



To complete the registration process,
please fill out and return the following:

- Registration Form
- Emergency Information and Immunization Record Card
 - A copy of your child's Immunization Record
 - Bring them into your local YMCA.

Thank you.



AHWATUKEE FOOTHILLS FAMILY YMCA 2010 – 2011 Childcare Registration Form

Child's Name _____ Birth Date _____ Grade (2010/2011) _____

Parent's Name _____ Address _____

City _____ Zip Code _____ Home # _____ Work # _____

Parent's E-mail Address _____ Cell # _____

Start Date: _____

| Check Site: <u>SIERRA</u> <u>YMCA</u> | Draft on the 5 th of every month Due on the FIRST of every month |
|---|--|
| 1. After School Plan FT (4 days or more) On-site after school child care from school dismissal until 6:30 P.M. Includes early release days. | \$215 |
| 2. After School Plan PT (3 days or less) On-site after school care from school dismissal until 6:30 P.M. Includes early release days. (Sierra Only) | \$171 |
| 3. Wednesday Early Release (Sierra Only) 12:35 PM – 6:30 PM | \$105 |
| 4. Transportation From: (minimum number required per school) ___ Cerritos ___ Colina ___ Esperanza ___ Lagos ___ Monte Vista ___ Estrella ___ Lomas ___ Milenio | \$44 |

Program Closed: Labor Day (Sept 6th), Thanksgiving Day and day after (Nov 25th & 26th), Christmas Eve & Christmas Day (Dec 24th & 25th),
 New Year's Eve & New Year's Day (Dec 31st & Jan 1st), Memorial Day (May 30th)

Registrations will not be accepted without the following attached:

- Signed registration form
 Completed blue card
 Immunization record
 Bank draft form & credit debit number or "voided" check

ALL PLANS ARE ON A LEVEL PAY SYSTEM. ALL THE DAYS OF SCHOOL ARE ADDED TOGETHER AND DIVIDED INTO 10 EQUAL PAYMENTS DUE MONTHLY THROUGHOUT THE YEAR. PAYMENTS WILL REMAIN CONSTANT, INCLUDING MONTHS THAT CONTAIN INTERSESSIONS & WINTER BREAK. FULL PAYMENTS ARE DUE IN DECEMBER, MARCH, AND MAY. ALL PLANS USE THE BANK DRAFT (CHECKING ACCOUNT OR CREDIT/DEBIT CARD) AND ARE WITHDRAWN ON THE 5TH OF EACH MONTH. NO ACCOUNT CREDIT FOR ABSENT DAYS. PLEASE READ STATEMENT OF SERVICES REGARDING POLICIES. DUE DATES ARE LISTED BELOW. IF YOUR PAYMENT IS RETURNED NSF FOR ANY REASON, THE ITEMS WILL BE RE-PRESENTED ELECTRONICALLY AND YOU WILL BE CHARGED A \$25 PROCESSING FEE. YOU MAY DISENROLL WITH A 2 WEEK PRIOR WRITTEN NOTICE.

BANK DRAFT DUE DATES:

* **AUG 5 SEP 5 OCT 5 NOV 5 DEC 5 JAN 5 FEB 5 MAR 5 APR 5 MAY 5**

*Payment **DUE** at time of registration

I have read, understand, and agree to adhere to the YMCA child care program Statement of Services, payment policies, and give the YMCA permission to use photographs of my child, in a group setting, for YMCA promotional materials.

Parent/Guardian's Signature _____ Date _____

DUE AT TIME OF REGISTRATION:

| | | | | | | |
|---|---|--|-----|----|----|--|
| \$ | Total due that will not be bank drafted (<i>Staff: Must collect one draft please</i>) | For office use only | | | | |
| \$ 104 | Annual Youth Facility Membership | Member # | | | | |
| \$ | Total due today | Starfund # | | | | |
| Paid by: Check # _____ If CASH Please Check _____ | | Comments: | | | | |
| Credit Card # | Exp Date | | | | | |
| Cardholder's Name | | Staff initials: _____ Date in: _____ | | | | |
| Draft Begins on | | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">CCC</td> <td style="width: 25%;">BC</td> <td style="width: 25%;">IR</td> <td style="width: 25%;"></td> </tr> </table> | CCC | BC | IR | |
| CCC | BC | IR | | | | |

Financial Assistance is available upon request. You must fill out and attach a Financial Assistance Form and provide proof of income. DES participants must attach your Certificate of Authorization to this form.



CDC/SGH # or name: _____

Emergency Information and Immunization Record Card

| | | |
|--|-----------------------|--|
| Child's Name: | Date Enrolled: | Updated: |
| Home Address (#, Street, City): | | Date Disenrolled: |
| Home Phone: | Date of Birth: | Sex: <input type="checkbox"/> male <input type="checkbox"/> female |

| | | |
|---------------------------------|--|------------------------|
| Mother or Guardian Name: | Home Address (#, Street, City): | Home Phone: |
| Cell Phone (optional): | Business Address (#, Street, City): | Business Phone: |

| | | |
|---------------------------------|--|------------------------|
| Father or Guardian Name: | Home Address (#, Street, City): | Home Phone: |
| Cell Phone (optional): | Business Address (#, Street, City): | Business Phone: |

I authorize the following individuals to collect my child from the facility if I cannot be located:

| | | |
|--------------|-----------------------------------|---------------|
| Name: | Address (#, Street, City): | Phone: |
| Name: | Address (#, Street, City): | Phone: |
| Name: | Address (#, Street, City): | Phone: |
| Name: | Address (#, Street, City): | Phone: |

The following individual(s) may NOT remove my child from the facility:

| |
|-----------------|
| Name(s): |
|-----------------|

Custody papers have been provided and are on file at the facility. yes no

If Medical care is necessary, CALL:

| | | | |
|-----------------|--------------|-----------------------------------|---------------|
| DOCTOR | Name: | Address (#, Street, City): | Phone: |
| HOSPITAL | Name: | Address (#, Street, City): | Phone: |

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

| |
|---|
| In case of injury or sudden illness, I request that this individual be called first: |
|---|

Does your child have insurance coverage? No Yes Name of Insurance Company:

Telephone Authorization Code : _____ (optional)

Immunization Information

For information regarding current immunization requirements go to:
www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

| | |
|--------------------------|---|
| <input type="checkbox"/> | Copy of current official documented immunization record attached |
| <input type="checkbox"/> | Religious Beliefs exemption form signed by parent/guardian attached |
| <input type="checkbox"/> | Medical Exemption form signed by physician and parent/guardian attached |
| <input type="checkbox"/> | Signed Laboratory Proof of Immunity form attached |

| | | | |
|--|-------------|-------------|-------------|
| Notification of immunizations needed sent to Parent(s) or Guardian(s): | mo /day/ yr | mo /day/ yr | mo /day /yr |
| Updated immunizations received and attached: | mo /day/ yr | mo /day/ yr | mo /day /yr |

Medical Information

| |
|--|
| Is child allergic to food or other substances? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs: |
| Is child usually susceptible to infections and if so, what precautions need to be taken? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list precautions: |
| Is child subject to convulsions and what should be our procedure if one occurs? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify procedure: |
| Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list precautions: |
| Additional comments: |
| Other special instructions: |

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

| | | |
|-------------------------------|--------------|-------|
| Parent/Guardian PRINTED Name: | SIGNED Name: | DATE: |
| | | |