Maple Street YMCA’s School’s Out Fun Club 2018-2019

Child’s First Name: _________________________ M.I.:___  Last Name: __________________________

Check boxes to the left of the week your child will be attending.

- [ ] October 25th
- [ ] October 26th
- [ ] November 21st
- [ ] December 26th
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Swim Permission:
- My child has permission to swim during School’s Day Out. Yes ___  No ___
- My child has permission to swim in the deep end. Yes ___  No ___
- Swimming Ability: Non-swimmer ___  Fair ___  Good ___

**Child must pass a deep water test prior to being allowed to swim in the deep end each day**

Information/Photo and Video Release:
- I give the YMCA, its nominees, agents and assigns, unlimited permission to use and publish testimonials, photos, videos, etc. for purposes of advertising and/or education. Yes ____  No ____

Parent/Guardian Signature: _______________________________ Date: __________

Payment:
- A one-time, $20 registration fee is due at sign up, and $5, non-refundable deposits are due at the time of registration for each day.
- I understand that if I cancel, I will still be responsible for paying the $5 deposit fee.

Parent/Guardian Signature: _______________________________ Date: __________

Documents Needed:
- Your child’s **2018/2019 immunization records and a photograph** are needed before allowed in the program.

What to bring every day:
- Lunch
- Two Snacks
- Swimsuit
- Towel
- Books/Journals
CHILD INFORMATION & HEALTH FORM

Child: First Name ____________________________ MI __________ Last Name ____________________________

Address _____________________________________________________________ Home Phone ____________________________

City ____________________________ State ______ Zip __________ Gender ______

Birthday __________ Age _____ School ____________________________________________ Grade going into _____

Family’s Annual Income __________________________________________________________

☐ Under $10,000
☐ $10,000 - $19,000
☐ $20,000-$29,000
☐ $30,000-$39,000
☐ $40,000-$49,000
☐ $50,000-$59,000
☐ $60,000 and over
☐ Unknown

Ethnic Background _____________________________________________________________

☐ Hispanic or Latino
☐ Not Hispanic
☐ Unknown

Race ____________________________________________________________

☐ Native American
☐ Asian
☐ Black
☐ Pacific Islander
☐ White
☐ Other
☐ Unknown

How did you hear about us? ______________________________________________________

Mother’s (or Guardian) First Name ____________________________ Last Name ____________________________

Mother’s DOB __________________________________ (We must have this to register your child)

Address _____________________________________________________________ Home Phone ____________________________

City ____________________________ State ______ Zip ______ Work Phone ____________________________

Employed By ____________________________ Address ________________________________________________

Father’s (or Guardian) First Name ____________________________ Last Name ____________________________

Father’s DOB __________________________________ (We must have this to register your child)

Address _____________________________________________________________ Home Phone ____________________________

City ____________________________ State ______ Zip ______ Work Phone ____________________________

Employed By ____________________________ Address ________________________________________________

Name of Family Doctor ____________________________________________ Phone ____________________________

Address ____________________________________________ City ____________________________ State ______ Zip ______

Name of Dentist ________________________________________________ Phone ____________________________

Address ____________________________________________ City ____________________________ State ______ Zip ______
In case of EMERGENCY, we should contact the following person(s) if parents cannot be reached:
(Please list names in order you would like them to be called)

A. ___________________________ Phone ________________ Relation ________________
B. ___________________________ Phone ________________ Relation ________________
C. ___________________________ Phone ________________ Relation ________________
D. ___________________________ Phone ________________ Relation ________________

Authorized person(s) to take child from site:
(You MUST list anyone who may pick up your child, including parents or guardians and emergency contacts)

A. ___________________________ Relation to child ___________________________
B. ___________________________ Relation to child ___________________________
C. ___________________________ Relation to child ___________________________
D. ___________________________ Relation to child ___________________________

Please list any additional names on an additional sheet of paper.
Please speak with the Director if there is a person that is NOT authorized to pick-up or see child.

GENERAL HEALTH QUESTIONS

Medication, if any: ____________________________ Possible side effects: ____________________________

Will this medication be taken while he/she is in Schools Out Fun Club Yes ☐ No ☐

Please note, it is the parent’s responsibility to supply the staff with the medication paperwork and directions.

Any recent operations, accidents, broken bones, vision or hearing conditions, or illnesses we should be aware of? __________

Any special devices used (glasses, hearing aids, crutches, etc.)? ____________________________

Date of last tetanus shot ____________________________

Names and ages of child’s brothers and sisters: ____________________________

Does your child have any fears we should be aware of? (insects, water, heights, animals, etc.) ____________________________

Has any event occurred that could cause an emotional concern that we should be aware of? (Death in the family, divorce, etc.?) ____________________________

Any known intolerance to food, insect bites/stings, or other factors that result in medical reaction? Please provide us with clear instructions in the event of an exposure to the factor.
PAYMENT AGREEMENT
Scheduled Payments: Payments must be scheduled at time of registration. Payments will be withdrawn automatically the day of the SOFC instance. Payments must be made in order to attend.

DEBIT/CREDIT CARD INFORMATION
Card Type (check one): □ Visa □ Mastercard □ American Express □ Discover
Last 4 of credit card __________ (Card must be presented at time of registration) □ Please use the account the YMCA has on file. Last 4 of credit card __________

Please note:
Returned payments will be assessed a $10 return payment fee and may be electronically collected. Camp Fees not collected will be referred to an outside collection agency.

Child Care Subsidy: Families who receive State Assistance will be responsible for all unpaid fees, copays, or fees if authorization expires. Proof of Authorization must be provided to YMCA before child can be registered for Camp. Copays are due at the beginning of each month.

Attendance: I understand I am responsible for payment of all days registered, whether my child attends or not. I also understand that my child cannot attend if payment has not been made.

Signature________________________________________________________________________________________ Date____________________________

AUTHORIZATION FOR EMERGENCY MEDICAL CARE
I (we) expect to be notified at once in case of accident or illness to my/our child; I/we will make arrangements for medical care of my/our child with the physician or hospital of my/our choice; If I/we cannot be reached to make the necessary arrangements, I/we hereby authorize the YMCA to contact:
Dr._________________________________________________________ at
ADDRESS
PHONE
or the nearest hospital for emergency medical treatment of ________________________________

CHILD’S NAME
Furthermore, I/we certify that my child is, to my/our knowledge, in good health and free of disabilities that would endanger him/her or other children in the YMCA programs.

Parent’s signature________________________________________________________________________________________ Date____________________________

MEDICATION PERMISSION AND COMPETENCY
I ___________________________________________ have determined that
the YMCA staff is competent to give or apply medication to my child(ren). I understand that YMCA has the responsibility to assess the ability of staff to give or apply medication safely and may give or apply medications to my child.

Parent Signature: ____________________________________________ Date: __________________________

REQUIRED INFORMATION
ANY KNOWN ALLERGIES?________________________________________________________

ANY KNOWN SPECIAL NEEDS OR HEALTH ISSUES?________________________________________

ANY ACTIVITIES YOUR CHILD MAY NOT ENGAGE IN?_____________________________________

ANYONE UNAUTHORIZED TO PICK UP OR VISIT? _______________________________________________ FIRST AND LAST NAME