FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

School Age Child Care Program Application - 2023-2024 school year

Child's Name _____ Date of Birth _____ M___ F___

Address _____ Town _____ Zip_____

Home Phone _____

Email Address _____

1st Parent/Guardian's Name

_____

2nd Parent/Guardian's Name

_____

1st Parent/Guardian's Employer

_____

2nd Parent/Guardian's Employer

_____

Work/Cell Number

_____

Work/Cell Number

_____

Doctor's Name & Phone _____ Hospital _____

List two contacts that can pick up your child if there is a problem and you can not be reached.

Name _____ Phone_____
Address _____ Relationship _____

Name _____ Phone_____
Address _____ Relationship_____

I am registering this child for the following program:

PM Partial Care: School dismissal until 4:30pm

5 Days/Wk _____

PM Care: School dismissal until 6:30pm

5 Days/Wk _____

3 Days/Wk List days:_____

2 Days/Wk List days:_____

School Child Attends_____ Grade _____

BANK DRAFT AGREEMENT FOR SCHEDULED PAYMENTS

I understand that School Age Child Care program payments will be paid from the bank account/credit card of the person listed below on the 1st of the month, September through June. Should any program payment not be honored by my bank or credit card for any reason, I realize that I am still responsible for payment plus a $25.00 service charge applied by the YMCA. This is in addition to any service fee my bank may charge

_____ _____
Print Name Last 4 Digits of Card for Scheduled Payments

_____ _____
Signature of Parent/Guardian Date

PROGRAM WITHDRAWL OR SCHEDULE CHANGE

I understand that written notice is required if I need to withdraw my child from the program. If I need to change the schedule, I must complete the School Age Child Care Change Form available at the Welcome Center before the 1st of the month. I also understand **THAT ALL REGISTRATION AND PROGRAM FEES ARE NON-REFUNDABLE**. If 30 days written notice is given, the registration fee will be applied to my last month's tuition. If 30 days notice is not given, a credit will be applied to my account that can be used towards other programming. The credit will be good for 1 year. Refunds are not given for days your child does not attend (which would include sick days), or for days the school does not open due to emergency closings, delayed openings or early closings. Days cannot be rescheduled.

_____ _____
Signature of Parent/Guardian Date

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--New Jersey State Law requires a medical form on file in our office before the child attends our program. If parents cannot be reached in an emergency the YMCA's doctor will be contacted and if needed the local Rescue Squad will take your child to the nearest hospital. Continued efforts will be made to reach you.

RELEASE AND WAIVER OF LEGAL LIABILITY

--I, individually and on behalf of my minor child(ren), hereby release and hold the Fanwood-Scotch Plains YMCA, its assigns and successors, its directors, officers, volunteers, and/or others acting on its behalf harmless from all claims that I/we may have arising from activities that I/we may be involved in with the YMCA. I expressly and specifically assume any and all risk of injury, illness, death, or property damage resulting from my/our YMCA activities. I give permission for the YMCA to transport my child(ren) from their school to the YMCA building. I hereby give permission for emergency medical treatment to be administered as deemed appropriate. I understand that the YMCA does not carry insurance to cover injuries and losses that may befall me/us. I consent to be photographed and to allow YMCA's use of any photos of me or my minor child(ren) at its sole discretion. The Y is a membership facility. Members are required to scan in when entering the Y main facility. The Y conducts regular sex offender screenings on all members, participants, and guests. If a sex offender match occurs, the Y reserves the right to cancel membership, end program participation, and remove visitation access. I have also received the Family Handbook and acknowledge receipt of it.

HAVING READ, UNDERSTOOD, AND AGREED WITH THESE TERMS, I HAVE EXECUTED THIS RELEASE, TO BE EFFECTIVE I MM E D I A T E L Y .

Signature of Parent/Guardian_____ Date_____

Personal Health and Medical Information

Child's Name _____ Date of Birth _____ M___ F___

Address _____ Town _____ Zip_____

Home Phone _____

Health Information

The following information must be filled in by the parent/guardian. The intent is to provide the staff background to provide appropriate care. Provide complete information so we can be aware of your child's needs.

Allergies — Describe reaction and management of the reaction

- Medications (e.g. penicillin) _____
- Food (e.g. eggs, dairy) _____
- Other (e.g. insect stings) _____

Medications

Medication requires a separate form. Please contact the School Age Child Care Director for more information.

Health History

Any activities that child cannot participate in or needs one-on-one assistance? Yes__ No __

If yes, please explain _____

Is your child currently being treated or followed by a medical professional for any of the following:

Asthma	Yes __ No __	Diarrhea/Constipation	Yes __ No __
Convulsions	Yes __ No __	Fainting Spells	Yes __ No __
Diabetes	Yes __ No __	Seizures	Yes __ No__
Heart Trouble	Yes __ No __	High Blood Pressure	Yes __ No__

If yes, please explain _____

Any additional information about the child's behavior and physical, emotional or mental health the staff should be aware of?

_____

Special information – IEP, walkers, wheelchair, behavior issues, special diets, habits etc.?