



CHILD'S INFORMATION

Legal First Name	MI	Legal Last Name
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School	Grade in Fall
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MONTHLY CARE OPTIONS	FACILITY MEMBER RATE	PROGRAM MEMBER RATE
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<input type="checkbox"/> Before School Care • Cost includes Before School Care • Does not include cost of Early Release days, Non-Student Days and Breaks	\$265/month	\$290/month
<input type="checkbox"/> After School Care • Cost includes After School Care and Early Release days • Does not include cost of Non-Student Days and Breaks	\$335/month	\$360/month
<input type="checkbox"/> After School Care Plus • Cost includes After School Care, Early Release days, Non-Student Days and Breaks	\$375/month	\$400/month
<input type="checkbox"/> Before and After School Care • Cost includes Before and After school care, Early Release days, Non-Student Days and Breaks	\$470/month	\$495/month
<input type="checkbox"/> Before and After School Care – Family Budget Option • Cost includes Before and After School Care, Early Release days, Non-Student Days and Breaks • Payments continue through the summer and include all weeks of our Summer Camp options (some restrictions may apply) • Not available for those with DSHS or other government subsidy • Must register for this option by September 30 th	\$530/month	\$555/month
<input type="checkbox"/> Early Release Days, Non-Student Days, or School Breaks	\$30/day for Early Release \$40/day for Non-Student Days and Breaks	\$40/day for Early Release \$50/day for Non-Student Days and Breaks

SITE SELECTION

Please select site and transportation if applicable:

<input type="checkbox"/> Bear Creek Elementary <input type="checkbox"/> Eastridge Elementary <input type="checkbox"/> Kenmore Elementary <input type="checkbox"/> Kokanee Elementary	<input type="checkbox"/> Maywood Hills Elementary <input type="checkbox"/> Sunrise Elementary <input type="checkbox"/> Woodin Elementary <input type="checkbox"/> Woodmor Elementary <input type="checkbox"/> Cottage Lake Elementary (serving Wellington Elementary)
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DEPOSIT

Start Date: _____ (minimum 48 hours are needed to process a registration, prior to care)

A \$50 deposit per child or payment for first month of care is required at the time of registration. \$ _____

Program Membership Fee \$50 (if applicable, is good for one year and covers the whole family) \$ _____

Total \$ _____

YMCA OF GREATER SEATTLE
Youth Program Registration Form



YOUTH INFORMATION

<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Preferred Name</i>	<i>Date of Birth</i>	<i>Gender</i>	<i>Ethnicity</i>
<i>Home Address</i>			<i>Apt</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>

SPECIFIC MEDICAL, BEHAVIORAL OR DEVELOPMENTAL NEEDS

<i>Date of Last Physical</i>	<i>Date of Last Tetanus</i>
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Depending upon your child's need, additional paperwork and a meeting with a YMCA Director may be required prior to your child's start to ensure your child can best be accommodated. Failure to share information that identifies your child's special care, accommodations or supervision needs may jeopardize the placement of or continued participation by your child in the program. Write "none" if none.

<i>Dietary Modifications/Allergy</i>	<i>Chronic/Recurring Illness</i>
<i>Current Medications (medication authorization may be required)</i>	<i>Operations/Serious Injury</i>
<i>Physical Disability</i>	<i>Behavioral Disorder</i>
<i>Developmental Delays</i>	
<i>List any activities from which your child should be exempted for health reasons:</i>	

EMERGENCY & INSURANCE INFORMATION

<i>Child's Physician</i>	<i>Phone Number</i>
<i>Local Emergency Contact (other than parents or doctor) & Phone Number</i>	<i>Out of Emergency Contact & Phone Number</i>

It is the responsibility of every individual, their parent or legal guardian, to provide for their own accident and health coverage while participating in all YMCA activities. The YMCA of Greater Seattle does not provide any accident or health coverage for its participants.

<i>Medical Insurance Company</i>	<i>Policy Number</i>
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PARENT OR GUARDIAN

<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Preferred Name</i>	<i>Date of Birth</i>	<i>Gender</i>	<i>Ethnicity</i>
<i>Home Address (if different than child)</i>			<i>Apt</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<i>Phone Number</i>	<i>Cell Phone</i>	<i>Work Phone</i>	<i>Does Child Live With You?</i>			
<i>Primary Email</i>						
<i>Employer Name</i>						

PARENT OR GUARDIAN

<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Preferred Name</i>	<i>Date of Birth</i>	<i>Gender</i>	<i>Ethnicity</i>
<i>Home Address (if different than child)</i>			<i>Apt</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
<i>Phone Number</i>	<i>Cell Phone</i>	<i>Work Phone</i>	<i>Does Child Live With You?</i>			
<i>Primary Email</i>						
<i>Employer Name</i>						

PICK UP AUTHORIZATIONS

<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Phone Number</i>		
<i>Address</i>		<i>Apt</i>	<i>City</i>	<i>St</i>	<i>Zip</i>
<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Phone Number</i>		
<i>Address</i>		<i>Apt</i>	<i>City</i>	<i>St</i>	<i>Zip</i>
<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Phone Number</i>		
<i>Address</i>		<i>Apt</i>	<i>City</i>	<i>St</i>	<i>Zip</i>
<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Phone Number</i>		
<i>Address</i>		<i>Apt</i>	<i>City</i>	<i>St</i>	<i>Zip</i>

YMCA POLICIES

Everyone is Welcome: The YMCA is a membership organization open to all people.

Financial Assistance: If you cannot afford the full cost of a program or membership, please ask for a confidential scholarship application. Financial assistance, to the extent possible, is available to those in need.

Personal Safety Discussions: Our staff will engage children in discussions to help them understand how they can set their own personal safety and touching limits. These discussions will emphasize respect, set the ground rules for appropriate behavior, and encourage children to tell if someone touches them in a way that makes them feel uncomfortable. The YMCA of Greater Seattle respects the diversity and rights of the individuals it serves.

AUTHORIZATIONS

Participation: I give permission for my child to participate in all activities, including field trips, climbing wall, overnights, and swimming and to be transported as authorized by the YMCA. I give permission for the YMCA to use any pictures of my child for future promotional purposes.

Medical Treatment: I hereby give permission for my child to be given cardiopulmonary resuscitation (CPR) and first aid treatment by a qualified staff member of the YMCA. In the event I cannot be contacted, I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I further consent to the disclosure of health information and to the medical, surgical and hospital care treatment and procedures (including, but not limited to, administration of necessary anesthetics, tests, x-ray examinations, transfusions, injections, drugs) to be performed for my child by a licensed physician or hospital selected by the YMCA director when deemed immediately necessary or advisable by the physician to safeguard my child's health.

Property Loss: I understand that the YMCA is not responsible for personal property lost, damaged or stolen while participating in these activities.

Insurance: I understand it is my responsibility to provide for my child's accident and health coverage while participating in these programs and I further understand that the YMCA does not provide this coverage.

Release from Liability and Indemnification: Recognizing that the YMCA will do its best to ensure a safe experience, I understand that accidents may occur both from my child's participation in program activities and from transportation to and from the program. I agree to assume these risks. By signing below, I release the YMCA of Greater Seattle, its employees, volunteers, independent contractors, directors and agents from all liability based on any damage, loss or injury whether it is the result of ordinary negligence or otherwise, caused to my child or to me from participation in YMCA programs. I further agree to indemnify and hold the YMCA harmless from all claims which are in any way connected with my child's participation in this program.

I have read and understand the above and have completed this form to the best of my ability.

Signature of parent or legal guardian: _____ Date: _____



Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

Office Use Only:	
Reviewed by: _____	Date: _____
Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

Child's Last Name: _____	First Name: _____	Middle Initial: _____	Birthdate (mm/dd/yyyy): _____	Sex: _____	I certify that the information provided on this form is correct and verifiable.
Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only				Parent/Guardian Name (please print): _____	

Vaccine	Dose	Date		
		Month	Day	Year
◆ Hepatitis B (Hep B)				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
Rotavirus (RV1, RV5)				
	1			
	2			
	3			
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
	1			
	2			
	3			
	4			
	5			
◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)				
	1			
	2			
● Haemophilus influenzae type b (Hib)				
	1			
	2			
	3			
	4			
● Pneumococcal (PCV, PPSV)				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
◆ Polio (IPV, OPV)				
	1			
	2			
	3			
	4			
Influenza (flu, most recent)				
◆ Measles, Mumps, Rubella (MMR)				
	1			
	2			
◆ Varicella (chickenpox) or verify disease 1-4 ▶				
	1			
	2			
Hepatitis A (Hep A)				
	1			
	2			
Meningococcal (MCV, MPSV)				
	1			
Human Papillomavirus (HPV)				
	1			
	2			
	3			
Office Use Only: Immunization information updated and verified with parent/guardian permission:				
Printed Staff Name	Date	Printed Staff Name	Date	
Printed Staff Name	Date	Printed Staff Name	Date	

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

1) Chickenpox disease verified by printout from CHILD Profile Immunization Registry
Must be marked by printout (not by hand) to be valid.

2) Chickenpox disease verified by Health Care Provider (HCP)
If you choose this box, mark 2A OR 2B below.
 2A) Signed note from HCP attached OR
 2B) HCP signed here and print name below:

 Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

3) Chickenpox disease verified by school staff from CHILD Profile Immunization Registry
If you choose this box, staff must initial that parent or guardian approves: _____ (initial) _____ (date)

4) Chickenpox disease verified by parent*
If you choose this box, fill in the date or child's age when he or she had the disease:
 Age/Date of disease: _____
 *Can ONLY verify for some grades, see back #5 (4).

If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.
Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. **Signed lab report(s) MUST also be attached.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	

Licensed health care provider (HCP) Signature _____ Date _____
 (MD, DO, ND, PA, ARNP)
 HCP Printed Name: _____

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.

#1 To print with info filled in: First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

EXAMPLE

#2 To fill in by hand: Print your child's name, birthdate, sex, and your own name in the top box.

#3 Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

Vaccine	Dose	Date		
		Month	Day	Year
◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)				
DTaP	1	01	12	2011
DTaP	2	03	20	2011
DTaP	3	06	01	2011

#4 If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#5 If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

- 1) If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2) If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3) If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4) If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

#6 Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

#7 Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

#8 If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Vaccine Trade Names in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)									
Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menaetra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqa	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf)							
Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	<i>Haemophilus influenzae</i> type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

2010-01-13 05:10



PARENT/GUARDIAN STATEMENT OF UNDERSTANDING

The following information is important for the safety and protection of your child. Please read the information and sign this form.

I understand that the adult who signs the child up for the program is responsible for payments to the YMCA.

I understand all financial, attendance, enrollment and other business documents will be provided only to the adult who signs the child up for the program and is responsible for payment.

I understand that YMCA staff are not allowed to baby-sit or transport children outside of the YMCA program.

I understand children should not receive gifts (video games, jewelry, movie tickets...) that are not part of the YMCA program from YMCA staff or volunteers, and I should report this to a supervisor if they do.

I understand that I have free access, at all times, to areas of the program used by my child. I also understand that I will have opportunities to participate in program activities, and that this participation may require me to go through a screening process. I also understand that if my participation obstructs the program in any way, this privilege will be revoked.

I understand that I am not to leave my child at the YMCA or program site unless a YMCA staff is there to receive and supervise my child.

I understand that my child will not be allowed to leave the program with an unauthorized person.

I understand that should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police.

I understand that YMCA staff will engage children in discussions to help them understand how they can set their own personal safety and touching limits.

I understand that I will be provided information about my child's progress and/or any issues related to his/her care, however, both parents/guardians may receive this information upon request.

I understand that staff in licensed child care programs, family and mental health services and specific staff in other programs are mandated by state law to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation. I also understand that employees in all YMCA programs follow the same reporting protocol. Furthermore, our staff are protected from liability for good faith reporting.

I understand that the Health Care Plan is posted and available for my review.

I have read and understand the statements above and I have received a copy of:

_____ Family Handbook (Containing all policies, procedures, philosophy, Medical Procedures, Disaster Preparedness Plan, Pesticide Policy, Statement for Prevention of Abuse and the Creating a Child Safe Environment brochure)

Child's Full Name

Parent/Guardian Signature

Date

COPY OF STATEMENT WILL BE FILED WITH CHILD'S RECORDS.



YMCA OF GREATER SEATTLE
Payment Authorization Form – Child Care

PRIMARY MEMBER
Legal First Name MI Legal Last Name
Address Phone Number

PAYMENT AUTHORIZATION
Electronic Funds Transfer or Recurring Credit Card or Debit Card
Type of Account: Checking Savings Visa MC Amex Discover
Name on Account (please print) Name as it appears on Credit Card (please print)
Routing Number Credit Card Number
Account Number Expiration Date
I hereby authorize my financial institution to honor pre-authorized debit entries by the YMCA on my account for child care payments and when my financial institution honors such debits by charging my account this shall constitute my receipt for payment. ___initial
I hereby authorize the YMCA to charge my credit card on a monthly basis for payments as indicated below. When my financial institution honors such debits by charging my account this shall constitute my receipt for payment. ___initial

PAYMENT DATE SELECTION
Charge my monthly payment in full one week prior to the start of each month's care
Charge my monthly payment in full on the ___ day of the month prior to care (must be paid in full by the 25th)
Divide my monthly payment into ___ payments to be paid on the ___ (must be paid in full by the 25th)
Split my monthly payment between multiple forms of payment. I would like \$___ to be charged to this account on the ___ day of the month prior to care (must be paid in full by the 25th). Please complete a separate Payment Authorization Form for each account.

YMCA OF GREATER SEATTLE FINANCIAL POLICIES

I further stipulate the following conditions (please read and sign at the bottom):

- I understand that my Child Care tuition is due one week prior to the start of each month. If payment is not received by the due date, my child will not be permitted to attend the program until all fees are paid.
I understand that YMCA programs are continuous and that monthly charges or debits, as indicated above, will continue until I give written notice to change or terminate the program. The frequency and occurrence of my visits has no bearing on my monthly dues.
I understand that I must give the YMCA written notice 14 days prior to the next scheduled draft to change or cancel my program fees and to make changes to my name, address, telephone number or payment information. Failure to do so will make the subsequent draft non-refundable. Any outstanding balances will be due at the time of cancellation. I am liable for any fees that the YMCA may incur in its effort to collect any remaining balance due.
I understand that the YMCA will notify me at least 30 days in advance of any increase to my monthly dues or program fees.
I understand that it is my responsibility to bring any billing discrepancies to the YMCA's attention within 60 days after they first appear on my financial statements. After 60 days, I waive my right to dispute such discrepancies.
I understand and authorize that NSF or collection of fees will be charged to me for any declined or returned monthly dues. Such non-sufficient fees will be the maximum amount allowed by law and will include applicable taxes.

Signed: _____ Date: _____