

Y-CLUB CHILD ENROLLMENT 2018-2019

This form must be COMPLETED FULLY in order to enroll your child in Y-Club. Incomplete forms will be put on hold. If your form is put on hold, you may lose your spot in Y-Club. Please double-check before submitting to the YMCA.

CHILD'S NAME:

DOB:

GENDER:

Grade:

CIRCLE: Y-MEMBER

NON-MEMBER

OUTREACH

FSD Subsidy

Foster/Adopted

Child's Street Address:

City & Zip:

PARENT/GUARDIAN

NAME:

DOB (required):

STREET ADDRESS:

CITY/ZIP:

HOME & CELL PHONE:

EMAIL ADDRESS:

EMPLOYER:

EMPLOYER STREET ADDRESS:

EMPLOYER CITY & ZIP CODE:

WORK SHIFT:

WORK PHONE:

NAME:

DOB (required):

STREET ADDRESS:

CITY/ZIP:

HOME & CELL PHONE:

EMAIL ADDRESS:

EMPLOYER:

EMPLOYER STREET ADDRESS:

EMPLOYER CITY & ZIP CODE:

WORK SHIFT:

WORK PHONE:

COURT DOCUMENTATION IS REQUIRED FOR ANY BIOLOGICAL PARENT BARRED FROM ACCESSING THEIR CHILD.

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EMERGENCY CONTACT OTHER THAN PARENTS

NAME: _____
 STREET ADDRESS: _____
 CITY/ZIP: _____
 PHONE: _____
 RELATIONSHIP: _____

AUTHORIZED PICK UP: PLEASE LIST OTHER PEOPLE WHOM YOU AUTHORIZE TO PICK UP YOUR CHILD:

AUTHORIZATION FOR MEDICAL CARE

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize YMCA to contact the following:

DOCTOR: _____ PHONE NUMBER: _____
 HOSPITAL: _____ PHONE NUMBER: _____

PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

My child is in good health, is able to participate in group care, and has no special health or medical requirements. If my child is able to participate in group care but has special health or medical requirements, I have listed them here. PLEASE LIST ANY SPECIAL HEALTH OR MEDICAL CONDITIONS, including chronic health problems (Asthma, seizures), behavioral disorders, special needs, etc:

An **INDIVIDUALIZED CARE PLAN FORM** is **REQUIRED** for any child with a condition as listed above.

PARENT SIGNATURE: _____ DATE: _____

| CACFP (Child and Adult Food Program) Requirement | | | |
|--|---|---|--|
| CHECK HERE DAYS your child will attend | What time does your child arrive? AM or PM? | What time does your child leave? AM or PM? | WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES. |
| MON | <i>AM or PM</i> | <i>AM or PM</i> | |
| TUES | <i>AM or PM</i> | <i>AM or PM</i> | |
| WED | <i>AM or PM</i> | <i>AM or PM</i> | |
| THUR | <i>AM or PM</i> | <i>AM or PM</i> | |
| FRI | <i>AM or PM</i> | <i>AM or PM</i> | |
| SNACK provided in PM only | | | |
| Snack provided on the following holidays: Columbus Day, Veterans Day, Election Day | | | |

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ACKNOWLEDGEMENTS

I have received a copy of the Y-Club Parent Handbook, which contains policies regarding admission, care and discharge of children (Available online at www.southernbooneymca.org. Printed copies by request).

I have been informed that a copy of the licensing rules for child care centers is available at this facility for review.

The YMCA and I have agreed on a plan for continuing communication regarding my child's development, behavior and individual needs.

When my child is ill, I understand and agree that s/he may not be accepted for or remain in care.

I give the YMCA permission to transport my child if necessary. I understand that Y-Club will take field trips.

I understand that before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations, or exemptions from immunizations.

I have been notified that I may request notice at initial enrollment or any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.

PARENT SIGNATURE:

DATE:

LIABILITY RELEASE

I, the undersigned, request permission for _____ to enter the Southern Boone Area YMCA (hereinafter the YMCA) school age programs and to participate in the YMCA activities associated with the program. I know and assume all risks related to the participation in such activities, where such risks arise on or off the YMCA premises. In consideration of demands, damage actions and cause of action (present or future, whether known or unknown, anticipated or unanticipated) for any and all personal damages to my property relating to my presence on the YMCA premises and participation in any YMCA activity. I certify that I am 18 years of age and that my participation in the YMCA activities are voluntary. I give consent for my child to be photographed, videotaped or to appear in local newspaper articles or other local media.

PARENT SIGNATURE:

DATE:

USDA Nondiscrimination Statement

For all other FNS nutrition assistance programs, State or local agencies, and their subrecipients, must post the following Nondiscrimination Statement:

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;
- (2) Fax: (202) 690-7442; or
- (3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

October 14, 2015



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION
PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

SAVE
PRINT
RESET

IDENTIFYING INFORMATION

CHILD'S NAME

BIRTHDATE

HEALTH STATEMENT (CHECK ONE)

- My child is in good health, is able to participate in group care, has no special health or medical requirements.
- My child is able to participate in group care but has special health or medical requirements as listed below.

SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

PARENT OR LEGAL GUARDIAN SIGNATURE

DATE