

CHILD'S FULL NAME: _____

DATE OF BIRTH: _____

Spring Break Registration 2021

YMCA Child Care

YMCA OF PIERCE AND KITSAP COUNTIES



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Return registration to one of the following by March 31, 2021:

- 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	
SITE YOUR CHILD WILL ATTEND		SELECT DAYS OF ATTENDANCE	
<input type="checkbox"/> Geiger 7401 S. 8th St, Tacoma, WA 98465 <input type="checkbox"/> Washington 2615 N Adams St, Tacoma, WA 98465		<input type="checkbox"/> Monday, April 5 th <input type="checkbox"/> Tuesday, April 6 th <input type="checkbox"/> Wednesday, April 7 th <input type="checkbox"/> Thursday, April 8 th <input type="checkbox"/> Friday, April 9 th	

CLOVER PARK SCHOOL DISTRICT		Site Hours: 6:30am-6:30pm	
SITE YOUR CHILD WILL ATTEND		SELECT DAYS OF ATTENDANCE	
<input type="checkbox"/> Custer 7801 Steilacoom Blvd SW Lakewood, WA 98498		<input type="checkbox"/> Monday, April 5 th <input type="checkbox"/> Tuesday, April 6 th <input type="checkbox"/> Wednesday, April 7 th <input type="checkbox"/> Thursday, April 8 th <input type="checkbox"/> Friday, April 9 th	

FRANKLIN PIERCE SCHOOL DISTRICT		Site Hours: 6:30am-6:00pm	
SITE YOUR CHILD WILL ATTEND		SELECT DAYS OF ATTENDANCE	
<input type="checkbox"/> TBD		<input type="checkbox"/> Monday, April 5 th <input type="checkbox"/> Tuesday, April 6 th <input type="checkbox"/> Wednesday, April 7 th <input type="checkbox"/> Thursday, April 8 th <input type="checkbox"/> Friday, April 9 th	

FEES	
YMCA Member <input type="checkbox"/> 5 days per week \$225.00 per week <input type="checkbox"/> \$50 daily Total number of days _____	

Everyone is welcome. Financial assistance, fee subsidy for qualifying military families, DSHS and other third party provider assistance is available. The military provides fee assistance to Army Civilians and Active Duty Military.

FOR OFFICE USE ONLY			
DATE ACCEPTED	BY: STAFF NAME	<input type="checkbox"/> Verified Information <input type="checkbox"/> Entered In Daxko <input type="checkbox"/> Welcome Letter <input type="checkbox"/> Copied for Site	
DATE PROCESSED	BY: STAFF NAME		
APPROVED BY PROGRAM DIRECTOR <input type="checkbox"/> Yes <input type="checkbox"/> No	PROGRAM DIRECTOR NAME	CC SITE	DATE APPROVED

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 <input type="checkbox"/> Male <input type="checkbox"/> Female
HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR
WHO DOES CHILD LIVE WITH? (Check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Step Parent <input type="checkbox"/> Other _____			

MEDICAL INFORMATION**OPERATIONS/CHRONIC ILLNESSES**

LAST MEDICAL EXAM/PHYSICAL	DATE OF LAST DENTAL EXAM
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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:	Administered daily by staff?
			<input type="checkbox"/> No <input type="checkbox"/> Yes*
			<input type="checkbox"/> No <input type="checkbox"/> Yes*
			<input type="checkbox"/> No <input type="checkbox"/> 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	

CHILD'S FULL NAME: _____

DATE OF BIRTH: _____

PARENT/GUARDIAN INFORMATION

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

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

EMERGENCY CONTACT FULL NAME	RELATIONSHIP TO CHILD	
ADDRESS (no PO Box)	CITY	ZIP CODE
CONTACT PHONE NUMBER	AUTHORIZED TO PICK UP CHILD? <input type="checkbox"/> Yes <input type="checkbox"/> 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 are due by March 31st 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	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 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 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.



Certificate of Immunization Status (CIS)

For Kindergarten-12th 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

Parent/Guardian Signature Required

Date

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

CHILD'S FULL NAME: _____

DATE OF BIRTH: _____

◆ Required for School and Child Care/Preschool	Date	Date	Date	Date	Date
● Required Only for Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	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 <i>Healthcare provider use only</i>		
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:		
<input type="checkbox"/> a verified history of Varicella (Chickenpox).		
<input type="checkbox"/> 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: _____

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 INFORMATIONIs your child a military dependent? ☐ Yes ☐ NoBranch of Military: ☐ N/A ☐ Army ☐ Air Force ☐ Navy ☐ Marines ☐ Coast Guard ☐ National Guard ☐ DOD CivilianWould 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 due by Wednesday, March 31st, 2020.☐ I choose to auto draft with credit card or debit card
☐ Visa ☐ MasterCard ☐ American Express ☐ Discover | **Draft Date** ☐ 1st ☐ 5th ☐ 15th

Name on Card _____ Expiration Date _____

Card Number _____ Verification Code _____

☐ **I choose not to auto draft.** I understand my payment is expected by the 1st of April 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