



Program: School Age Child Care
 App. rec'd by: _____
 Date rec'd: ___/___/___

RARITAN BAY AREA YMCA Child Care Enrollment Application

Check the school your child is or will be attending for this school year:

A.V. Ceres 445 State St. <input type="checkbox"/>	Dr. H.N. Richardson 318 Stockton St. <input type="checkbox"/>	J.J. Flynn 850 Chamberlain Ave. <input type="checkbox"/>	R.N. Wilentz 51 State St. <input type="checkbox"/>	E.J. Patten 500 Cortland St. <input type="checkbox"/>
S.E. Shull 380 Hall Ave. <input type="checkbox"/>	W.C. McGinnis 271 State St. <input type="checkbox"/>		Holiday Care <input type="checkbox"/>	

Are you an Active Member at our Y? No Yes If no, would you like information about the Y? No Yes

How did you hear about the YMCA?

- Radio Television Billboard Live in Area YMCA Direct Mail E-mail
 Yellow Pages Newspaper Magazine Place of Employment Member Former Member
 Friend/Family Medical Referral Website/Internet Other: _____

Participant's Information:

Child's Name: _____ Age: _____ D.O.B.: ___/___/___ Gender: M / F
 Home Address: _____ City: _____ State: ___ Zip: _____

Parent's Information:

Mother's Name: _____ D.O.B.: ___/___/___
 Home Address: _____ City: _____ State: ___ Zip: _____
 Phone No.: _____ Cell No.: _____
 Employer: _____ Address: _____ Work No.: _____
 E-mail Address: _____

Father's Name: _____ D.O.B.: ___/___/___
 Home Address: _____ City: _____ State: ___ Zip: _____
 Phone No.: _____ Cell No.: _____
 Employer: _____ Address: _____ Work No.: _____
 E-mail Address: _____

Who is Guardian? Both Parents Mother Father Grandparents Guardian

Emergency Contact/Authorized Pick-Up

Person(s) authorized to pick-up and/or contact in case of emergency, if neither parent is available. These people are required to show identification when picking-up your child and must be 18-years old and over.

1. Name: _____ Relationship to child: _____ Phone No.: _____
 Address: _____ City: _____ State: ___ Zip: _____

2. Name: _____ Relationship to child: _____ Phone No.: _____
 Address: _____ City: _____ State: ___ Zip: _____

(PLEASE COMPLETE OTHER SIDE)

Health and Insurance Information:

Does your child have health insurance? No Yes

If no, would you like information/resources regarding health insurance? No Yes

Child's Physician: _____ Address: _____ Phone No.: _____

Insurance Provider: _____ Policy No.: _____ Phone No.: _____

EMERGENCY MEDICAL INFORMATION: Please check, if the participant has a history of any of the following:		IMMUNIZATION INFORMATION: Please provide a copy of your child's most recent record		
<input type="checkbox"/>	ASTHMA		Date Received	Check, if Needed
<input type="checkbox"/>	DIABETES	TETANUS		<input type="checkbox"/>
<input type="checkbox"/>	HEART TROUBLE	POLIO		<input type="checkbox"/>
<input type="checkbox"/>	FAINTING SPELLS	CHICKEN POX		<input type="checkbox"/>
<input type="checkbox"/>	HIGH BLOOD PRESSURE	WHOOPING COUGH		<input type="checkbox"/>
<input type="checkbox"/>	CONVULSIONS	MEASLES		<input type="checkbox"/>
<input type="checkbox"/>	CONTACT LENS	RUBELLA		<input type="checkbox"/>
<input type="checkbox"/>	ALLERGY, if so what?	DIPHTHERIA		<input type="checkbox"/>
<input type="checkbox"/>	ANY OTHER CONDITIONS REQUIRING SPECIAL CARE, MEDICATION OR KNOWLEDGE, IF SO WHAT?	MUMPS		<input type="checkbox"/>

Demographic Information Optional:

Race: Asian/Pacific Islander African American/Black Alaskan Native Caucasian/White
 Hispanic Native American Other: _____

Household Income: 0-\$13,999 \$14,000-\$24,999 \$25,000-\$39,999
 \$40,000-\$54,999 \$55,000-\$74,999 \$75,000 and over

Marital Status: Single Married Separated Divorced Widowed

HEALTH VERIFICATION, ACTIVITY AUTHORIZATION and PHOTOGRAPHY RELEASE:

As the parent/guardian, I verify that my child is in good physical health and is authorized to participate in all activities including but not limited to HIKING, WATER ACTIVITIES and COMPETITIVE SPORTS. I understand that the program may take WALKING TRIPS within the neighborhood. Initial _____

I understand that in the event of an emergency, I authorize the transfer of my child's health record to the health provider. Initial _____

I authorize YMCA staff to provide minor first aid, as deemed necessary, for the well being of my child. Initial _____

I understand that my child may be photographed while at activities, camp, and programs. I give the Y permission to use the pictures/videos of my child for the Y's promotional and marketing materials such as newsletters, local newspaper, website and or brochures. Initial _____

STATEMENT OF VERIFICATION:

I have completed this application accurately and I understand that misinformation can result in immediate dismissal from all YMCA programs.

Parent's Signature: _____ Date: _____

I have received the Parent Handbook which outlines the general organizational information, fees, and certain child care policies including the Required Parent Information Statement, Guidelines for Positive Discipline Policy, Child Release Policy, Expulsion Policy, and Management of Communicable Diseases.

Parent's Signature _____ Date: _____