

# FLOYD COUNTY FAMILY YMCA SCHOOL-AGE CHILD CARE • 2018-19 SCHOOL YEAR REGISTRATION FORM

Print legibly, complete all fields and include your registration fee. Register Online at [ymcalouisvillechildcare.org](http://ymcalouisvillechildcare.org).

<b>First day child will attend</b>	<b>Email address</b> <small>(To receive important program updates and registration information)</small>
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**1<sup>ST</sup> CHILD'S INFORMATION**

First name	Middle initial	Last name	Date of birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age
Race <input type="checkbox"/> Caucasian/white <input type="checkbox"/> African American/black <input type="checkbox"/> Multi racial <input type="checkbox"/> Asian American <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other					
Physical conditions/special needs			Medications/allergies		
To better serve your child, please indicate if he/she has been diagnosed with any of the following: <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Convulsions <input type="checkbox"/> Bleeding/Clotting Disorders <input type="checkbox"/> Autism <input type="checkbox"/> Aspergers <input type="checkbox"/> Fragile X <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Tourettes <input type="checkbox"/> Rhett Syndrome <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Chronic Health Problems <input type="checkbox"/> Asthma/Severe Allergies <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Other					
Does this child have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>YMCA Child Care Site</b>					
<b>Name of Child's School</b>					
Attendance <input type="checkbox"/> 1-2 Days <input type="checkbox"/> 3-5 Days		Grade in School (2018-19)			
Participation <input type="checkbox"/> Before-School Care <input type="checkbox"/> After-School Care <input type="checkbox"/> Before- & After-School Care <input type="checkbox"/> In-Service Day Care <input type="checkbox"/> Snow Day Care					

**2<sup>ND</sup> CHILD'S INFORMATION**

First name	Middle initial	Last name	Date of birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age
Race <input type="checkbox"/> Caucasian/white <input type="checkbox"/> African American/black <input type="checkbox"/> Multi racial <input type="checkbox"/> Asian American <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other					
Physical conditions/special needs			Medications/allergies		
To better serve your child, please indicate if he/she has been diagnosed with any of the following: <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Convulsions <input type="checkbox"/> Bleeding/Clotting Disorders <input type="checkbox"/> Autism <input type="checkbox"/> Aspergers <input type="checkbox"/> Fragile X <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Tourettes <input type="checkbox"/> Rhett Syndrome <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Chronic Health Problems <input type="checkbox"/> Asthma/Severe Allergies <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Other					
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Participation <input type="checkbox"/> Before-School Care <input type="checkbox"/> After-School Care <input type="checkbox"/> Before- & After-School Care <input type="checkbox"/> In-Service Day Care <input type="checkbox"/> Snow Day Care					

**1<sup>ST</sup> PARENT/GUARDIAN**

Name	Relationship to child	Date of birth / /
Address	City	State Zip
Primary phone	Cell phone (for emergency communications)	
Work phone	Employer	

**2<sup>ND</sup> PARENT/GUARDIAN**

Name	Relationship to child	Date of birth / /
Address	City	State Zip
Primary phone	Cell phone	Work phone Employer

**METRO UNITED WAY INFORMATION**

School lunch classification <input type="checkbox"/> Free <input type="checkbox"/> Reduced <input type="checkbox"/> Full pay	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
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**INSURANCE INFORMATION**

Health insurance company	Policy number
Name of physician	Physician phone

**PLEASE LIST ANY ADULT OTHER THAN THE ABOVE THAT MAY BE PICKING UP THIS CHILD OR THAT MAY BE CONTACTED IN AN EMERGENCY.**  
 Anyone picking up your child must be at least 18 years of age or older. A picture ID is required at pick-up.

Name	Relationship to child	Phone 1	Phone 2
Name	Relationship to child	Phone 1	Phone 2
Name	Relationship to child	Phone 1	Phone 2

The YMCA has permission for my children to be photographed and/or interviewed for promotional purposes  Yes  No  
 Yes, I would like to make a charitable donation to the Annual Campaign  \$10  \$25  \$50  \$100  Other/please contact me  
 Check here if either parent is  YMCA employee  Y financial assistance recipient

**You must choose one option below to process your registration. Drafts will occur each Wednesday for the current week unless otherwise scheduled through our main office.**

I am currently on draft. Please use the account on file ending in \_\_\_\_\_. **Authorized account holder signature** \_\_\_\_\_

Full payment attached. (Check or money order only!)

I am authorizing a NEW bank draft from my checking account and I have attached a voided check.

I am authorizing a NEW credit card draft and I have provided all the information below:

Credit Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	
Name on card	Authorized cc signature
Card number	Expiration date
Billing street address	Billing zip code

I have the legal authority to sign up the child/ren named on this form and to the best of my knowledge the information on this application form is complete and accurate. I understand that my application will not be processed unless it includes the full fee or automatic draft authorization. I understand that the YMCA prohibits staff members from being alone with children they meet in YMCA programs outside of the YMCA. This includes but is not limited to baby-sitting, tutoring, sleep-overs, etc. In the event I cannot be reached in an emergency, I hereby give permission to the director of the program or designee to secure emergency medical services, including transportation and medical care. I also give permission for the attending physician to order injections, anesthesia or surgery for the child/ren as named above. I understand that medical and accident insurance is the responsibility of the parent or guardian. By signing this form, I am giving the YMCA permission to communicate and exchange information with school personnel for the purpose of providing and enhancing services to my child/ren. I also authorize my child/ren to be transported by bus and engage in activities and field trips, except as noted by me. I understand that this release may be revoked by me at any time by written request. I am aware there is a Parent Packet with more detail on policies/procedures available to me. I have read and agree to these terms and conditions.

<b>Signature</b>	<b>Date Signed</b>
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