

NAZARETH YMCA SCHOOL AGE CHILD CARE REGISTRATION

Italicized areas will be filled out by YMCA staff

Child:

Name: _____ Sex: M F
Address: _____ Date of Birth: ___/___/___
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Social Security #: _____
School: _____ Grade Entering: _____
Admittance Date: ___/___/___ Enrollment Date: ___/___/___

First Parent/Guardian:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Social Security #: _____
Company/Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Work Phone: (_____) _____ Cell/Pager: (_____) _____
How did you hear about our program? _____

Second Parent/Guardian:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Social Security #: _____
Company/Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Work Phone: (_____) _____ Cell/Pager: (_____) _____

Medical Information:

Physician: _____ Phone: (_____) _____
Address: _____
City: _____ State: _____ Zip: _____
Dentist: _____ Phone: (_____) _____
Address: _____
City: _____ State: _____ Zip: _____
Preferred Hospital: _____
Insurance Provider: _____ Policy #: _____
Allergies/Medical Problems: _____
Medical Form on File: Yes No Effective Date: ___/___/___ Expires: ___/___/___

Emergency Transportations:

Authorization Date: ___/___/___ Parent/Guardian Signature: _____
Special Instructions (if any): _____

Emergency Contact/Authorized Pick-up People:

1st Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Other: (_____) _____
Emergency Contact: Yes No Authorized to Pick-up: Yes No

2nd Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Other: (_____) _____
Emergency Contact: Yes No Authorized to Pick-up: Yes No

3rd Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Other: (_____) _____
Emergency Contact: Yes No Authorized to Pick-up: Yes No

Schedule:	Check Days	Time In	Time Out
[]	Monday	_____	Monday _____
[]	Tuesday	_____	Tuesday _____
[]	Wednesday	_____	Wednesday _____
[]	Thursday	_____	Thursday _____
[]	Friday	_____	Friday _____

Program(s):

_____ Before School _____ After School _____ After Am Kindergarten

Signature of Parent/Guardian

Date

Membership Expiration Date: ____/____/____

MID PID: _____

CHILD HEALTH ASSESSMENT

Child's Last Name:	First Name:	
Date of Birth:	Home Phone:	
Child Care Facility Name: Nazareth YMCA	Child Care Facility Phone: 610-759-3440	County: Northampton

Parent/Guardian:		
Address:		
City:	State:	Zip:
Work Phone:		
I give my consent for my child's Physician and Child Care Provider to discuss my child's health concerns. _____		
Signature		Date

Health history and medical information pertinent to routine child care and emergencies:	<div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;">DATE OF EXAM</div>
<input type="checkbox"/> NONE	
ALLERGIES TO FOOD OR MEDICINE:	<input type="checkbox"/> NONE

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PREASURE
_____ IN/CM _____ %ILE	_____ LB/KG _____ %ILE	_____ IN/CM _____ %ILE	_____ / _____

PHYSICAL EXAMINATION	NORMAL	ABNORMAL/COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC/TONE		
DEVELOPMENTAL (e.g. DDST)		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTP/DTaP	1	2	3	4	5	
Polio	1	2	3	4		
HIB	1	2	3	4		
HEP B	1	2	3	4		
MMR	1	2	3	4		
Varicella	1	2	3	4		
Other	1	2	Note: Ages and number of boosters may vary when immunizations start at older ages			

SCREENING TESTS	NORMAL	ABNORMAL/COMMENTS
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

DATE OF LAST DENTIST'S EXAMINATION	NOTE: Age appropriate health services and immunizations must follow the schedule recommended by The American Academy of Pediatrics, 141 Northwest Point Blvd., Elf Grove Village, IL 60007
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Health Problems or Special Needs <input type="checkbox"/> No Problems	Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)
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Medical Care Provider:	Next Appointment: (Month/Year)
Address:	Phone:
Signature of physician or CRP:	Date:

2009/2010 YMCA Child Care Parent Agreement

I, _____, agree to abide by the rules and regulations set forth by the Nazareth YMCA for the School Age Child Care Program. I agree to the following Child Care rates:

- One Program - \$11.50 per day
- Two Programs - \$16.50 per day
- Three Programs - \$21.50 per day
- Early Dismissals - \$5.00 charge will be added to the per day rate for early dismissals
- School's Out - \$25.00 per day (only on scheduled school holidays)
- Snow Days – no care is available on these days

I understand that if I am delayed in picking up my child at 6:00 p.m., I will be charged \$15.00 for the first on to fifteen minutes, then \$1.00 for each minute after. I understand that payment is due by 6:00 p.m. On the Friday of the week that I receive my bill. If payment is not made on time, I will be charged a \$15.00 late fee. If I do not make a payment for two consecutive weeks my child(ren) will be suspended from the School Age Child Care Program until my account is up to date.

Signature: _____ **Date:** _____

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Photographic Release Form

I grant the Nazareth YMCA permission to use my child's photograph in any official publicity pieces. Publicity pieces included but are not limited to news releases, publications, and web use.

Signature: _____ **Date:** _____

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Field Trip Permission Form

My child, _____, has my permission to go on all scheduled YMCA field trips with the YMCA School Age Child Care. In accepting this enrollment, I intend to bind myself, my heirs, executors and administrator to hereby release any claim against, but not limited to, the Nazareth YMCA, their agents, representative, successors, emergency personnel, and all event officials.

Signature: _____ **Date:** _____