



Sussex YMCA
Blairstown
 Before & After School Program
 Registration Form
2016-2017 School Year

School: **Blairstown**

Child: _____

Birthdate: _____ **Gender:** F M

Grade as of 9/1/16: _____

Start Date: _____

Before Care: Mon Tues Wed Thurs Fri

After Care: Mon Tues Wed Thurs Fri

Please circle days needed (2-day minimum per program)

Please return this completed form to the Sussex YMCA to register for the School Age Child Care Program for the 2016-2017 school year. Please update any incorrect information.

PARENT/ GUARDIAN #1	Member#:
Name: _____	Birthdate: _____
Address: _____	Email: _____
_____	Home Phone: _____
City, State Zipcode	Work Phone# _____
Employer: _____	Cell Phone: _____

PARENT/ GUARDIAN #2	Member#:
Name: _____	Birthdate: _____
Address: _____	Email: _____
_____	Home Phone: _____
City, State Zipcode	Work Phone# _____
Employer: _____	Cell Phone: _____

EMERGENCY CONTACTS: These persons will be authorized to pick your child up at any time and must be able to arrive within one hour in case of emergency. Please provide 3 options.

Name	Relationship	Phone#1	Phone#2

Allergies / Medications:	Who may NOT pick up your child? Please provide supporting documentation.
	Name: _____ Name: _____
Special Needs:	<input type="checkbox"/> Permission granted to use photographs/video of my child in YMCA publicity
	<input type="checkbox"/> No photos or videos permitted of my child
Signature _____	

For additional information, including fill-in enabled forms, please go to our website:
www.sussexcountyyymca.org

Sussex County YMCA

Blairstown Elementary School

Monthly Tuition Schedule: 2016-2017 School Year

	Before Care	After Care	Both
5 Days/week	\$165	\$240	\$380
4 Days/week	\$145	\$220	\$360
3 Days/week	\$125	\$185	\$305
2 Days/week	\$95	\$140	\$230

Sibling Discount: A 10% discount reduction will be applied to the lesser tuitions for those families having more than one child participating in any Metro YMCA child care programs.

Financial Assistance is available to those who qualify. Please complete a Financial Assistance (F/A) application and submit it with your registration for the Before/After School program. All F/A applications must be received in our office by **July 15th**. Applications are available at our website: www.sussexcountyyymca.org

- All registration forms must be returned with payment of the first month's tuition, one month's security deposit, the \$35 registration fee, and the membership fee.
- Registration is not considered active until **payment** and **completed paperwork** is received. If space is still available, parents intending to have their child attend the program on the **first day of school** must hand in **ALL** registration paperwork no later than August 15th.



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

The following documents (available on our website) must be received to process your registration:

- Registration Form
- All Fees
- Medical Release Form
- Parent Agreement

Please send all completed paperwork and fees to:

**Sussex County YMCA
Attn: SACC Registrar
15 Wits End Road
Hardyston, NJ 07419**

\$	Annual Program Membership Fee \$80 Youth \$150 Family
\$	Registration Fee: \$35 Waived if registering before 6/30/2016
\$	First Month's tuition (less 10% sibling discount if applicable)
\$	Security Deposit: equal to one month's tuition (less 10% sibling discount if applicable)
\$	TOTAL DUE at Registration

- Checks payable to Sussex County YMCA.**
- Payment by Visa, Amex, MC, or Discover**

Name on Card: _____

CC#: _____

Exp Date: _____

Signature: _____

I am applying for Financial Assistance with: YMCA Norwescap



**SUSSEX COUNTY YMCA SCHOOL AGE CHILD CARE
MEDICAL RELEASE FORM**

Child's School _____

Child's Name: _____ Date of Birth _____

Physician: _____ Phone: () _____ - _____

Address: _____
Street Town/City State Zip

Dentist: _____ Phone: () _____ - _____

Hospital: _____

Insurance Carrier: _____ Policy#: _____

Child Information:

List any current allergies: _____

Food reactions/ restrictions: _____

Medications being taken (prescription and over the counter):

Reasons for medications: _____

The School Age Child Care Program does not dispense medication without written documentation from a doctor and the approval of the Director. Please complete the **Permission to Give Medication Form.**

Please share any special physical, educational (including IEP or 504) or emotional concerns or past medical treatments so that we can ensure our staff provide a suitable environment for your child

Parent's Authorization:

The health history is correct as far as I know, and the child herein described has vaccination records on file with the Board of Education, is in good health and has permission to engage in all the normal activities of the Before/After Care Program.

In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the medical personnel selected by the Director to transport, hospitalize, and secure proper treatment, order x-rays, injection, anesthesia or surgery and to release any records necessary for insurance purposed for my child as named above.

_____ _____
Parent/Guardian Signature **Date**



**SUSSEX COUNTY YMCA SCHOOL AGE CHILD CARE
PARENT AGREEMENT**

Child's School _____

Child's Name _____

I acknowledge that I have read the Program Policies and Parent Handbook (<http://www.metroymcas.org/sussex-county-ymca/child-care/>) and I am fully aware of the policies of the Sussex County YMCA School Age Child Care Programs. Any questions have been answered to my satisfaction by the YMCA staff.

Please retain the Program Policies and Parent Hand Book for your records. The registration process is not complete until your registration and deposit fees are paid and the following forms are completed and returned to the Sussex County YMCA:

- Registration Form
- Medical Release Form
- Parent Agreement

I also agree to complete the Permission to Give Medication Form and Permission to Walk Home Form *if applicable* for my child.

By signing below, I (we) understand and agree to accept the terms and conditions of the following YMCA policies listed in the Handbook:

- Changes, Withdrawals or Absences p.3 - 4
- Information to Parents Statement prepared by the Bureau of Licensing p.5-6
- Enrollment and Payment Policy p. 6-7
- Policy on the Release of Children p.7
- Babysitting Policy p.8
- Discipline and Expulsion Policy p.8
- Policy on Illnesses and Communicable Diseases p.9 - 10
- Inclement Weather Policy p.3

Parent/Guardian Signature

Date

Send completed paperwork to:

**Sussex County YMCA
15 Wits End Road, NJ 07419
(973) 209-9622 FAX: (973) 209-1483**



Sussex County YMCA SCHOOL AGE CHILD CARE
PERMISSION TO GIVE MEDICATION

The following information is to be completed by the child's Health Care Provider

School: _____ Child's Name: _____

DOB _____ Wt. _____

Medication: _____

Dosage _____ Route _____

Time of day medication is to be given: _____

Purpose of medication: _____

Special instructions: _____

Possible side effects: _____

Start date _____ End date _____

Health Care Provider: _____ Phone _____

PLEASE PRINT

Signature of Health Care Provider

Date

The following is to be completed by the parent or legal guardian:

I hereby give permission for my child, _____, to receive the above medication, according to the listed directions and precautions, from the Child Care Director or the Child Care Director Designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give an accurate dose of the medicine.

I authorize the Director or their Designee to contact the pharmacist or Health Care Provider for more information about this drug, if necessary. I also authorize the Director or their Designee to contact the health care provider regarding my child's health, if necessary.

Amount of medication brought to YMCA: _____

Signature of parent or legal guardian

Date

Date & amount of medication returned to Parent _____

Signature of Director/ Director Designee

Signature of Parent/ Legal Guardian



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Metro YMCAs of the Oranges
CHILD CARE AUTO-PAY AGREEMENT
AUTOMATIC MONTHLY CREDIT CARD CHARGE PLAN

CHILD(REN)'S NAME _____

PARENT/GUARDIAN NAME _____

ADDRESS _____

PHONE NUMBER (____) _____ WORK (____) _____

I HEREBY GIVE AUTHORITY TO THE METROPOLITAN YMCA OF THE ORANGES TO CHARGE MY CREDIT CARD FOR MONTHLY CHILD CARE PAYMENTS IN THE AMOUNT OF \$ _____ ON THE FIRST DAY OF THE MONTH. I UNDERSTAND ANY ADDITIONAL FEES INCURRED DURING THE MONTH WILL ALSO BE CHARGED TO MY ACCOUNT IN THE SUBSEQUENT MONTH.

VISA / MASTER CARD / DISCOVER	EXP. DATE
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AMERICAN EXPRESS	EXP. DATE
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SHOULD I DECIDE TO TERMINATE THIS AGREEMENT OR WITHDRAW MY CHILD(REN) FROM THE PROGRAM, I AGREE TO NOTIFY THE YMCA IN WRITING GIVING ONE MONTH'S NOTICE. AFTER RECEIPT OF WRITTEN NOTIFICATION, THE YMCA WILL END THE PRE-AUTHORIZED CHARGES AGAINST MY ACCOUNT AND WILL APPLY THE DEPOSIT TO THAT MONTH'S OBLIGATION.

THE YMCA RESERVES THE RIGHT TO TERMINATE THIS AGREEMENT SHOULD THE AUTHORIZED CHARGE TO MY CREDIT CARD ACCOUNT BE DECLINED AFTER TWO CONSECUTIVE ATTEMPTS.

PARENT (GUARDIAN) /CREDIT CARD HOLDER'S SIGNATURE	DATE
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