



YMCA CHILD CARE

2011-'12 BEFORE AND/OR AFTER SCHOOL REGISTRATION FORM

(Complete both child care forms in black ink)

All registration information must be completely filled out before your child is registered. (both child care forms)

Child(ren)'s Information

Name (Last, First)	Sex	Home Address (Street, City, State)	Zip Code	Telephone #
1)				
2)				

Please list your main E-mail address here to receive school-age childcare correspondence

Parent or Guardian

Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Hm. Ph. #	Cell Ph. #	Work Name and Address	Work Phone #
Mother							
Father							
Guardian							

Emergency Contact - List information of person to contact when mother, father or guardian cannot be reached.

Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Hm. Ph. #	Cell Ph. #	Work Name and Address	Work Phone #

Person(s) Authorized to Pick-up Child(ren) (Include Parents)

Relationship to Child	Name	Home Address (If not listed above)	Telephone #	Work Name and Address (If not listed above)	Work Phone #

Parents' Marital Status? Married Single Divorced Separated Spouse Deceased

Note any custody arrangements or restrictions (Attach court order if applicable): _____



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Current YMCA Membership? Yes No If yes, Family Membership Youth Membership

• BEFORE SCHOOL •

Child's Name _____ Sex _____ Age as of Sept., 2011 _____ Grade as of Sept., 2011 _____ Birth Date _____

Child's Name _____ Sex _____ Age as of Sept., 2011 _____ Grade as of Sept., 2011 _____ Birth Date _____

School: _____ Site Desired: _____

Circle Desired Days M T W Th F Child(ren)'s Starting Date: _____

• AFTER SCHOOL •

Child's Name _____ Sex _____ Age as of Sept., 2011 _____ Grade as of Sept., 2011 _____ Birth Date _____

Child's Name _____ Sex _____ Age as of Sept., 2011 _____ Grade as of Sept., 2011 _____ Birth Date _____

School: _____ Site Desired: _____

Circle Desired Days M T W Th F Child(ren)'s Starting Date: _____

Registration fee for all participants is \$25.00 per child for Before and/or After School and must be submitted with registration form.

*Total fee enclosed \$ _____ (make checks payable to YMCA) Financial Assistance Requested Yes No

S Kids _____
Br Cty _____
3rd Party _____

Office Use Only: Paid _____ Draft _____ Immun. Confirmation Handbook Site File KDO Bussing Review Form

S	O	N	D	J	F	M	A	M	J
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____



The following are the minimum **required** immunizations. All children within the age range must meet these requirements at program entrance.

Age/Grade	Number of Doses						
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	1 MMR	3 HepB	3 Hib	3 PCV	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT/Td	4 Polio	2 MMR	3 HepB			2 Varicella

First Child's Name: _____

Immunization History:

List the MONTH, DAY and YEAR your child received each of the following immunizations. DO NOT USE (✓) or (X). If you do not have an immunization record for this child at home, contact your doctor or public health agency to obtain the dates.

TYPE OF VACCINE	First Dose mo/day/yr	Second Dose mo/day/yr	Third Dose mo/day/yr	Fourth Dose mo/day/yr	Fifth Dose mo/day/yr
DTP/DT/Td DIPHTHERIA-TETA-NUSPERTUSSIS (Whooping Cough)					
POLIO					
HAEMOPHILUS INFLUENZA b (HIB)					
PNEUMOCOCCAL CONJUGATE (PCV)					
HEPATITIS B					
MEASLES, MUMPS, RUBELLA (MMR)					
VARICELLA (Chicken Pox)					

- For religious reasons, this child should not be immunized.
- For personal conviction reasons, this child should not be immunized.

Child's Physician/Medical Facility:

Physicians Name: _____
 Address: _____
 Phone #: _____

Medication:

Will your child require any medication while at the Before/After School Program?

- Yes No
- If yes, please list medication _____

Second Child's Name: _____

Immunization History:

List the MONTH, DAY and YEAR your child received each of the following immunizations. DO NOT USE (✓) or (X). If you do not have an immunization record for this child at home, contact your doctor or public health agency to obtain the dates.

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VARICELLA (Chicken Pox)					

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Physicians Name: _____
 Address: _____
 Phone #: _____

Medication:

Will your child require any medication while at the Before/After School Program?

- Yes No
- If yes, please list medication _____

You will also be required to fill out a "Medication Authorization Form"

Health History

Please complete the health history section on the back side of this form. You must check at least one box in this section.

Parent Consent/Authorization *(Please initial each line & provide signature at bottom of page stating you have read and understand each item.)*

- ____ I am aware that a copy of the YMCA Licensing Policies and Wisconsin Licensing Rules for Day Care are available at the program for review at any time.
- ____ I authorize the YMCA to take my child on all field trips, whether by bus transportation or by walking during any of the Before/After School program days my child is enrolled.
- ____ I give or do not give permission for promotional photographs to be taken of my child. (Please check which box applies)
- ____ In the event of an emergency, I authorize any medical treatment that may be needed. I understand that in the event of an injury, I will be contacted first and this waiver will only be necessary if I or my emergency person cannot be reached.
- ____ I understand that all above said information is confidential and is only used as a guide in understanding my child(ren).
- ____ I understand that my \$25 registration fee per child is non-refundable and if I drop from the program but do not provide written notice to the SACC Office two weeks prior to my scheduled starting date, I am required to pay for these two weeks.

X Parent or Guardian's Signature: _____ Date: _____



(Complete this form in **black ink**)

First Child's Name: _____

Second Child's Name: _____

Health History:

Check any special medical condition(s) that your child may have.

- Asthma
- Cerebral Palsy/ Motor disorder
- Diabetes
- Heart Problems
- Epilepsy / Seizure disorder
- Any disorder including Cognitively Disabled, LD, ADD, ADHD or Autism
- Non-food allergies-specify _____
- Food allergies-specify food(s) _____
- Other condition(s) requiring special care-specify _____

- No medical condition

Emergency Care Plan:

If you checked any condition listed above, please answer the following questions. If something does not apply - write NA.

Triggers that may cause problems - specify

Signs or symptoms to watch for - specify

Action steps the YMCA staff should follow

Identify any staff to whom you have given specialized training/instructions to help treat symptoms

When to call parents regarding symptoms or failure to respond to treatment

When to consider that the condition requires medical care or reassessment.

Any additional information that may be helpful to staff.

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2011-2012 SCHOOL YEAR YMCA Bank Draft or Credit Card Draft Agreement

Draft amounts will occur for all before and/or after school child care weeks throughout the school year. All drafts will be drafted monthly on the 1st or 15th of the month per your request for the weeks of care occurring within that month. (Example: Weeks of September 1, September 5, September 12, September 19 and September 26 will be drafted in September). A draft guideline for the 2011-2012 school year will be provided to you prior to the school year starting.

Please fill out the information below and return this form to the SACC Office upon registration.

Child(ren)'s Name: _____ Child Care Site: _____

Your draft will occur monthly on the 1st or 15th of each month. Please select date. Monthly Draft Date: ___ 1st or ___ 15th

If checking or savings draft, please supply the following information:

Type of Account: ___ Checking or ___ Savings

Bank Name: _____ Account Holder's Name: _____

Bank Routing No: _____ Account Number: _____

If credit card draft, please supply the following information:

___ Discover Card ___ Master Card ___ Visa Name as it appears on the card: _____

Card Number: _____ Expiration Date: _____

Authorization:

I hereby authorize my financial institution to withdraw the amount based on my payment schedule from the account listed above.

- A. I understand my payment will continue until my scheduled payments are completed.
- B. It is my responsibility to notify the YMCA immediately of any account change or closing and to provide the YMCA with current account information. To make changes for drafts on the first of the month you must notify the YMCA by the 25th of the month prior. Notification for accounts drafting on the 15th must be in by the 10th of the month.
- C. The YMCA reserves the right to refuse entrance into the facility or programs if payments are delinquent. Full payment of delinquent payments will be required for reinstatement into programs.

Cancellation:

- A. A *two week advance written notice* must be given prior to withdrawing from a program.
- B. Following one month of insufficient funds or declined credit card, the YMCA will send a letter and statement to be paid within 15 days.
- C. Following a second month of insufficient funds or declined credit card, you will be contacted by the program director so that you can make arrangements to pay your balance due.
- D. If you do not comply with the arrangements, you will be terminated from the program. Your account will be frozen and you must pay any past due amount before participating in any YMCA program or membership in the future.

Parent/Payee Signature: _____ Date: _____

**RETURN THIS DRAFT AGREEMENT ALONG WITH
YOUR COMPLETED SCHOOL YEAR REGISTRATION FORM.**

