Summer Camp 2021
New Participant Registration
YMCA OF PIERCE AND KITSAP COUNTIES

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Return completed registration to:

- YMCA Child Care office: 3330 Kitsap Way Ste. A, Bremerton, WA 98312, Fax 360-627-9047 Email: kitsapchildcare@ymcapkc.org
- YMCA Child Care office: 1614 S Mildred St Tacoma, WA 98465, Fax 253-853-0459, Email: childcare@ymcapkc.org

SELECT A LOCATION	
PIERCE COUNTY	**KITSAP COUNTY:**
☐ **CUSTER | 7 AM-6:30 PM** ☐ **FRANKLIN PIERCE (Location will be announced once confirmed) | 6:30 AM-6:30 PM** ☐ **PURDY | 6:30 AM-6:30 PM** ☐ **WASHINGTON | 7 AM-6 PM** ☐ **SHERMAN | 7 AM – 6PM** ☐ **UNIVERSITY PLACE ELC | 6 AM-6PM**	☐ **CROWNHILL | 6 AM-6 PM** ☐ **EPO | 6 AM-6 PM** ☐ **CENTRAL KITSAP (Location will be announced once confirmed) | 6 AM-6 PM**

JUNE		**PAYMENT DUE DATE:**
☐ WEEK 01	June 28-July 2	**WEEK 1 Fee Due: Wednesday June 23**
JULY		
☐ WEEK 02	July 6-July 9 **CLOSED MON.**	**WEEK 2 Fee Due: Wednesday June 30**
☐ WEEK 03	July 12-July 16	**WEEK 3 Fee Due: Wednesday July 7**
☐ WEEK 04	July 19-July 23	**WEEK 4 Fee Due: Wednesday July 14**
☐ WEEK 05	July 26-July 30	**WEEK 5 Fee Due: Wednesday July 21**
AUGUST		
☐ WEEK 06	Aug 2 Aug 6	**WEEK 6 Fee Due: Wednesday July 28**
☐ WEEK 07	Aug 9-Aug 13	**WEEK 7 Fee Due: Wednesday August 4**
☐ WEEK 08	Aug 16-Aug 20	**WEEK 8 Fee Due: Wednesday August 11**
☐ WEEK 09	Aug 23-Aug 27	**WEEK 9 Fee Due: Wednesday August 18**

Select weekly schedule for summer | $225 Full week or $50 per day					
	☐ 1 day a week	☐ 2 days a week	☐ 3 days a week	☐ 4 days a week	☐ 5 days a week
Select Days of attendance:					
	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday

Changes or Cancellations?

Changes & cancellations must be received at the child care office the **Monday prior to the week of care** you need to change. No credits or refunds will be given if notice has not been received by this deadline.

FOR OFFICE USE ONLY			
DATE ACCEPTED	**BY: STAFF NAME/SITE**	☐ **VERIFIED INFORMATION** ☐ **DISCOUNTS/SUBSIDIES** ☐ **AUTHORIZED PICK UP** ☐ **REG IN SALESFORCE**	☐ **SCHEDULED PAYMENTS** ☐ **WELCOME LETTER** ☐ **CHILD FILE COPIED**
DATE ENTERED IN SF	**BY: STAFF NAME**		
DATE APPROVED:	**PD APPROVAL | SIGNATURE**		

CHILD NAME: ______________________________ BIRTHDATE: ______________

All fields must be completed for registration packet to be considered complete.

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN FULL NAME	**DOB:**	**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**	

PARENT/GUARDIAN FULL NAME	**DOB:**	**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**	

WHO DOES CHILD LIVE WITH? (SELECT ALL THAT APPLY)

☐ **PARENT(S)** ☐ **STEPPARENT** ☐ **GRANDPARENT(S)** ☐ **GUARDIAN** ☐ **OTHER**

IF APPLICABLE, WHO IS CUSTODIAL PARENT/GUARDIAN?

IF APPLICABLE, WHO IS NOT AUTHORIZED TO PICK UP CHILD? (Must provide legal documentation with registration packet.)

EMERGENCY CONTACTS

(Local contacts only, must be different than parent/guardians listed above. 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 NAME: _____ BIRTHDATE: _____

All fields must be completed for registration packet to be considered complete.

CHILD'S INFORMATION (One form per child)

CHILD'S FIRST NAME		CHILD'S LAST NAME	
DATE OF BIRTH	**AGE**	**GRADE (FALL 2021)**	**GENDER** ☐ Male ☐ Female
HEIGHT	**WEIGHT**	**EYE COLOR**	**HAIR COLOR**

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 Plan of Success 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

(If child has no medical or dental provider, parent/guardian must provide a written plan for medical or dental injury or incident.)

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**

MUST BE SIGNED ON BOTH SIGNATURE LINES.

BIRTHDATE:

All fields must be completed for registration packet to be considered complete.

CHILD 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

Required Vaccines for School or Child Care Entry	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**
♦ **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

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-**397-0337.**

CHILD NAME: _____ BIRTHDATE: _____

All fields must be completed for registration packet to be considered complete.

PARENT/GUARDIAN GUIDE ACKNOWLEDGEMENT

READ AND INITIAL EACH STATEMENT

INITIAL	I understand that I can find the Parent/Guardian Guide online at ymcapkc.org/childcare and I am responsible for reading it.
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. Please refer to Parent/Guardian Guide for clarification.

STATEMENT OF UNDERSTANDING, PERMISSION, AND COMPLIANCE

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 understand I can request a health care plan that includes the child care disaster plan, from the business office and am responsible for reading it.
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 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 themselves while at site.
INITIAL	**Acknowledgement of Attendance policy:** The YMCA Child Care branch is committed to the safety of students and staff. 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 and no refunds will be provided for lack of attendance. All participants who are registered for care are expected to attend.** 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 2020-2021 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.
INITIAL	With my signature below, I agree to the policies outlined in this form and the Parent Handbook Guide information, including cancellations (due to unpaid tuition and behavior) and refund policies.
INITIAL	By signing this you are acknowledging that you understand our health screen process and when you sign your child into our program you are confirming that you have read and answered "no" to all the health screening questions.

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.

CHILD NAME: _____ BIRTHDATE: _____

All fields must be completed for registration packet to be considered complete.

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 ☐ Facebook ☐ I'm a 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

FEES –Fees are due weekly each Wednesday prior to week

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**

☐ **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 fees are due <u>weekly</u> each Wednesday.** If fees are not received, On Thursday, a $25 late payment fee will apply. On Friday, care for the following week will be cancelled. The late payment fee plus weekly fees will be due in order to return to care.
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. **No changes or credits will be made or given after this deadline.**

Signature _____ Date _____