the YMCA

TROY YMCA
PRE-K AFTER SCHOOL CHILDCARE
REGISTRATION FORM (2018-2019)

Start Date ________________

Program Rates & Times

PM Care
(2:15 - 5:15PM)

☐ **Full Time**
Y Member: **$230/mo**
Non-Member: **$280/mo**

☐ **Part Time** (Circle up to 3 days)
Y Member: **$165/mo**
Non-Member: **$215/mo**

Mon Tue Wed Thurs Fri

☐ Gardner-Dickinson

A non-refundable $50 deposit is due at the time of registration. The balance for September is due by September 1st.

☐ Sibling Discount ($10/mo)

Name ____________________

Child's Information

First Name ____________________ Last Name ____________________

DOB ____ /____ /_______ ☐ Male ☐ Female Emergency Contact (___) _____ - _________

Address ____

City ______________________________ State ______ Zip ___________

Billing Party Information (all correspondence will be delivered to this party)

☐ Capital District YMCA Member ☐ Non-Member ☐ Capital District YMCA Staff

First Name ____________________ Last Name ____________________

DOB ____ /____ /_______ ☐ Male ☐ Female

Address ____

City ______________________________ State ______ Zip ___________

Home (___) _____ - _________ Work (___) _____ - _________ Cell (___) _____ - _________

Email ____

Billing Payment Information

☐ **Cash**: Due monthly at your local YMCA

☐ **Online Payment**: Accessible at www.cdymca.org *Manage My Account*

☐ **Check**: Due monthly at your local YMCA or by mail. Made payable to CDYMCA.
(Childcare Billing, Capital District YMCA, 465 New Karner Rd., Albany NY, 12205)

☐ **Automatic Withdrawal**: Credit Card charge or Direct Bank withdrawal (ACH)

Credit Card (If account information is on file, please write just the last 4 digits)

Name on Card ______________________________ Card Type ___________

Card Number ____ Exp ____ /____

Address ____

City ______________________________ State ______ Zip ___________

Bank Withdrawal (ACH) (If account information is on file, please write just the last 4 digits)

Name ____

Bank Name ____

Routing Number (9 Digits) ___ ___ ___ ___ ___ ___ ___ ___ ___ ☐ Checking ☐ Savings

Account Number ____

***Terms**: I authorize my financial institution to honor pre-authorized debit/charges initiated by the YMCA on my account for childcare payments. Should any payments not be honored by the above financial institution, I understand that in addition to the regular payment, I will be charged a $20 NSF (Non-Sufficient Funds) fee. I also authorize a second attempted charge on my card/account if the first payment declines.*

____ ______________

Signature (I have read and understand the terms of this draft authorization) Date

Financial Assistance

☐ Department of Social Services (attach DSS approval letter)

☐ YMCA Scholarship

☐ Third Party

Payments are due by the 1st of each month. Payments received after the 8th will incur a $25 late fee. If payment is not received by the 15th, your child will be subject to removal from our care. Please print your child's name in the memo section of your check. When you provide a check as payment, you authorize a one-time EFT (Electronic Fund Transfer) from your account to process the payment. Errors found must be reported within 90 days to ensure the appropriate amount is refunded.

[OFFICE USE ONLY] Staff Signature ______________________ Date __________ Receipt # ___________

Payment Attached ☐ Y ☐ N Scholarship Percentage ______ Executive Signature ______________________

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Child's Enrollment Information

First Name ______________________ Last Name ______________________ DOB ____ /____ /_______

☐ Male ☐ Female Sibling's Name(s) & Age(s) ______________________________________

Primary Street Address ____

City ________________________ State ______ Zip _____________ Main Contact (___) _____ - _________

School Attending ____ Grade in Fall ______

Parent/Guardian #1

First Name ______________________ Last Name ______________________ DOB ____ /____ /_______

Contact Information: Primary Contact (___) _____ - _________ Work (___) _____ - _________ Cell (___) _____ - _________

Email ______________________________ Relationship to Child ______________________

Parent/Guardian #2

First Name ______________________ Last Name ______________________ DOB ____ /____ /_______

Contact Information: Primary Contact (___) _____ - _________ Work (___) _____ - _________ Cell (___) _____ - _________

Email ______________________________ Relationship to Child ______________________

Medical Information

Medications Child Is Currently Taking ______________________________________

Allergies ____

Does your child have disabilities? ☐ Hearing ☐ Speech ☐ Vision ☐ Seizures ☐ Other _________

Please Describe ____

Physical Handicaps ____

Services Received Through School ______________________________________

Special Needs Requiring an Individual Health Care Plan ______________________________

A child with a special health care need means a child who has a chronic physical, developmental, behavioral, or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Emergency Contacts

Primary Care Physician ______________________________________ (___) _____ - _________

Child's Medical Care Facility ____

Family Dentist ______________________________________ (___) _____ - _________

Specialist Required ______________________________________ (___) _____ - _________

Consent to Release/Emergency Contact Information

Please list secondary individuals who may pick up your child

1. First Name ____________________ Last Name ____________________ Relationship ____________________
   Address______________________________ City____________________ State__________ ZIP__________
   Contact Information: Main (___) _____ - _________ Work (___) _____ - _________ Cell (___) _____ - _________

2. First Name ____________________ Last Name ____________________ Relationship ____________________
   Address______________________________ City____________________ State__________ ZIP__________
   Contact Information: Main (___) _____ - _________ Work (___) _____ - _________ Cell (___) _____ - _________

3. First Name ____________________ Last Name ____________________ Relationship ____________________
   Address______________________________ City____________________ State__________ ZIP__________
   Contact Information: Main (___) _____ - _________ Work (___) _____ - _________ Cell (___) _____ - _________

Custody Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

If divorced or separated, who has legal custody? ____

Note: Court orders are needed if a parent is denied access to the child

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Parental Agreement

Please read and initial each statement, then provide your signature at the bottom of the page

______ I agree to the policies and procedures set forth by the childcare program

______ I understand that the YMCA Parent Handbook is available online at cdymca.org

______ I understand that the YMCA does not carry health and accident insurance and that I am responsible for Health/Accident incurred costs

______ I agree to notify YMCA staff if my child is going to be absent from the program

______ I agree to give the YMCA written notice 2 weeks in advance if I choose to remove my child from the program

______ I agree to keep registration forms updated throughout the year

______ I agree to pay fees as stated on page 1

______ I give permission for the Capital District YMCA to take video and/or photographs of myself and/or my child(ren) for the purpose of promoting YMCA programs

______ I give permission for my child to be released from YMCA care with the individuals listed on the prior page. I understand that the people listed are required to show identification for a child to be released. I also agree to notify YMCA staff in advance when I will not be picking up my child.

______ In the event that I/we cannot be reached to make arrangements for emergency medical attention, I/we, being the parent(s) legal guardian(s) of the named minor, do hereby appoint the YMCA staff to act on my/our behalf in authorizing emergency medical, dental, or surgical care and hospitalization in my/our absence for the named minor.

______ I, the legal guardian/parent of the enrolled child, give the Capital District YMCA personal permission to speak with School personnel (teacher) regarding my child.

____ ______________

Parent/Guardian Signature (I have read and understand each of the above statements) Date

Please keep a copy of this form for your records. Thank you.