



Y-COP OF MOUNT VERNON
227 East Lincoln Avenue* Mount Vernon, NY 10552
914-215-3063 * 914-646-0735

Out-of-School Care 2026-2027

8:00am – 6:00pm

A fun-filled day for children when school is not in session.
Activities include arts & crafts, field trips, group games and more.

Cost: 2026/2027 Afterschool Participants per day... \$55.00

Non-Participant per day \$75.00 (medical exam must accompany application)

****All 3rd Party payments must complete a provider form****

Breakfast, Lunch & Light Meal provided!!

Please place a check in the box next to the date that you will need care

☐ September 21 -Yom Kippur	☐ March 10-Eid-al-Fitr
☐ November 3-Election Day	☐ March 22-29 -Spring Recess
☐ February 16-19-Mid Winter Recess	☐ April 22-Passover
	☐

Child's Name: _____ Age: _____ Parent's Name: _____

Address: _____

Phone #: Work Phone #: _____

Emergency Contact Name & Phone #: _____

Enclosed is my non-refundable payment of \$ _____. Assistance provided by: _____. In signing this form you are giving and agreeing to the following:

A) My child may leave the premises of the Y-COP under the supervision of authorized personnel to attend field trips, community service & events.

B) My child may be included in all photos, videos or film likeness to be used for any legitimate purposes that promote the Y-COP program.

I agree to the enrollment of my child in the Y-COP (out of school day) program and have been advised of the policies regarding its fees.

I hereby give permission to the Y-COP staff to take whatever steps necessary to obtain medical care for my child. These steps may include, but are not limited to:

1. Administer basic first aid.
2. Attempt to contact a parent/guardian, emergency contact person and/or the child's physician.
3. Attempt to contact a parent/guardian or the child's physician, the Y-COP will do any or all of the following:
 - . Call another physician
 - . Call an ambulance or have the child taken to the nearest hospital
4. While participating in Y-COP activities, I understand that my child will be covered under my medical insurance.

Parent/ Guardian Signature _____

Date _____