2023-2024 YMCA of North Central WV

SCHOOL AGE CHILD CARE REGISTRATION

A. **Family Information:**

Child's Name__________________ Birth Date ___/___/___ Male ___ Female ___Age___

Child's Address ______________________City _______________State_____Zip______

Mother's/Guardian's Name _____________________Employer/School _______________

Home Address ______________________Work/School Address ____________________

City/State/Zip ______________________City/State/Zip __________________________

Home Telephone ___________________ Work Telephone _____________________

Cell Number ____________________ Email ______________________________

Father's/Guardian's Name _____________________Employer/School _______________

Home Address ______________________Work/School Address ____________________

City/State/Zip ______________________City/State/Zip __________________________

Home Telephone ___________________ Work Telephone ____________________

Cell Number _______________________ Email ______________________________

List of people (*including parents*) with permission to pick child up from care (***anyone not listed CANNOT*** pick up child without written permission from parent):

I _________________ give my permission for the following people to pick up my child.

1. **Name** ____________________________________
   Address __________________________________
   ____
   Phone ___________________________________
2. **Name** ____________________________________
   Address __________________________________
   ____
   Phone ___________________________________
3. **Name** ____________________________________
   Address __________________________________
   ____
   Phone ___________________________________

Child's Name ____

Child's School ____

Hours of Enrollment _________to _________

Days of Enrollment (Please circle) Monday Tuesday Wednesday Thursday Friday

Please complete one application per child. Please note all forms must be submitted and completed in full, registration fee and first week' s fee must be paid in order to complete registration.

Billing Information/ YMCA Account Holder Information

Payer Name: ____

Select Payment Option: Please check one:

- Cash - available only by paying at the YMCA front desk
- EFT Check - I hereby authorize the Harrison County YMCA to electronically debit the account associated with the checks submitted for payment.
- Credit/ Debit Card Auto Payment Option - Weekly fees will be scheduled to pull automatically from a chosen card/account. Fees may be paid weekly, bi-weekly or monthly (but must be paid in advance of care). If choosing this option, please contact the YMCA to arrange a payment schedule.

Please select any that apply:

- I require a monthly receipt as proof of my payments.
- I wish to apply for Financial Assistance. •not available if you are receiving CHOICES subsidy.
- I will be receiving CHOICES subsidy - please attach documentation of subsidy.
- I will be splitting payment for childcare with a second person outside of my home - please note, in this case the second party must sign below. The account holder is responsible for coordination of all payments. The YMCA is not responsible for contacting any additional parties for payment other than the account holder.

Select Program Option: Please circle one:

NON-MEMBER RATES:

- Nutter Fort $65.00 per week
- Norwood $65.00
- Choices Payment- School Name: __________

MEMBER RATES:

- Nutter Fort $50.00 per week
- Norwood $50.00
- Choices Payment- School Name: ____________

By signing below, I acknowledge and agree to the following:

- Weekly fees are due no later than the Friday before care Is received. unless there are adjustments that need to be made.
- Any account with a balance larger than one week worth of care will be ineligible for attendance until the account is paid in full.
- Payer may not adjust weekly fees due to attendance, holidays or weather related closings.
- There will be a $1.00 per child per minute late fee assessed for any child picked up as of 6:01 pm or later. This fee must be paid before child returns to care.
- The YMCA reserves the right to close any site or program that does not maintain adequate enrollment.

Payer Signature:______________________________ Date: ______________

Emergency Contact List

1. Name ______________Telephone (H)________(W)_________C)_________
   Address ______________City ____________State______Zip_________
2. Name ______________Telephone (H)________(W)_________(C)_________
   Address ______________City ____________ State______Zip_________
3. Name ______________Telephone (H) ________(W) _________(C)_________
   Address ______________City ____________ State______Zip_________
4. Name ______________Telephone (H) ________(W) _________(C)_________
   Address ______________City ____________State______Zip_________
5. Name ______________Telephone (H) ________(W) _________(C)_________
   Address ______________City ____________State______Zip _________

Special Instructions: Biological/custodial parents must be given access to their children unless there is a court order preventing contact. Individuals with court orders against them preventing child pick up:

Name______________Relationship to Child ____________

Name ______________Relationship to Child ____________

Other restrictions on pick up: ________________________

2023-2024 Photographic, Audio and Video Release

I, hereby ______do ______do not consent and authorize the Harrison County YMCA to use photos, audio and video of my child__________________________to promote future Harrison County YMCA programs.

____
Signature of Parent/ Guardian   Print parent name

Permission to apply sunscreen

I, parent or guardian of ____, gives the Harrison County YMCA school aged child care staff permission to administer sunscreen when needed.

____
Signature of Parent/Guardian   Print parent name

Permission to administer CPR/AED/First Aid

I, parent/guardian of _____________________________, give my permission for the Harrison County YMCA staff to administer First Aid or CPR/AED on my child if the need arises.

____
Signature of Parent/Guardian   Print parent name

Parent Handbook Sign Off

I, ___________________________, parent of ____________________________, have read the parent handbook for the Harrison County YMCA School Aged Child Care or Day Camp program. I understand the procedures for the child care and I am willing to follow the procedures. If I have any questions I will ask the Program Director or an appropriate member of the YMCA management.

____
Signature of Parent   Date

____
Signature of Witness   Date

Childs Name:_________________________ Date of Enrollment:_______________

2023-2024 Permission for Medical Treatment: To be filled in duplicate

Name________________________________Birthdate___/___/___ Age____

Has the child ever had:	Does the child:
Yes/No Chronic or recurrent illness? (Diabetes, Asthma, Seizures)	Yes/No Have any allergies?
Yes/No Any Hospitalizations?	Yes/No Have any problem with heart/blood pressure?
Yes/No Any surgery?	Yes/No Has anyone in your family ever fainted during exercise?
Yes/No Any injuries that prohibited participation in sports or exercise?	Yes/No Take any medication?
Yes/No Dizziness or frequent headaches?	Yes/No Wear glasses __contact lenses __ dental appliances __
Yes/No Concussion/knocked out?	Yes/No Organs missing? (Eye, kidney, testicle)
Yes/No Knee, ankle or neck injuries?	Yes/No Has it been longer than 10 years since your last tetanus shot?
Yes/No Any appliances? (prosthetics)	Yes/No Have you ever been told not to participate in sports or exercise?
Yes/No Broken bones or dislocation?	Yes/No Do you know of any reason this child should not participate in sports or exercise?
Yes/No Heat exhaustion/sun stroke?	Yes/No Have a sudden death in your family?
Yes/No Fainting/passing out?	Yes/No Have a family history of heart attack before age 50?
	Yes/No Develop coughing, wheezing or shortness of breath when exercising?

PLEASE EXPLAIN ANY "YES" ANSWERS OR ANY OTHER ADDITIONAL CONCERNS

List any allergies, illness, regular medications, special needs and concerns________________________________

____

Signature of Parent or Guardian________________________Date______________

Physician________________________________Telephone__________

Address____________________________City/State/Zip______________

Dentist________________________________Telephone__________

Address____________________________City/State/Zip______________

Insurance: ____________________Policy Holder's Name____________________Policy Number______________

I,____________________________, give my permission to the Harrison County YMCA for

______________________to receive emergency medical, dental, or surgical treatment if I cannot
(Name of child)
be reached. I place the following restrictions on medical treatment________________________________

____

Permission to Transport:

__In the event of an emergency, I prefer that the childcare provider call an ambulance to transport my child.

__In the event of an emergency, I give permission for the childcare provider to transport my child.

Indemnification Agreement, Medical Treatment Authorization & Parent Authorization

In consideration of acceptance of my child or ward, ____________________, for participation in the below named activities made available by the Harrison County YMCA, the undersigned parent or guardian, individually and on behalf of my child or ward and our executors and administrators agree to indemnity and hold harmless the Harrison County YMCA, including the directors, officers, agents, employees, members and volunteers, connected with or participating in the activity designated below, including transportation to and from the site for such activity, of and from all claims, demands, actions, judgments and damages which, at any time, may arise against the YMCA, as a consequence of my child's or ward's participation in such activity. Further, the undersigned parent or guardian of the child or ward designated herein authorizes any adult designated by the Harrison County YMCA to consent to the medical, dental and surgical procedure and treatment for the child or ward which may be appropriate for the child or ward as a consequence of participation in the activity authorized.

Activity Involved: Harrison County YMCA Summer Day Camp

Parent Signature ____ Date ______________

2023-2024 Permission for Medical Treatment: To be filled in duplicate

Name_______________________________Birthdate__/___/__ Age____

Has the child ever had:	Does the child:
Yes/No Chronic or recurrent illness? (Diabetes, Asthma, Seizures)	Yes/No Have any allergies?
Yes/No Any Hospitalizations?	Yes/No Have any problem with heart/blood pressure?
Yes/No Any surgery?	Yes/No Has anyone in your family ever fainted during exercise?
Yes/No Any injuries that prohibited participation in sports or exercise?	Yes/No Take any medication?
Yes/No Dizziness or frequent headaches?	Yes/No Wear glasses __contact lenses __ dental appliances __
Yes/No Concussion/knocked out?	Yes/No Organs missing? (Eye, kidney, testicle)
Yes/No Knee, ankle or neck injuries?	Yes/No Has it been longer than 10 years since your last tetanus shot?
Yes/No Any appliances? (prosthetics)	Yes/No Have you ever been told not to participate in sports or exercise?
Yes/No Broken bones or dislocation?	Yes/No Do you know of any reason this child should not participate in sports or exercise?
Yes/No Heat exhaustion/sun stroke?	Yes/No Have a sudden death in your family?
Yes/No Fainting/passing out?	Yes/No Have a family history of heart attack before age 50?
	Yes/No Develop coughing, wheezing or shortness of breath when exercising?

PLEASE EXPLAIN ANY "YES" ANSWERS OR ANY OTHER ADDITIONAL CONCERNS

List any allergies, illness, regular medications, special needs and concerns_______________________________

____

Signature of Parent or Guardian__________________________Date____________

Physician_______________________________Telephone__________

Address___________________________City/State/Zip______________

Dentist_______________________________Telephone__________

Address___________________________City/State/Zip______________

Insurance: ____________________Policy Holder's Name____________________Policy Number______________

I,____________________________, give my permission to the Harrison County YMCA for

_______________________to receive emergency medical, dental, or surgical treatment if I cannot
(Name of child)
be reached. I place the following restrictions on medical treatment_______________________________

____

Permission to Transport:

__In the event of an emergency, I prefer that the childcare provider call an ambulance to transport my child.

__In the event of an emergency, I give permission for the childcare provider to transport my child.

Indemnification Agreement, Medical Treatment Authorization & Parent Authorization

In consideration of acceptance of my child or ward, ____________________, for participation in the below named activities made available by the Harrison County YMCA, the undersigned parent or guardian, individually and on behalf of my child or ward and our executors and administrators agree to indemnity and hold harmless the Harrison County YMCA, including the directors, officers, agents, employees, members and volunteers, connected with or participating in the activity designated below, including transportation to and from the site for such activity, of and from all claims, demands, actions, judgments and damages which, at any time, may arise against the YMCA, as a consequence of my child's or ward's participation in such activity. Further, the undersigned parent or guardian of the child or ward designated herein authorizes any adult designated by the Harrison County YMCA to consent to the medical, dental and surgical procedure and treatment for the child or ward which may be appropriate for the child or ward as a consequence of participation in the activity authorized.

Activity Involved: Harrison County YMCA Summer Day Camp

Parent Signature ______________________________________ Date ______________

Harrison County YMCA

List of Allergies

Late Updated : _______________ By: ________________

Number	Child Name	Age	Allergies	Medication	Special Information

Medical History

(To be completed by parent/guardian *prior to examination*)

Name________________________________Birth Date__________Grade____Age_______

Has the child ever had:	Does the child:
Yes/No Chronic or recurrent illness? (Diabetes, Asthma, Seizures)	Yes/No Have any allergies?
Yes/No Any Hospitalizations?	Yes/No Have any problem with heart/blood pressure?
Yes/No Any surgery?	Yes/No Has anyone in your family ever fainted during exercise?
Yes/No Any injuries that prohibited participation in sports or exercise?	Yes/No Take any medication?
Yes/No Dizziness or frequent headaches?	Yes/No Wear glasses __contact lenses __ dental appliances __
Yes/No Concussion/knocked out?	Yes/No Organs missing? (Eye, kidney, testicle)
Yes/No Knee, ankle or neck injuries?	Yes/No Has it been longer than 10 years since your last tetanus shot?
Yes/No Any appliances/prosthetics?	Yes/No Have you ever been told not to participate in sports or exercise?
Yes/No Broken bones or dislocation?	Yes/No Do you know of any reason this child should not participate in sports or exercise?
Yes/No Heat exhaustion/sun stroke?	Yes/No Have a sudden death in your family?
Yes/No Fainting/passing out?	Yes/No Have a family history of heart attack before age 50?
(Females Only) Yes/No Any problems with menstrual periods?	Yes/No Develop coughing, wheezing or shortness of breath when exercising?

Please explain any "yes" answers or any other additional concerns.

____

____

____

Signature of Parent/Guardian ______________________________**Date** __________

Vital Signs

Height _________Weight _________Pulse ________Blood Pressure ________

Visual Acuity: Uncorrected ____/____Corrected ____/____Pupils equal diameter Y N

Screening/Physical Exam

Mouth:	Respiratory:	Abdomen:
Appliances Y N Missing/loose teeth Y N Caries needing treatment Y N	Symmetrical breath sounds Y N Wheezes Y N	Masses Y N Organomegaly Y N
Enlarged Lymph Nodes Y N	Cardiovascular: Murmur Y N Irregularities Y N Murmur with Valsalva Y N	Genitourinary (Males Only) Inguinal hernia Y N Bilaterally descended testicles Y N
Skin – Infectious lesions Y N		
Peripheral pulses equal Y N		

Musculoskeletal: (note any abnormalities)			
Neck Y N	Elbow Y N	Knee/Hip Y N	Hamstrings Y N
Shoulder Y N	Wrist Y N	Ankle Y N	Scoliosis Y N

RECOMMENDATIONS BASED UPON EVALUATION:

After my evaluation, I give my:

_______Full Approval

______Full Approval, but needs further evaluation by Family Dentist _______Eye Doctor_______Family Physician _______Other_______

_______Limited Approval with the following restrictions

____

_______Denial of approval for the following reasons

____

____

Signature____ ____________

MD/DO/DC/Advanced Registered Nurse Practicioner/Physicians Assistant **Date**