



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# SCHOOL AGE CARE YMCA OF SPRINGFIELD 2018-2019 SCHOOL YEAR

Chatham, Riverton, Rochester, Williamsville - Sherman

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Please register my child for the following program:

- Chatham Elementary After Care
- Ball Elementary After Care
- Glenwood Elementary Before Care
- Riverton Elementary After Care
- Rochester Elementary After Care
- Glenwood Elementary After Care
- Williamsville-Sherman After Care
- Glenwood Elementary BOTH

After Care Week (Three days or more):	Member: \$60	Public: \$70
After Care Part-Time (Two days or less):	Member: \$30	Public: \$35
Before Care Week (Glenwood Only):	Member: \$32	Public: \$42
Before and After Week (Glenwood Only):	Member: \$75	Public: \$85

**Preferred Start Date:**

A \$35 non-refundable fee is due at time of registration. If enrollment is cancelled during the 2018-2019 school year, a \$100 non-refundable fee will be assessed prior to re-enrollment in 2018-2019 school year.



### YMCA of Springfield Authority to Draw Preauthorized Checks for YMCA School Age Program

Name of Customer	Name of Financial Institution
Mailing Address of Customer	City, State, Zip Code
Select Bi Monthly or Monthly Withdrawal Date: 1st 15th	Select Account <b>checking</b> - submit a voided check <b>savings</b> - submit routing and transit number on bank letterhead

I have given authority to the above named financial institution to honor preauthorized payments drawn by you from my account for payments as indicated above. It is understood that your sending of a preauthorized check to the bank as a payment becomes due shall constitute valid notice of such payment due on this membership. When the bank honors the check by charging my account, such check shall constitute my receipt for the payment. Should any preauthorized check not be honored by said bank when received by them, it is understood the payment is to be made by you in the amount of said payment.

\_\_\_\_\_  
Signature of Bank Depositor



For Office Use Only: SAP18 Branch 1 Date \_\_\_\_\_ Amount \_\_\_\_\_ Staff \_\_\_\_\_



## PARTICIPANT

\_\_\_\_\_   
 First and Last Name

### PARENT/GUARDIAN (1)

Full Name \_\_\_\_\_

Work # \_\_\_\_\_

Cell (Required) \_\_\_\_\_

Day/Work Location \_\_\_\_\_

Primary E-Mail (Required) \_\_\_\_\_

Address (if different than child's) \_\_\_\_\_

### PARENT/GUARDIAN (2)

Full Name \_\_\_\_\_

Work # \_\_\_\_\_

Cell (Required) \_\_\_\_\_

Day/Work Location \_\_\_\_\_

### EMERGENCY NOTIFICATION INFO (Required)

In case of an emergency, if after both primary guardians cannot be reached, please list two additional people who can be contacted and would be authorized to pick up your child. Photo ID required.

1. Name \_\_\_\_\_

Phone # \_\_\_\_\_ Relation \_\_\_\_\_

2. Name \_\_\_\_\_

Phone # \_\_\_\_\_ Relation \_\_\_\_\_

### PAYMENT INFORMATION

Fees due for child care services are billed one month in advance. Automatic Bank Draft is the preferred method of payment.

A bank draft is a continuous contract that is automatically renewed on an ongoing basis.

Any changes to services (including cancellation of draft), must be submitted in writing via the change request form no later than 10 business days in advance.

The YMCA reserves the right to discontinue services at any time due to outstanding balances. If you are unable to resolve your balance in full or make your scheduled payment you must contact the YMCA billing department, prior to your payment due date, to make a payment arrangement. All payment arrangements are up to the discretion of the billing department and will be considered on a case by case basis. Payment arrangements are not guaranteed.

For school breaks or participant absences that are a week long (Monday-Friday), a 50% reduction of fees will apply. \_\_\_\_\_

Initial

### HEALTH HISTORY

List any current allergies:

\_\_\_\_\_

List any current dietary restrictions:

\_\_\_\_\_

List any current or past medical treatment that would affect your child's day:

\_\_\_\_\_

Describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations:

\_\_\_\_\_

List any current medications (prescription and over the counter):

\_\_\_\_\_

Reasons for the above medications:

\_\_\_\_\_

### CURRENT IMMUNIZATIONS, REQUIRED (Check One)

I attest, by my signature following this statement, that all immunizations required by the IL Department of Public Health for my child's are up to date and that my child has a current DTap shot with the month and year stated below.

I attest that I have signed and provided to the YMCA a waiver exempting my child from vaccination due to religious or other reasons.

Date of last DTap shot: Month \_\_\_\_\_ Year \_\_\_\_\_

Child's medical insurance carrier: \_\_\_\_\_

Group Policy # \_\_\_\_\_

Name of Physician: \_\_\_\_\_

This information is correct and complete as far as I know, and person herein described has permission to engage in all program activities except as noted in a separate written form. I hereby give permission to the program to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the program to arrange necessary related transportation for the participant. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied as necessary for treatment or for program related travel.

Signed: \_\_\_\_\_ Date \_\_\_\_\_

### ADDITIONAL AUTHORIZATION

I have received and read a copy of the Parent Handbook and agree to abide by policies within. \_\_\_\_\_

Signature