School Age Child Care Enrollment Form

Name _____Birth date _____ Age ____
Last First Middle ☐ Male☐Female

Home address_____
Street address City State Zip

Parent/Guardian applying for child: Name _____

Relationship:_____ Email address: _____

Address: _____ Home # _____ Work # _____

Cell # _____ ☐ This person is authorized to pick up my child.

Do you have a YMCA Family Membership? ____Yes _____No
Do you have any other children enrolled in YMCA child care? ___Yes ___No What site?_____

Parent/Guardian or Emergency Contact: Name _____

Relationship _____ Home # _____Work # _____

Cell #_____ ☐ This person is authorized to pick up my child.

Emergency Contact: Name _____

Relationship _____Home # _____ Work # _____

Cell # _____ ☐ This person is authorized to pick up my child.

Authorization of Release (child may only be released to an adult):

I hereby authorize the following adults to pick up my child at program. These adults are in addition to those noted above.

1. Name _____ Home # _____Work#_____ Cell#_____

2. Name _____ Home # _____Work # _____Cell # _____

3. Name _____ Home # _____Work#_____Cell # _____

Please list any special instructions or any persons who are NOT authorized to pick up your child: _____

_____

_____

Please note any custody arrangements or restrictions (Attach court order if applicable):

_____

_____

Please list any medical conditions:

_____

_____

Food and Medication Allergies:

_____

_____

_____

Other Health or Behavioral Conditions:

_____

_____

_____

MEDICATIONS BEING TAKEN:

Please note we are only authorized to administer emergency medications such as epi-pens, rescue inhalers, and nebulizers. These medications will only be accepted on site with the appropriate documentation. Please be sure to keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis OR ☐ This person takes medications as follows:

Med #1 _____Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____Dosage _____ Specific times taken each day_____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: _____

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever had back problems?	☐	☐
16. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
17. Have an orthodontic appliance being brought to program?	☐	☐
18. Have any skin problems? (e.g. itching, rash)	☐	☐
19. Have diabetes?	☐	☐
20. Have asthma?	☐	☐
21. Had mononucleosis in the past 12 months?	☐	☐
22. Had problems with diarrhea/constipation?	☐	☐
23. Ever had an eating disorder?	☐	☐
24. Ever had emotional difficulties for which professional help was sought?	☐	☐
25. Ever been diagnosed with a heart murmur?	☐	☐

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

Child's Source of Medical Care/Primary Care Physician: _____ Phone _____

Child's Source of Dental Care/Dentist's Name: _____ Phone_____

Name of Medical Care Facility/Hospital: _____ Phone_____

Medical Authorization

I hereby give permission to the medical personnel selected by the program director to order X-rays, routine tests, treatment; and to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization, for the person named above. I agree to review and update this information whenever a change occurs. This completed form may be photocopied for trips outside of program

Signature of parent or guardian:_____Date:_____

School Age Child Care Authorizations (Check if Yes or No):

I agree to communicate with the YMCA staff regarding any questions, or concerns, in a timely manner. ☐ **Yes** ☐ **No**

I have received and read the YMCA School Age Child Care Handbook and I agree to abide by the YMCA Policies ☐ **Yes** ☐ **No**

I understand that I am responsible for the child care fees and those they must be paid in advance. ☐ **Yes** ☐ **No**

I understand that I must send a nutritious non refrigerated/microwaveable lunch and drink(s) each day with my child for full and half day programs. ☐ **Yes** ☐ **No**

I grant permission for the YMCA to transport my child in the DOT inspected bus, to and from field trips/activities, to and from school (if required) and in emergency circumstances. ☐ **Yes** ☐ **No**

I also grant permission for my child to participate in walking field trips and activities. ☐ **Yes** ☐ **No**

I grant permission for my child to be photographed for YMCA and United Way promotions only. ☐ **Yes** ☐ **No**

I understand that my child is responsible for his/her own behavior, clothes, and belongings. ☐ **Yes** ☐ **No**

I grant permission for my child to participate in swimming activities in the Olean YMCA pool. I understand that my child must have the appropriate swim attire in order to participate in swimming. ☐ **Yes** ☐ **No**

I authorize the staff to administer the following over the counter topical medications to my child:

Sunscreen ☐ **Yes** ☐ **No**
Bug Spray ☐ **Yes** ☐ **No**

Parent/Guardian Authorizations: This registration form is correct and complete as far as I know, and the person herein described has permission to engage in all program activities except as noted.
Signed _____
Printed _____ Date _____

Screening Record *(For Program Use Only)* Screened by _____Date screened _____
Date of acceptance _____ Date of discharge_____Updates/additions to registration form noted ☐ Yes ☐ No ☐ None required

YCare_____School Name_____After School_____DaysOff_____Summer_____
KidZone_____School Name_____
Y-Camp_____ Olean_____Salamanca_____

CACFP Form Received _____
Enrollment Contract Received_____
Special Needs Form Received (if applicable) _____
Medication Authorization Form Received (if applicable) _____

Child Care Enrollment Contract

Child:_____ DOB_____
Is enrolled with the Olean-Bradford YMCA Child Care Program commencing on ___/___/___ at the _____ Site.

Parents:_____
Home Address:_____
Telephone:_____Home_____Work
Parents Employers:_____
Email Address _____

_____I hereby enroll in Plan _____and agree to pay the Olean-Bradford YMCA the following charges for my child care services: $_____per day/week.

Plan A: Everyday after school Part time contracts also available
Plan B: Everyday after school, days off during school year
Plan C: Year round care, including summer Plan D: KidZone only
YCamp only

_____YMCA Family Members

_____I understand that payment is required prior to services rendered unless other arrangements have been made. I have chosen automatic debit and have completed an automatic debit form.

_____I understand that debit will take place on the following dates of the month:_____

Signature of Parent Date

Director Date

Any questions and concerns regarding any YMCA School Age Child Care Program can be addressed to:

Mary Miller
Child Care Services Branch Executive
1101 Wayne Street
Olean, NY 14760
(716) 701-1381
marym@yourymca.org