

NAZARETH YMCA 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: _____
Admittance Date: ____/____/____ Enrollment Date: ____/____/____

First Parent:

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:

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 Transportation Authorization:

Authorization Date: ____/____/____ Parent 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:	Child Care Facility Phone:	County:

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

Health history and medical information pertinent to routine child care and emergencies:	<input type="checkbox"/> NONE	<table border="1" style="width: 100%; height: 30px;"> <tr> <td style="text-align: center; padding: 2px;">DATE OF EXAM</td> </tr> </table>	DATE OF EXAM
DATE OF EXAM			
ALLERGIES TO FOOD OR MEDICINE:		<input type="checkbox"/> None	

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____ 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., Elk Grove Village, IL 60007
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Health Problems or Special Needs	Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)
<input type="checkbox"/> No Problems	

Medical Care Provider:	Next Appointment: (Month/Year)
Address:	Phone:
Signature of physician or CRNP:	Date:

2008-2009 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 - \$11.00 per day
- Two Programs - \$16.00 per day
- Three Programs - \$21.00 per day
- Early Dismissals - \$16.00 per day for after the dismissal or \$21.00 per day for before school and after the dismissal
- School's Out - \$25.00 per day (only on scheduled school holidays)

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:** _____

Photographic Release Form

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

Signature: _____ **Date:** _____

Filed Trip Permission Form

My Child, _____, has my permission to go on all scheduled YMCA filed trips with the YMCA School Age Child Care.

In accepting this enrollment, I intending to bind myself, my heirs, executors and administrators to hereby release any claim against, but not limited to, the Nazareth YMCA, their agents, representatives, successors, emergency personnel, and all event officials.

Signature: _____ **Date:** _____