/Money Order, Credit/Debit Card, or AutoDraft)	$_____
TOTAL INITIAL PAYMENT (ENROLLMENT FEE + FIRST WEEK'S FEES / TUITION) (Initial Payment **CANNOT** be paid by Card or AutoDraft)	$_____

PARTICIPANT INFORMATION

_____ **DATE OF BIRTH** ___/___/___
FIRST AND LAST NAME **GENDER** MALE FEMALE

_____ **SOC. SECURITY #** _____
PRIMARY STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

PRIMARY PHONE # ( ) -

START DATE ___/___/___

ARRIVAL TIME ___:___ AM PM

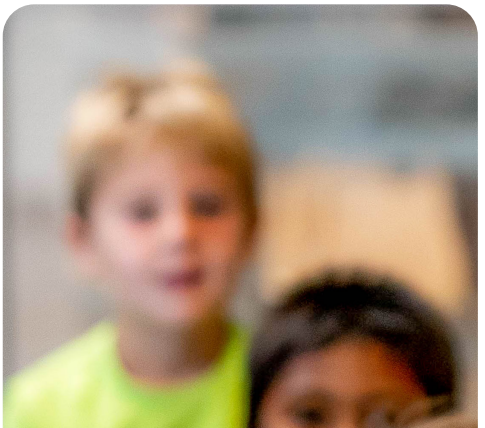
DEPARTURE TIME ___:___ AM PM

ROOM ASSIGMENT

- ☐ INFANT
- ☐ TODDLER
- ☐ PRE-SCHOOL
- ☐ PRE-K

CHILD LIVES WITH

- ☐ BOTH PARENTS SHARED HOUSEHOLD
- ☐ SHARED CUSTODY MOTHER ONLY
- ☐ FATHER ONLY
- ☐ LEGAL GUARDIAN
- ☐ _____ OTHER



_____ @ _____ .

PARENT/GUARDIAN INFORMATION

PRIMARY PARENT/GUARDIAN FIRST AND LAST NAME

EMAIL ADDRESS

STREET ADDRESS, STATE, ZIP CODE (if different from participant information)

( ) -
DAYTIME # (mark one) __ Cell __ Work __ Home

NAME OF (mark one) ____ Employer ____ School ____ Training

( ) -
ALT. DAY # (mark one) __ Cell __ Work __ Home

STREET ADDRESS, STATE, ZIP CODE OF EMPLOYER/SCHOOL/TRAINING

( ) -
EVENING # (mark one) __ Cell __ Work __ Home

MARITAL STATUS AND CUSTODIAL ARRANGEMENT(S)

WORK SCHEDULE

SECONDAY PARENT/GUARDIAN FIRST AND LAST NAME

@ .
EMAIL ADDRESS

STREET ADDRESS, STATE, ZIP CODE (if different from participant information)

( ) -
DAYTIME # (mark one) __ Cell __ Work __ Home

NAME OF (mark one) ____ Employer ____ School ____ Training

( ) -
ALT. DAY # (mark one) __ Cell __ Work __ Home

STREET ADDRESS, STATE, ZIP CODE OF EMPLOYER/SCHOOL/TRAINING

( ) -
EVENING # (mark one) __ Cell __ Work __ Home

MARITAL STATUS AND CUSTODIAL ARRANGEMENT(S)

WORK SCHEDULE

SIBLINGS

Please list participant's siblings (name, relationship, current ages). Additional sibling information can be listed on back of page.

SIBLING #1 FIRST AND LAST NAME — RELATIONSHIP TO PARTICIPANT — AGE

SIBLING #2 FIRST AND LAST NAME — RELATIONSHIP TO PARTICIPANT — AGE

Provide **EMERGENCY CONTACT INFORMATION** and **SIGN TERMS OF AGREEMENT STATEMENT** on the back of this form.

* To ensure access to Child Care and Camp programs, regardless of ability to pay, the Greater Wichita YMCA provides income-based financial assistance (scholarships/reduced rates) for Child Care and Camp participation to those who qualify. Separate from membership or other program assistance qualification, IBFA for Child Care and Camp services does not guarantee enrollment or placement. Confidential applications for assistance are available at ymcawichita.org/assistance or at any Greater Wichita YMCA branch locations. Contact Child Care Accounts for more information.

FOR OFFICE USE ONLY

RATE _____ **SELF** _____ **DCF** _____ **GWYMCA IBFA** _____

FIND MORE INFORMATION, ENROLLMENT FORMS, AND MORE AT YMCAWICHITA.ORG/CDC

2. I/we understand that, per KDHE regulations, a child cannot attend a CDC for more than ten (10) hours/day.
3. I/We understand that written notice of intent to exit the program must be given to the CDC Site Director a **MINIMUM OF TWO WEEKS IN ADVANCE**. If adequate notice is not given, I/we understand that two weeks of full payment will be billed to my/our account even though my/our child is not in attendance. If I/we choose to return to the program, I/we understand availability is not guaranteed.
4. I/We the below signed person/parent(s) having legal custody/legal guardianship of said minor, give permission for said minor to attend any Greater Wichita YMCA program activities supervised by authorized CDC and/or Greater Wichita YMCA staff. Said minor is physically able and mentally prepared to participate in all activities, including nutrition and wellness curriculum.
5. I release the Greater Wichita YMCA and its staff from all claims of injury which may be sustained by enrolled child while participating in any Greater Wichita YMCA-sponsored activity, whether caused by the negligence of the Greater Wichita YMCA or otherwise. If medical attention is required, I give my permission for such medical care.
6. I/We do hereby grant permission for photos and/or videos of my/our child to be used by the Greater Wichita YMCA for promotional purposes. I/We understand that I/we will receive no compensation for such use.
7. I/We understand fully and will abide by the Greater Wichita YMCA's policy concerning drop-off and pick-up of children. I/We shall be prepared DAILY to present photo ID to on-site staff to determine my/our identity as authorized persons to pick up my/our child. Further, I/We shall inform others who are authorized to call for our child to present photo ID when picking up my/our child.
8. I/We understand that in the event of withdrawal from the CDC program, my/our partcipant's records are available upon request.
9. I/We have read and understand the Greater Wichita YMCA CDC Program Parent Information and all CDC program policies and procedures set forth by the Greater Wichita YMCA. I/We shall abide by said policies/procedures. I/We support the Greater Wichita YMCA in its enforcement of these policies/procedures. I/We understand that the Greater Wichita YMCA reserves the right to dismiss any participant who fails to adhere to Greater Wichita YMCA CDC policies/procedures.
10. I/We agree to pay the first week of the above stated weekly fees prior to enrollment and will pay the above stated weekly rates for weekly services by **10PM Monday** on the week prior to paid services. for the entirety of my/our child's enrollment in the CDC program.

the program's end date (above), I must notify the Greater Wichita YMCA **IN WRITING** (CHILDCARE@YMCAWICHITA.ORG) **TWO (2) WEEKS PRIOR TO THE FINAL DRAFT.**

- Weekly payment, of the agreed amount, is due by **10PM** on the **Monday** of the week *prior* to paid services.
- Any/all late payment will result in a **$10 fee**.
- Any/all returned/payment refused checks or drafts will carry a **$20 fee**.
- Should any transfer/AutoDraft not be honored by my provided financial institution/card issuer for any reason I am responsible for that payment **PLUS** any/all applicable service fees assessed.
- Children will be denied access to CDC sites/services until any/all balance(s) due are paid.
- Consistent or ongoing late payment or payment issues may result in a required alternative payment method or schedule or suspension or termination of CDC services.
- CDC rates are subject to change and I will be notified, in writing, prior to fee adjustments.
- It is my responsibility to notify the Greater Wichita YMCA of any changes to my above-provided payment method prior to the next weekly AutoDraft of fees.
- It is my responsibility to notify the Greater Wichita YMCA of any changes to my address, phone number, email address, or other provided contact information.
- My Credit card information may be updated with "Account Updater Services" offered by Card Networks.
- The voided check provided with this enrollment form, if applicable, is for information purposes only.

PARENT/GUARDIAN/CUSTODIAN INITIALS: _____

☐ Accept my signature below as authorization to begin weekly AutoDrafting of indicated fees.

_____ SIGNATURE (Parent, Legal Guardian, Legal Custodian)

_____/_____/_____ DATE

IMPORTANT: Retain a copy of this enrollment form and receipt of payment. Weekly fees are based on the above schedule. Fees will not be prorated for absences, in-service days, or unscheduled closures. Find full list of policies, billing information, payment methods and more at **ymcawichita.org/cdc**.

RELATIONSHIP (CHECK ONE):

___Parent ___Legal Guardian ___Legal Custodian

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DATE RECEIVED ___ / ___ / ___
TIME RECEIVED ___ : ___ AM / PM
STAFF INITIALS: _____

__ GWYMCA ENROLLMENT FORM
__ GWYMCA PAYMENT AGREEMENT
__ KDHE HEALTH ASSESSMENT
__ KDHE MEDICAL RECORD FOR CHILDREN
__ CACFP ENROLLMENT / IEF
__ COMPLETE IMMUNIZATION RECORDS (EXEMPT DOCUMENTS)
__ AUTHORIZATION FOR EMERGENCY MEDICAL CARE

SPECIAL INSTRUCTIONS

_____ STAFF SIGNATURE

_____/_____/_____ DATE

FIND MORE INFORMATION, ENROLLMENT FORMS, AND MORE AT YMCAWICHITA.ORG/CDC

Best way to contact_____ 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_____ Phone Number_____

Child's Dentist_____ Phone Number_____

Hospital Preference (for emergencies)_____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? ___No ___Yes, as follows: _____

_____

_____

Any known allergies or medical conditions of child:

_____

_____

Any major changes at home that might affect your child in care:

_____

_____

Please provide additional information or special instructions that will help the person caring for your child:

_____

_____

Parent/Guardian Signature:_____**Date:**_____

Section II.
Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

☐ **(A) Certification from licensed physician stating that immunization would endanger child's life:**
Exempt from following immunizations:

_____DTaP/DT _____Tdap/TD ____Pertussis Only ____Polio ____MMR ____HepA _____HepB ____Hib

_____PCV ____Varicella ____Other

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.**

Section III.

Parent/Guardian Signature:_____**Date:**_____

Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	**Screening Date**	**Note Here if Results are Pending or Abnormal**
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)

☐ None

Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number

Address	City	Zip Code

Signature of Parent or Guardian	Date Signed

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of _____

Signed or attested before me on _____ by_____.
MM/DD/YYYY Name of Person

(Seal, if any.)

_____
Signature of notarial officer

_____
Title (and Rank)

My appointment expires: _____

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 transported by the facility.

FOR BEST RESULTS:
Pull forms one at a time from the center of the booklet.

REGISTRATION CHECKLIST

Please remember that incomplete forms will not be accepted nor considered for admission. Before submitting your packet for review please ensure you:

- ☐ Completed one, full set of forms for EACH CHILD to be considered.
- ☐ Provided FULL information for parents/guardians, physicians, and emergency contacts
- ☐ Specified desired Child Development Center (CDC) site and requested start date
- ☐ Read, agree with, signed, and dated the Terms of Agreement form
- ☐ Specified hospital and emergency medical care preferences and outlined custodial information and emergency medical care authorizations and had authorization form signed by an appropriate, present witness (CCL010)
- ☐ Listed dates for and provided proof of all required immunizations and latest Tetanus (DPT) shot
- ☐ Clarified all applicable medical conditions on medical records form (CCL029)
- ☐ Included all requested and applicable health insurance information, as instructed
- ☐ Scheduled additional time on the day of service to complete the required payment agreement with the Greater Wichita YMCA
- ☐ Downloaded and review CDC Program Policies and Parent Information document (available, separately, at ymcawichita.org/cdc)

CHILD DEVELOPMENT CENTERS

Child Development Centers (CDC) are an offering of the Child Care and Camp branch of the Greater Wichita YMCA, working in partnership with Wichita Public Schools (USD 259). All CDC programs are owned and operated by the YMCA and located on select high school campuses. The Greater Wichita YMCA is the largest provider of licensed child care in south central Kansas, the staff oversees child care and camp programs throughout the region including 21 schools-based latchkey programs (KEY Academy), 11 early childhood settings, and 10 summer camp sites. For more information on other YMCA Child Care and Camp programs contact our administrative offices.

CDC / USD 259 LOCATIONS*:

EAST HIGH SCHOOL
2301 E. Douglas Avenue, Wichita, KS 67211

HEIGHTS HIGH SCHOOL
5301 N. Hillside St. Wichita, KS 67219

NORTH HIGH SCHOOL
1437 Rochester, Wichita, KS 67203

NORTHWEST HIGH SCHOOL
1220 N. Tyler Road, Wichita, KS 67212

SOUTH HIGH SCHOOL
701 West 33rd St South, Wichita, KS 67217

SOUTHEAST HIGH SCHOOL
2641 South 107th St East, Wichita, KS 67201

WEST HIGH SCHOOL
820 South Osage, Wichita, KS 67213

GREATER WICHITA YMCA
CHILD CARE AND CAMP ADMINISTRATIVE OFFICES
402 N. MARKET STREET, 2ND FLOOR, WICHITA, KS 67202

Administrative Office: 316.264.1610
Branch Director: Andrea Eliot | 316.776.8241
Senior Program Director: Debbie Ogle | 316.776.8242
Program Director: Lisa Whalen | 316.776.8256

*Child Development Center phones will not be answered during Summer Break.
Please direct all enrollment questions to the CDC Program Director during this time.

For full Parent Policies and Information, please visit ymcawichita.org/CDC.

ymcawichita.org/CDC

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