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

Winter Break Registration 2020
YMCA Child Care | Pierce
YMCA OF PIERCE AND KITSAP COUNTIES

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Return registration to one of the following by December 4, 2020:

- YMCA Child Care Business Office: 1614 S. Mildred St., Tacoma WA 98465
- Fax to: 253-983-0459 or scan and email to: childcare@ymcapkc.org; phone: 253-534-7840

TACOMA SCHOOL DISTRICT **Site Hours: 7:00am-6:00pm**

☐ **Mason Middle School** 3901 N 28th St, Tacoma, WA 98407

CLOVER PARK SCHOOL DISTRICT **Site Hours: 7:00am-6:30pm**

☐ **Custer** 7801 Steilacoom Blvd SW, Lakewood, WA 98498

Custer is closed on Wednesday, December 30. You may register for care at another location on this day below.

FRANKLIN PIERCE SCHOOL DISTRICT **Site Hours: 6:30am-6:30pm**

☐ **Elmhurst** 420 133rd St. E., Tacoma, WA 98445

PENINSULA SCHOOL DISTRICT **Site Hours: 6:30am-6:30pm**

☐ **Harbor Heights** 4002 36th St NW, Gig Harbor, WA 98335

SELECT DAYS OF ATTENDANCE:

WEEK ONE

- ☐ Monday, December 21
- ☐ Tuesday, December 22
- ☐ Wednesday, December 23

CLOSED

Thursday, December 24
Friday, December 25

WEEK TWO

- ☐ Monday, December 28
- ☐ Tuesday, December 29
- ☐ Wednesday, December 30*

***CUSTER IS CLOSED ON 12/30. I would like child care at the following location (see options above) on 12/30: _____**

CLOSED

Thursday, December 31
Friday, January 1

FEES

WEEK ONE
☐ 3 days per week | $132.00 per week
☐ $50 daily | Total number of days _____

WEEK TWO
☐ 3 days per week | $132.00 per week
☐ $50 daily | Total number of days _____

FOR OFFICE USE ONLY

DATE ACCEPTED	**BY: STAFF NAME**		☐ **Verified Information** ☐ **Entered In Daxko** ☐ **Welcome Letter** ☐ **Copied for Site**
DATE PROCESSED	**BY: STAFF NAME**		
Approved by Program Director: ☐ **No** ☐ **Yes**	**Program Director Signature**	**Date:**	

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

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 _____

MEDICAL INFORMATION

OPERATIONS/CHRONIC ILLNESSES

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. If listed, a plan of care will need to be completed for each medication.

Medication:	Dosage:	Reason/Diagnosis:	Administered 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	
PHYSIAL 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**	

PARENT/GUARDIAN FULL NAME	**AUTHORIZED TO PICK UP CHILD?** ☐ Yes ☐ No	
PHYSIAL 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**	
ADDRESS	**CITY**	**ZIP CODE**
CONTACT PHONE NUMBER	**AUTHORIZED TO PICK UP CHILD?** ☐ Yes ☐ No	

EMERGENCY CONTACT FULL NAME	**RELATIONSHIP TO CHILD**	
ADDRESS	**CITY**	**ZIP CODE**
CONTACT PHONE NUMBER	**AUTHORIZED TO PICK UP CHILD?** ☐ Yes ☐ No	

EMERGENCY CONTACT FULL NAME	**RELATIONSHIP TO CHILD**	
ADDRESS	**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 camp activities including fieldtrips and swimming using rented or YMCA owned buses. I also authorize assistance to be given to my child, including staff administration of hand sanitizer.
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 the fees for both Winter Break Weeks are due by December 16th or a late fee will apply. If payment is not received by this date, a $25 late fee and suspension of care will apply.

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	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 registration fee/full payment for the month officially enrolls your child in the YMCA Child Care program. Your child will begin child care 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: _____

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 ☐ YMCA Child Care participant ☐ Friend ☐ YMCA Branch ☐ Mailer ☐ School ☐ 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

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 METHOD - Fees are for both weeks of winter camp are due by Wednesday, December 16, 2020.

☐ I choose to auto draft with credit card or debit card

Select your drafts dates: ☐ December 9th ☐ December 16th (*Mark both weeks to split draft between the two weeks*)

☐ **Use Card On File**

☐ **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 16th of December 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 and have read all payment policies and procedures, chosen my payment method, and agree to abide by all policies in place. I understand failure to uphold my payment arrangements will result in a $25 late fee as well as a suspension 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. I understand the late payment policy is enforced regardless of who is responsible for the late payment.
INITIAL	Returned debit/credit card charges will be assessed a $30 fee by the YMCA.
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.

Signature: _____ **Date:** _____

Please return this packet to:

YMCA Child Care Business Office
1614 S. Mildred St. Ste. #1, Tacoma, WA 98465
P 253-534-7840 **F** 253-983-0459 **E** childcare@ymcapkc.org