CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

Summer Experience at Child Care 2020
Pierce County | School Based Registration
YMCA OF PIERCE AND KITSAP COUNTIES

the YMCA
FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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

TACOMA | Site Hours: 7am – 6:30pm
☐ **Geiger**
☐ **Lowell**

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	**WEEK 10 Fee Due: Wednesday August 19**	☐ **$175 per week**
WEEK 11	August 31 – September 4	**NO CARE PROVIDED**	

TOTAL SUMMER FEES: $ _____

CHILD'S T-SHIRT SIZE

SELECT ONE: ☐ Youth ☐ Adult **SELECT ONE**: ☐ Extra Small ☐ Small ☐ Medium ☐ Large ☐ Extra Large

FOR OFFICE USE ONLY

DATE ACCEPTED	**BY: STAFF NAME/SITE**		☐ **VERIFIED INFORMATION** ☐ **CHILD CARE MEMBERSHIP**
DATE ENTERED IN DAXKO	**BY: STAFF NAME**		☐ **CHECKED FOR DISCOUNTS/SUBSIDIES** ☐ **SCHEDULED PAYMENTS**
APPROVED BY PROGRAM DIRECTOR ☐ Yes ☐ No	**PROGRAM DIRECTOR NAME**	**DATE APPROVED**	☐ **WELCOME LETTER** ☐ **CHILD FILE COPIED**

CHILD'S INFORMATION (One form per child)

CHILD'S FIRST NAME		CHILD'S LAST NAME	
DATE OF BIRTH	**AGE**	**GRADE (FALL 2020)**	**GENDER** ☐ Male ☐ Female
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

WILL STAFF NEED TO ADMINISTER ANY MEDICATIONS DAILY?
☐ No ☐ Yes: Fill out medical authorization form at site and turn in with medication in original prescription container

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

PARENT/GUARDIAN FULL NAME		AUTHORIZED TO PICK UP CHILD? ☐ Yes ☐ No
PHYSICAL ADDRESS (no PO Box)	CITY	ZIP CODE
MAILING ADDRESS	CITY	ZIP CODE
HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
EMAIL	RELATIONSHIP TO CHILD	
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.)

EMERGENCY CONTACT FULL NAME	RELATIONSHIP TO CHILD	
PHYSICAL ADDRESS (no PO Box)	CITY	ZIP CODE
CONTACT PHONE NUMBER	AUTHORIZED TO PICK UP CHILD? ☐ Yes ☐ No	

EMERGENCY CONTACT FULL NAME	RELATIONSHIP TO CHILD	
PHYSICAL ADDRESS (no PO Box)	CITY	ZIP CODE
CONTACT PHONE NUMBER	AUTHORIZED TO PICK UP CHILD? ☐ Yes ☐ No	

EMERGENCY CONTACT FULL NAME	RELATIONSHIP TO CHILD	
PHYSICAL ADDRESS (no PO Box)	CITY	ZIP CODE
CONTACT PHONE NUMBER	AUTHORIZED TO PICK UP CHILD? ☐ Yes ☐ No	

CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

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 <u>weekly</u> 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. **<u>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.</u>** 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.

INITIAL **Tacoma Public Schools Families Only:** I give permission for the YMCA of Pierce and Kitsap Counties to release information regarding my child's attendance and participation in YMCA programs to the Tacoma Public Schools and the Foundation for Tacoma Students.

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.

DATE OF BIRTH:

CHILD'S FULL NAME:

Washington State Department of Health

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

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

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

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate** (MM/DD/YY):	**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**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP, DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
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.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

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

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 of care.**

☐ **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 <u>NOT</u> 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 _____