

CHILD DEVELOPMENT CENTER

ENROLLMENT GUIDE AND FORMS PACKET



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.

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:

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

FirstLast

Date of Birth

Health history and medical information pertinent to routine child care and emergencies (describe, if any):	Do you see this child for regular health supervision:
☐ None	☐ 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: _____ First _____ Last _____ Date of Birth: _____ 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					
	1 st	2 nd	3 rd	4 th	5 th	6 th
Diphtheria, Tetanus, Pertussis (DTaP)						
Polio						
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					

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



**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 _____

Name of Child Care Facility _____

Child's Name _____
First Last

Date of Birth _____ MM/DD/YYYY Gender _____ M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____

Name _____

Home Address _____

Home Address _____

Street City Zip Code

Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Employer _____

Employer _____

Work Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Cell Phone Number _____

E-mail Address _____

E-mail Address _____

GREATER WICHITA YMCA CHILD DEVELOPMENT CENTER (CDC) 2023-2024 REGISTRATION/ENROLLMENT FORM (CONT.)

OFFICE USE ONLY

PARTICIPANT'S NAME _____
ID# _____

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#	_____
FIRST AND LAST NAME	_____
RELATIONSHIP TO PARTICIPANT	_____
PHONE#	_____

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	_____				() - _____
SECOND EMERGENCY CONTACT FIRST AND LAST NAME	_____	RELATIONSHIP TO PARTICIPANT	_____	PRIMARY PHONE#	() - _____
STREET ADDRESS, STATE, ZIP CODE	_____				() - _____
THIRD EMERGENCY CONTACT FIRST AND LAST NAME	_____	RELATIONSHIP TO PARTICIPANT	_____	PRIMARY PHONE#	() - _____
STREET ADDRESS, STATE, ZIP CODE	_____				() - _____

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#	() - _____

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 outstanding 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.

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

GREATER WICHITA YMCA CHILD DEVELOPMENT CENTER (CDC)
2023-2024 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.

☐ I have been awarded Greater Wichita YMCA Child Care and Camp Branch Income-Based Financial Assistance (IBFA)*.

OFFICE USE ONLY

PARTICIPANT NAME _____

ID# _____

CDC SITE FOR ENROLLMENT

☐ EAST H.S.

☐ SOUTHWEST H.S.

☐ HEIGHTS H.S.

☐ SOUTHEAST H.S.

☐ NORTH H.S.

☐ WEST H.S.

☐ NORTHWEST H.S.

INITIAL PAYMENT MADE

☐ Check/Money Order

YES

NO

CHECK # _____

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

FIRST AND LAST NAME _____

PRIMARY STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

DATE OF BIRTH _____ / _____ / _____

GENDER ☐ MALE ☐ FEMALE

SOC. SECURITY # _____

ROOM ASSIGNMENT

☐ INFANT

☐ TODDLER

☐ PRE-SCHOOL

☐ PRE-K

CHILD LIVES WITH

☐ BOTH PARENTS

☐ SHARED CUSTODY

☐ MOTHER ONLY

☐ FATHER ONLY

☐ LEGAL GUARDIAN

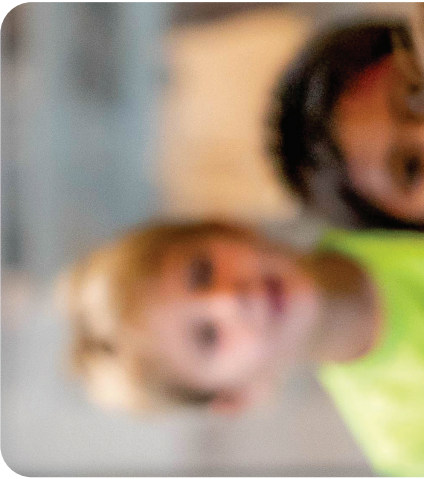
☐ OTHER _____

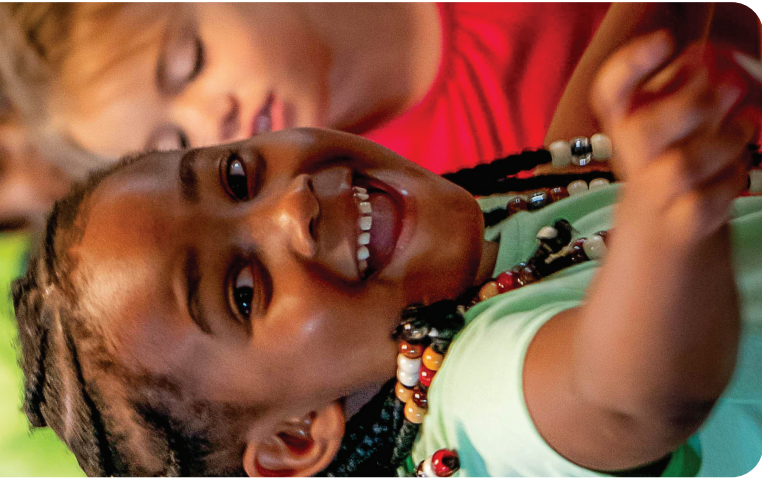
PRIMARY PHONE # () - _____

START DATE _____ / _____

ARRIVAL TIME _____ : _____ AM PM

DEPARTURE TIME _____ : _____ AM PM





PRIMARY PARENT/GUARDIAN FIRST AND LAST NAME

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

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

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

MARITAL STATUS AND CUSTODIAL ARRANGEMENT(S)

SECONDARY PARENT/GUARDIAN FIRST AND LAST NAME

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

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

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

MARITAL STATUS AND CUSTODIAL ARRANGEMENT(S)

EMAIL ADDRESS

DAYTIME # (mark one) _____ Cell _____ Work _____ Home

ALT. DAY # (mark one) _____ Cell _____ Work _____ Home

EVENING # (mark one) _____ Cell _____ Work _____ Home

WORK SCHEDULE

EMAIL ADDRESS

DAYTIME # (mark one) _____ Cell _____ Work _____ Home

ALT. DAY # (mark one) _____ Cell _____ Work _____ Home

EVENING # (mark one) _____ Cell _____ Work _____ Home

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.

RATE _____

FOR OFFICE USE ONLY

SELF _____

DCF _____

GWYMCA IBFA _____

- I/we understand that, per KDHE regulations, a child cannot attend a CDC for more than ten (10) hours/day.
- 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.
- I/we the below signed person(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.
- 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.
- 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.
- 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.
- I/we understand that in the event of withdrawal from the CDC program, my/our participant's records are available upon request.
- 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.
- 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.

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.

DATE RECEIVED ____/____/____ GWYMCA ENROLLMENT FORM
 TIME RECEIVED ____:____:____ AM / PM GWYMCA PAYMENT AGREEMENT
 STAFF INITIALS: ____ KDHE HEALTH ASSESSMENT
 ____ KDHE MEDICAL RECORD FOR CHILDREN

FOR OFFICE USE ONLY

CACFP ENROLLMENT / IEF
 COMPLETE IMMUNIZATION RECORDS (EXEMPT DOCUMENTS)
 KDHE HEALTH ASSESSMENT
 AUTHORIZATION FOR EMERGENCY MEDICAL CARE

SPECIAL INSTRUCTIONS

STAFF SIGNATURE _____

DATE ____/____/____

the program's end date (above), I must notify the Greater Wichita YMCA in writing (CHILDCARE@YMCAWICHTA.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.

RELATIONSHIP (CHECK ONE):

Parent ____ Legal Guardian ____ Legal Custodian ____

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: Beth Reeder | 316.776.8253

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