Summer Experience at Child Care 2020
Clover Park District | School Based Registration
YMCA OF PIERCE AND KITSAP COUNTIES

Return completed registration to one of the following:
- YMCA Child Care office: 1614 S Mildred St, Ste. 1, Tacoma, WA 98465
- Fax to: 253-983-0459 or scan and email to: childcare@ymcapkc.org; phone: 253-534-7840

Everyone is welcome.
The YMCA of Pierce and Kitsap Counties is an organization that embraces nondiscrimination, diversity, and inclusion. We welcome all people regardless of ability, age, background, income, ethnicity, race, faith, gender, gender identity, gender expression, or sexual orientation.

Financial Assistance, fee subsidy for qualifying military families, DSHS, and other Third Party Provider assistance is available.

CARE LOCATIONS | Select one site

CLOVER PARK | Site Hours: 7am – 6:30 pm

☐ CUSTER
7801 Steilacoom Blvd SW, Lakewood, WA 98498

Care Dates: June 22 – August 14

JUNE

WEEK 01 June 22-26 WEEK 1 Fee Due: Wednesday June 17 ☐ $175 per week
WEEK 02 June 29-July 3 WEEK 2 Fee Due: Wednesday June 24 ☐ $175 per week

JULY

WEEK 03 July 6-10 WEEK 3 Fee Due: Wednesday July 1 ☐ $175 per week
WEEK 04 July 13-17 WEEK 4 Fee Due: Wednesday July 8 ☐ $175 per week
WEEK 05 July 20-24 WEEK 5 Fee Due: Wednesday July 15 ☐ $175 per week
WEEK 06 July 27-31 WEEK 6 Fee Due: Wednesday July 22 ☐ $175 per week

AUGUST

WEEK 07 August 3-7 WEEK 7 Fee Due: Wednesday July 29 ☐ $175 per week
WEEK 08 August 10-14 WEEK 8 Fee Due: Wednesday August 5 ☐ $175 per week
WEEK 09 August 17-21 WEEK 9 Fee Due: Wednesday August 12 ☐ $175 per week
WEEK 10 August 24-28 NO CARE PROVIDED
WEEK 11 August 31-September 4 NO CARE PROVIDED

TOTAL SUMMER FEES: $ _______
<table>
<thead>
<tr>
<th><strong>CHILD'S INFORMATION</strong> (One form per child)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILD’S FIRST NAME</strong></td>
</tr>
<tr>
<td><strong>DATE OF BIRTH</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>HEIGHT</strong></td>
</tr>
<tr>
<td><strong>WHO DOES CHILD LIVE WITH?</strong> (Check all that apply)</td>
</tr>
<tr>
<td>[ ] Mother  [ ] Father  [ ] Guardian  [ ] Grandparent(s)  [ ] Step Parent  [ ] Other _______</td>
</tr>
</tbody>
</table>

**OPERATIONS/CHRONIC ILLNESSES**

**DATE OF LAST MEDICAL EXAM/PHYSICAL** | **DATE OF LAST DENTAL EXAM**

**ALLERGIES TO FOOD OR DRUGS**

[ ] No  [ ] Yes: List allergies and fill out Individual Care Plan form at site with any other necessary medical information

**DIETARY MODIFICATIONS**

[ ] No  [ ] Yes: List dietary modifications and fill out Individual Care Plan form at site with any other necessary medical information

**PHYSICAL, EMOTIONAL, PSYCHOLOGICAL, OR BEHAVIORAL NEEDS/CONSIDERATIONS**

[ ] No  [ ] Yes: List needs/considerations and fill out Individual Care Plan form at site with any other necessary medical information

**DOES YOUR CHILD TAKE ANY MEDICATIONS ON A REGULAR BASIS?**  [ ] No  [ ] Yes: List medications and dosages below

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Dosage:</th>
<th>Reason/Diagnosis:</th>
<th>Administer daily by staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>[ ] No  [ ] Yes*</td>
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<td></td>
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<td>[ ] No  [ ] Yes*</td>
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<td></td>
<td>[ ] No  [ ] Yes*</td>
</tr>
</tbody>
</table>

* Yes: Fill out medical authorization form at site and turn in with medication in original prescription container

**MEDICAL CONTACT INFORMATION**

**FAMILY DENTIST**

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>CITY</th>
<th>ZIP CODE</th>
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</thead>
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**FAMILY PHYSICIAN**

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>CITY</th>
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**HOSPITAL OF CHOICE**

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>CITY</th>
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</table>
# PARENT/GUARDIAN INFORMATION

<table>
<thead>
<tr>
<th>PARENT/GUARDIAN FULL NAME</th>
<th>AUTHORIZED TO PICK UP CHILD?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>PHYSICAL ADDRESS</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>MAILING ADDRESS (no PO Box)</td>
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<tr>
<td>HOME PHONE NUMBER</td>
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<tr>
<td>CELL PHONE NUMBER</td>
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<tr>
<td>WORK PHONE NUMBER</td>
<td></td>
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<tr>
<td>EMAIL</td>
<td></td>
</tr>
<tr>
<td>RELATIONSHIP TO CHILD</td>
<td></td>
</tr>
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</table>

# IF APPLICABLE, WHO IS CUSTODIAL PARENT/GUARDIAN?

# IF APPLICABLE, WHO IS NOT AUTHORIZED TO PICK UP CHILD? (Must provide legal documentation to site director)

# EMERGENCY CONTACTS *(Local contacts only. Minimum of three emergency contacts required. Child will not be released unless they are listed below. Contacts must be at least 14 years old and must be able to provide photo identification.*

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
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STATEMENT OF UNDERSTANDING, PERMISSION, AND COMPLIANCE

READ AND INITIAL EACH STATEMENT

INITIAL My child has permission to participate in summer activities including fieldtrips to local attractions and/or parks using rented or YMCA owned buses. I also authorize assistance to be given to my child, including staff administration of hand sanitizer. I understand that sunscreen must be approved by me and that my child is responsible for applying it to him or herself while at site.

INITIAL I am aware and I approve of my child having an opportunity to participate in program activities which may involve a degree of risk and I hereby release the YMCA of Pierce and Kitsap Counties from any and all responsibility and liability of any nature resulting from my child’s participation in YMCA activities and transportation as required.

INITIAL In the event my child is injured, I give YMCA first-aid and CPR-certified staff the authority to provide basic first-aid and CPR as the situation requires including splinter removal, if necessary, and/or if they become seriously ill or injured and I cannot be reached.

INITIAL I authorize any emergency transportation, hospitalization, x-ray, medical, dental, and/or emergency surgical treatment advisable by the circumstances by any member of the medical staff of the medical facility.

INITIAL I understand it is my responsibility to provide my own accident and health insurance while participating in all YMCA activities, and that the YMCA does not provide any health or accident coverage for its participants.

INITIAL I grant permission for photographs/videos which include my child in YMCA records, program projects, marketing, and public relations to be used in media releases and benefit the center to be taken.

INITIAL I recognize participants are expected to follow all safety instructions, remain in areas designated by staff, and refrain from behavior harmful to oneself or others. I understand that failure to adhere to program and behavior policies could be cause for participant’s dismissal without refund of program fees.

INITIAL I understand summer fees are due weekly each Wednesday prior to selected week(s).

INITIAL With my signature below, I agree to the policies outlined in this form and the Parent Hand Guide information, including cancellations (due to unpaid tuition and behavior) and refund policies.

INITIAL Acknowledgement of Summer 2020 Attendance policy:
The YMCA Child Care branch is committed to the safety of students and staff. We will adhere to the Department of Health Guidelines regarding smaller staff to student ratios. Group sizes will not exceed 10 individuals per licensed room within the school building. There will be registration limits and expected waitlists at our sites. Due to the implementation of capacity limits for safety, spaces are extremely limited and we know the need is still high within our community. For these reasons, the YMCA Child Care branch will disenroll any participants that have not attended. All participants who are registered for care are expected to attend weekly. Attendance will be monitored closely and students who do not attend will have future weeks removed from their accounts. By initialing, I acknowledge my understanding of the YMCA Child Care branch Summer 2020 attendance policy.

INITIAL Acknowledgement of COVID-19 risks:
I understand that an outbreak of the COVID-19 virus has occurred in the State of Washington and that the virus is novel and may cause known, unknown, foreseen, and unforeseeable risks. I understand that the virus poses health risks to those who contract it and to those who come into contact with individuals who have contracted it. I understand that the virus may pose a higher risk to certain individuals such as those who are immunocompromised, have chronic medical conditions, are pregnant, and in older adults. I understand that the virus may cause illness and symptoms including fever, cough, shortness of breath, mild to severe respiratory illness, and death. I understand that childcare facilities are currently allowed to continue to operate during the COVID-19 outbreak, but that the virus is highly contagious and cannot be eliminated from the childcare environment. I certify that I am the parent and/or legal guardian of the above-named child, that I accept and agree to be bound by the requirements for continued childcare above, and give permission for my child to continue to participate in childcare with the childcare provider and at the facility stated above. I release all and hold the YMCA/District harmless of all claims that may arise out of or in connection with this Consent and Agreement to Continue Childcare and/or related in any way to COVID-19.

PARENT/GUARDIAN SIGNATURE __________________________________________ DATE ____________

Completion of registration packet, immunization form, USDA eligibility form, and the full payment for the week officially enrolls your child in the YMCA Child Care program. Your child will begin childcare two business days following completed registration and payment processing. It is your responsibility to update all information in this form as needed.

The Y is open to all, regardless of gender, race, age, background, income, or physical or mental ability. Financial Assistance is available.
**Certificate of Immunization Status (CIS)**

**CHILD’S FULL NAME:**

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**Parent/Guardian Signature Required**

- Date
- Parent/Guardian Signature

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**Record Immunization Information in My Child's School**

- I certify that the information provided on this form is correct and verifiable.

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**For Kindergarten-12th Grade / Child Care Entry**

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**Follow-up**

- MMR
- MR
- Varicella
- Hepatitis A
- Hepatitis B
- Polio
- Pertussis
- IPV
- Mumps
- Hib
- Haemophilus influenzae type b
- DTaP
- Tetanus
- Tuberculosis
- Chickenpox

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**Recommended Vaccines (Not Required for School or Child Care Entry)**

- History of disease verified by
- Varicella
- IPV
- Mumps
- Polio
- Tetanus
- Tuberculosis
- Pertussis

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**For Health Care Provider Use Only**

- Personal Health Information
- Immunization
- History of disease
- Vaccines
- Other

---

**Parent/Guardian Signature Required**

- Date
- Parent/Guardian Signature

---

**Record Immunization Information in My Child's School**

- I certify that the information provided on this form is correct and verifiable.

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**For Kindergarten-12th Grade / Child Care Entry**

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**Follow-up**

- MMR
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- Tuberculosis
- Chickenpox

---

**For Health Care Provider Use Only**

- Personal Health Information
- Immunization
- History of disease
- Vaccines
- Other
PAYMENT POLICIES AND PROCEDURES

ANNUAL HOUSEHOLD INCOME (Please select from the choices below)

☐ Less than $15,000  ☐ Less than $30,000  ☐ Less than $45,000  ☐ Less than $60,000  ☐ More than $60,000

CHILD’S ETHNICITY/RACE

☐ Asian/Pacific Islander  ☐ Native American  ☐ African-American  ☐ Hispanic  ☐ Caucasian  ☐ Other

MILITARY INFORMATION

Is your child a military dependent?  ☐ Yes  ☐ No

Branch of Military:  ☐ N/A  ☐ Army  ☐ Air Force  ☐ Navy  ☐ Marines  ☐ Coast Guard  ☐ National Guard  ☐ DOD Civilian

Would you like information on a NACCRRA application?  ☐ Yes  ☐ No

HOW DID YOU HEAR ABOUT OUR PROGRAM? (Check all that apply)

☐ Website  ☐ Telephone book  ☐ YMCA Child Care participant  ☐ Friend  ☐ YMCA Branch  ☐ Mailer  ☐ Other

☐ Private Pay

☐ State Pay

DCYF/DSHS Authorization must be received directly from State in order to register.

Contact the Child Care office to get provider # for school

PAYMENT METHOD AND BILLING

SUMMER FEES – Summer fees are due weekly each Wednesday prior to selected week(s)

PRIMARY PERSON RESPONSIBLE FOR PAYMENTS

Name (First) __________________________ (Last) __________________________

Child’s Name (First) __________________________ (Last) __________________________

SECONDARY PERSON RESPONSIBLE FOR PAYMENTS (Additional form required with account information)

Name (First) __________________________ (Last) __________________________

PAYMENT OPTIONS: (Select One)

☐ Auto Draft using Debit or Credit Card | Auto draft applies weekly, Wednesday prior to the start of each week of care.

☐ Use card on file, Last 4 of card # to confirm: __________

☐ Use new card:  ☐ Visa  ☐ MasterCard  ☐ American Express  ☐ Discover

Name on Card __________________________

Card Number __________________________

Expiration Date __________________________

Verification Code __________________________

☐ I choose NOT to auto draft. I understand my payment is expected by the Wednesday prior to the start of each week or I am responsible for a late fee of $25 and a suspension of care will apply if my payment is late.

STATEMENT OF UNDERSTANDING (Please read and initial each statement below)

☐ I understand payment expectations and have chosen my payment method. I agree to abide by all policies in place, including that any changes must be in writing direct to YMCA Child Care. I understand failure to uphold my payment arrangements will result in cancelation of registration from the program.

☐ I have included all information as requested above, and if there is a secondary responsible party, it is my responsibility to have this form duplicated and submitted to that party for their acceptance of payment policies and procedures.

☐ I understand that if the payment is not able to be collected at the weekly draft, a $30 NSF/processing fee will automatically be added to the account.

☐ I understand that if I am receiving assistance from a Third Party Provider, it is my responsibility to begin the process with a caseworker or call center. I understand I may not be able to register or have my child attend child care until authorization is received in writing from the state. I understand that Third Party Provider reviews must be made on time to continue child care and full payment is expected without authorization until matter is resolved.

☐ I understand to cancel a week of care; you must do so in writing before close of business on Monday, one week prior to the start of the week you wish to cancel. There will be a $25 cancellation fee for any cancellation that is not made by this deadline.

Signature __________________________ Date __________________________