

Downriver Family YMCA
School-Age Care

Registration Form

Please print and complete one registration form for each child

Member #: _____

Child's Name: _____

Child's Birthday: _____ / _____ / _____

Parent's Name: _____

Address: _____

City & Zip: _____

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Second Parent's Name: _____

Address: _____

City & Zip: _____

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Note: A \$30 non-refundable, non-transferable registration fee is required at the time of registration

School child will be attending: _____

Care requested (circle all appropriate):

MON TUES WED THU FRI
 BEFORE CARE AFTER CARE

HALF DAYS ONLY

Start Date: _____

Schedule Changes and Termination: All termination requests and changes to your regular schedule must be done in writing and turned into the Downriver Family YMCA at least two weeks in advance. All schedule changes take effect at the beginning of a new period (Monday) and your account will be charged through the end of the period (Friday). Forms are available at the front desk for your convenience.

If you need to add a single day, please submit the request in writing to the Downriver Family YMCA by no later than 2p.m. that day.

If you need special accommodations to a regular schedule please contact Sandra Wolff-Aller directly at 734.282.9622 x210. Processing charges will apply to any special scheduling accommodations.

Signature of mother/legal guardian

Date

Signature of father/legal guardian

Date

Parent Agreement

Please read and sign

I/we understand that I/we will be billed monthly and that payment is due no later than the first of each month. I/we understand that my invoice is based on the information listed in this packet.

I/we understand that I/we as parent(s)/guardian(s) for the child being enrolled am/are responsible for payments regardless of whether or not my child is in attendance.

If there are any revisions to my/our child's schedule, I/we understand that I/we must notify the director in writing, at least two weeks in advance. If my/our child attends part-time, I/we understand that I/we can enroll my/our child for additional time at an additional cost.

I/we hereby also read the school-age care registration brochure and understand the policies of the YMCA School-Age Care Program.

MEDICAL RELEASE

1. I/we hereby grant permission to the YMCA staff to take whatever steps necessary to obtain emergency medical care if wanted. These steps may include, but are not limited to the following:
2. Attempt to contact a parent or guardian.
3. Attempt to contact the child's physician
4. Attempt to contact the parent or guardian through the list of persons listed on the emergency information completed.
5. If we cannot contact any of the above persons, the YMCA will:
 - Call an ambulance.
 - Call another physician.
 - Have the child transported to an emergency room by a YMCA staff member.
6. Any expenses listed under No. 5 above will be charged to the child's parents and/or legal guardian.

SWIMMING PERMISSION

I/we give my/our child permission to swim during YMCA's School-Age Care Program.

I HAVE READ AND AGREE TO THE PARENT INFORMATIONAL HANDBOOK.

TRANSPORTATION

I/we understand that my/our child may be transported in the YMCA bus or van.

PICTURE RELEASE POLICY

I/we hereby grant full and irrevocable consent to release my/our child's photograph to the YMCA of Metropolitan Detroit for commercial and art purposes in any medium of advertising, communications, publication or publicity, alone or in conjunction with other persons, objects, photos, voice or text materials and either with or without my name or accompanying quotation.

FINANCIAL RESPONSIBILITY

I/we certify by my/our signature(s) that I/we will be financially responsible for all charges, fees, etc. I/we understand that in the event of non-payment, the YMCA may elect to refer my/our account to a collection agency or may seek other legal redress for non-payment. I/we understand that there will not be any credit given for days not used.

Signature of mother/legal guardian

Date

Signature of father/legal guardian

Date

**CHILD INFORMATION RECORD
STATE OF MICHIGAN
Department of Human Services
Bureau of Children and Adult Licensing**

Date of Admission		Allergies					
Date of Discharge							
Name of Child (Last, First, Middle Initial)				Address (Number and Street, Building/Apartment Number)			
Child's Date of Birth		Home Phone ()		City		State	Zip Code
Father/Legal Guardian's Name		Home Phone		Mother/Legal Guardian's Name		Home Phone	
Home Address (if not child's address)		Cell Phone		Home Address (if not child's address)		Cell Phone	
City	State	Zip Code		City	State	Zip Code	
Employer/School Name				Employer/School Name			
Address (Employer/School)				Address (Employer/School)			
City	State	Zip Code		City	State	Zip Code	
Employer/School Phone		Daily Work/School Times		Employer/School Phone ()		Daily Work/School Times	
Name(s) of Person other than Parent or Legal Guardian to whom child may be released							

BCAL-3731 (Rev. 3-08) Previous edition may be used.

See Reverse Side

I give permission to _____, licensed by the Department of Human Services (Provider's Name)			
to secure emergency medical and/or emergency surgical treatment for the above named minor child while in care.			
Signature of Parent or Guardian			Date Signed
Name of Child's Physician or Health Clinic		Physician's or Health Clinic's Phone Number ()	
Address of Child's Physician or Health Clinic		Name of Health Insurance Carrier	
Hospital Preferred for Emergency Treatment		Health Insurance Policy Number	
Special Needs:		Date of Last DTaP (Diphtheria, tetanus, pertussis) Shot	
Name of Local Person to be Notified in an Emergency When Parents Not Available		Local Address of Emergency Person	
Home and/or Cell Phone ()	Work Number ()	City, State	Zip code
Special Instructions:			
Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.			AUTHORITY: 1973 PA 116 COMPLETION: Required PENALTY: Rule Violation Citation.

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CHILD INFORMATION FORM

Child's Name: _____

Parent's Name: _____

Is there any special information the staff should know about your child in order to make your child's experience in the summer day camp program safe and enjoyable?

Please list any known allergies:

PICK UP & DROP OFF POLICIES

Before Care: 7a.m.

After Care: End of school-6p.m.

For the safety of all children we ask that you please refrain from picking your child or children up after 6:00 p.m. If it is past 6:00 p.m. when my child is picked up I understand that I am subject to late charges of **\$5.00 for the first 15 minutes and \$1.00 for ever minute there after.**

I understand and agree to the terms presented in this document.

Parents or Guardian Signature: _____

Date: _____

EXPECTATIONS OF A YMCA SACC PARTICIPANT

The YMCA staff uses developmentally appropriate positive methods of discipline which encourage self-control, self-direction, self-esteem, and cooperation.

While attending the Downriver YMCA SACC Program, I will pledge to do the following:

1. I will not use bad language or obscene gestures.
2. I will not call other Camp participants or YMCA staff names or tease.
3. I will not hit or threaten another Camp participant or YMCA staff.
4. I will not fight or cause harm to others.
5. I will not spit on other SACC participants or adults.
6. I will not leave my group without letting my YMCA staff know where I am.
7. I will not destroy the property of the YMCA or other Camp participants.
8. I will not bring any object to the YMCA program that may be used as a weapon (pocket knives, matches, ropes, etc.).
9. I will be responsible for my garbage and will clean up any mess that I make.
10. I will follow direction given to me by my YMCA staff or other adults.
11. I will be respectful to other people who are in the building or YMCA.
12. I will not steal anything from other Camp participants or the YMCA.

Pool Rules (when visiting the YMCA):

1. I will not run on the pool deck.
2. I will not jump in an area where others are swimming.
3. I will not splash those who choose not to be splashed.
4. I will not spit or urinate in the pool.

I understand that if I do not follow these rules and/or continue to be disrespectful to others, I will no longer be allowed to attend the YMCA Summer Day Camp program. I also understand that if I fight or cause harm to others, my parents will be called and I will not be allowed to return to the program.

SACC Participants Name: _____ Date: _____

Parents Signature: _____ Date: _____

SECTION III -- PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS
EXAMINATIONS AND/OR INSPECTIONS

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

TESTS AND MEASUREMENTS

	Within Normal Limits	Under Care	Referred		Within Normal Limits	Under Care	Referred
Vision Tested? <input type="checkbox"/> Visual Activity <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Muscle Imbalance Date _____ <input type="checkbox"/> Other _____ (Specify)				Urinalysis Done? <input type="checkbox"/> Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Albumin Date _____ <input type="checkbox"/> Microscopic			
Hearing Tested? <input type="checkbox"/> Audiometer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____ Date _____ (Specify)				Blood Pressure Measured? <input type="checkbox"/> Yes <input type="checkbox"/> No Reading _____			
Hemoglobin/Hematocrit Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No				Height _____ Weight _____ Other:			
Blood Lead Level Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Result _____				Blood Lead level recommended for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high risk areas should be tested at the same intervals as noted above.			

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

Tuberculin Test (if given) Date _____ Type _____ Negative Positive _____ mm.

SECTION IV -- RECOMMENDATIONS

Is there any defect of vision, hearing, or other condition for which the school could help by seating or other action? Yes No
If yes, please explain:

Should the student's activity be restricted because of any physical defect or illness? Yes No If yes, check below and explain degree of restriction:

Classroom Playground Gymnasium Swimming Pool Competitive Sports Camp Other

Examiner's Signature _____ Date _____ Examiner's Name (print or type) _____ Degree or License _____

Number & Street _____ City _____ Zip _____ Telephone _____

SECTION V -- DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ Child's Name _____ teeth and make the following recommendations as for treatment:

Dentist's Signature _____ Date _____

COMMENTS
