

CHILD'S FULL NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

## Summer Experience at Child Care 2020 Kitsap & Peninsula | School Based Registration YMCA OF PIERCE AND KITSAP COUNTIES



Return completed registration to one of the following:

- YMCA Child Care office: 3330 Kitsap Way Suite A, Bremerton, WA 98312
- Fax to: 360-627-9047 or scan and email to: kitsapchildcare@ymcapkc.org; phone: 360-813-1813

**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			
<b>Bremerton   6 am - 6 pm</b>		<b>Central Kitsap   6 am - 6 pm</b>	
<input type="checkbox"/> Crownhill		<input type="checkbox"/> Pinecrest <input type="checkbox"/> Silverdale	
<b>South Kitsap   *Time varies</b>		<b>Peninsula   6:30 am - 6:30 pm</b>	
<input type="checkbox"/> East Port Orchard   <b>6 AM to 6 PM</b>		<input type="checkbox"/> Harbor Heights	
<input type="checkbox"/> Manchester   <b>7 AM to 6 PM</b>		<input type="checkbox"/> Purdy	
JUNE			
WEEK 01	June 22-26	<b>WEEK 1 Fee Due: Wednesday June 17</b>	<input type="checkbox"/> \$175 per week
WEEK 02	June 29-July 3	<b>WEEK 2 Fee Due: Wednesday June 24</b>	<input type="checkbox"/> \$175 per week
JULY			
WEEK 03	July 6-10	<b>WEEK 3 Fee Due: Wednesday July 1</b>	<input type="checkbox"/> \$175 per week
WEEK 04	July 13-17	<b>WEEK 4 Fee Due: Wednesday July 8</b>	<input type="checkbox"/> \$175 per week
WEEK 05	July 20-24	<b>WEEK 5 Fee Due: Wednesday July 15</b>	<input type="checkbox"/> \$175 per week
WEEK 06	July 27-31	<b>WEEK 6 Fee Due: Wednesday July 22</b>	<input type="checkbox"/> \$175 per week
AUGUST			
WEEK 07	August 3-7	<b>WEEK 7 Fee Due: Wednesday July 29</b>	<input type="checkbox"/> \$175 per week
WEEK 08	August 10-14	<b>WEEK 8 Fee Due: Wednesday August 5</b>	<input type="checkbox"/> \$175 per week
WEEK 09	August 17-21	<b>WEEK 9 Fee Due: Wednesday August 12</b>	<input type="checkbox"/> \$175 per week
WEEK 10	August 24-28 <b>PENINSULA ONLY</b>	<b>WEEK 10 Fee Due: Wednesday August 19</b>	<input type="checkbox"/> \$175 per week
WEEK 11	August 31- September 4th	<b>NO CARE PROVIDED</b>	
			<b>TOTAL SUMMER FEES: \$ _____</b>

FOR OFFICE USE ONLY			
DATE ACCEPTED	BY: STAFF NAME/SITE		MEMBER #
DATE ENTERED IN DAXKO	BY: STAFF NAME		<input type="checkbox"/> WELCOME LETTER <input type="checkbox"/> CHILD FILE COPIED <input type="checkbox"/> CHILD CARE MEMBERSHIP
APPROVED BY PROGRAM DIRECTOR <input type="checkbox"/> Yes <input type="checkbox"/> No	PROGRAM DIRECTOR NAME	CC SITE	DATE APPROVED

CHILD'S INFORMATION (One form per child)			
CHILD'S FIRST NAME		CHILD'S LAST NAME	
DATE OF BIRTH	AGE	GRADE (FALL 2020)	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female

CHILD'S FULL NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**HEIGHT****WEIGHT****EYE COLOR****HAIR COLOR****WHO DOES CHILD LIVE WITH?** (Check all that apply) Mother  Father  Guardian  Grandparent(s)  Step Parent  Other \_\_\_\_\_**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**Medication:****Dosage:****Reason/Diagnosis:****Administer daily by staff?** No  Yes\* No  Yes\* No  Yes\*

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

**MEDICAL CONTACT INFORMATION****FAMILY DENTIST****PRIMARY PHONE NUMBER****ADDRESS****CITY****ZIP CODE****FAMILY PHYSICIAN****PRIMARY PHONE NUMBER****ADDRESS****CITY****ZIP CODE****HOSPITAL OF CHOICE****PRIMARY PHONE NUMBER****Address****CITY****ZIP CODE****PARENT/GUARDIAN INFORMATION****PARENT/GUARDIAN FULL NAME****AUTHORIZED TO PICK UP CHILD?** Yes  No**PHYSICAL ADDRESS****CITY****ZIP CODE**

CHILD'S FULL NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

<b>MAILING ADDRESS (no PO Box)</b>		<b>CITY</b>	<b>ZIP CODE</b>
<b>HOME PHONE NUMBER</b>	<b>CELL PHONE NUMBER</b>	<b>WORK PHONE NUMBER</b>	
<b>EMAIL</b>		<b>RELATIONSHIP TO CHILD</b>	

<b>PARENT/GUARDIAN FULL NAME</b>		<b>AUTHORIZED TO PICK UP CHILD?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>PHYSICAL ADDRESS (no PO Box)</b>		<b>CITY</b>	<b>ZIP CODE</b>
<b>MAILING ADDRESS</b>		<b>CITY</b>	<b>ZIP CODE</b>
<b>HOME PHONE NUMBER</b>	<b>CELL PHONE NUMBER</b>	<b>WORK PHONE NUMBER</b>	
<b>EMAIL</b>		<b>RELATIONSHIP TO CHILD</b>	
<b>IF APPLICABLE, WHO IS CUSTODIAL PARENT/GUARDIAN?</b>			
<b>IF APPLICABLE, WHO IS NOT AUTHORIZED TO PICK UP CHILD?</b> (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.)

<b>EMERGENCY CONTACT FULL NAME</b>	<b>RELATIONSHIP TO CHILD</b>	
<b>PHYSICAL ADDRESS (no PO Box)</b>	<b>CITY</b>	<b>ZIP CODE</b>
<b>CONTACT PHONE NUMBER</b>	<b>AUTHORIZED TO PICK UP CHILD?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>EMERGENCY CONTACT FULL NAME</b>	<b>RELATIONSHIP TO CHILD</b>	
<b>PHYSICAL ADDRESS (no PO Box)</b>	<b>CITY</b>	<b>ZIP CODE</b>
<b>CONTACT PHONE NUMBER</b>	<b>AUTHORIZED TO PICK UP CHILD?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>EMERGENCY CONTACT FULL NAME</b>	<b>RELATIONSHIP TO CHILD</b>	
<b>PHYSICAL ADDRESS (no PO Box)</b>	<b>CITY</b>	<b>ZIP CODE</b>
<b>CONTACT PHONE NUMBER</b>	<b>AUTHORIZED TO PICK UP CHILD?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

### STATEMENT OF UNDERSTANDING, PERMISSION, AND COMPLIANCE

READ AND INITIAL EACH STATEMENT

CHILD'S FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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 in care.

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

**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.

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 area 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

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.

**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)

For Kindergarten-12<sup>th</sup> Grade / Child Care Entry

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

**Office Use Only:** Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Signed Cert. of Exemption on file?  Yes  No

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Birthdate (MM/DD/YYYY): \_\_\_\_\_ Sex: \_\_\_\_\_

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required \_\_\_\_\_ Date \_\_\_\_\_

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

Parent/Guardian Signature Required \_\_\_\_\_ Date \_\_\_\_\_

CHILD'S FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

	Date	Date	Date	Date	Date
	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
<b>Required for School and Child Care/Preschool</b>					
◆ DTaP, DT (Diphtheria, Tetanus, Pertussis)					
◆ Tdap (Tetanus, Diphtheria, Pertussis)					
◆ Td (Tetanus, Diphtheria)					
◆ Hepatitis B					
□ 2-dose schedule used between ages 11-15					
● Hib ( <i>Haemophilus influenzae</i> type b)					
◆ IPV / OPV (Polio)					
◆ MMR (Measles, Mumps, Rubella)					
● PCV / PPSV (Pneumococcal)					
◆ Varicella (Chickenpox)					
□ History of disease verified by IIS					
<b>Recommended Vaccines (Not Required for School or Child Care Entry)</b>					
Flu (Influenza)					
Hepatitis A					
HPV (Human Papillomavirus)					
MCV, MPSV (Meningococcal)					
MenB (Meningococcal)					
Rotavirus					

**Documentation of Disease Immunity**  
*Healthcare provider use only*

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

a verified history of Varicella (Chickenpox).

laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other:
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	_____

Licensed healthcare provider signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)

Printed Name \_\_\_\_\_

CHILD'S FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**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.**

**Use card on file**, Last 4 of card # to confirm: \_\_\_\_\_

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

Name on Card \_\_\_\_\_ Expiration Date \_\_\_\_\_

Card Number \_\_\_\_\_ 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)

INITIAL

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

INITIAL

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.

INITIAL

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.

INITIAL

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.

INITIAL

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 \_\_\_\_\_