



FOR YOUTH DEVELOPMENT®
 FOR HEALTHY LIVING
 FOR SOCIAL RESPONSIBILITY

Summer Day Camp Registration

STEP 1

Please select the programs you need

| Weekly Pricing | Members | | Program Members | | Non-Members | |
|--|------------|--------|-----------------|--------|-------------|--------|
| | School Age | Teen | School Age | Teen | School Age | Teen |
| <input type="checkbox"/> Summer Day Camp | \$ 155 | \$ 135 | \$ 228 | \$ 203 | \$ 310 | \$ 270 |
| <input type="checkbox"/> Before Camp Care | \$ 35 | | \$ 53 | | \$ 70 | |
| <input type="checkbox"/> After Camp Care | \$ 45 | | \$ 68 | | \$ 90 | |
| <input type="checkbox"/> Before & After Care | \$ 65 | | \$ 98 | | \$ 130 | |

STEP 2:

The following fees must be paid at the time of registration

Weekly Payment _____
 Membership Dues _____
 Total Paid _____

Office Use:
 Starting program on: _____
 MSR Initials _____
 CCD Initials _____

STEP 3:

I certify that my child is in good health and is amiable to normal discipline necessary for a successful group experience. I understand that the registration fee and pre-paid membership fees are **non-refundable**. I also understand that failure to pay the balance when due could result in cancellation of my registration. I understand that I will be responsible for the balance due should I not cancel with a 30 days written notice. I, the parent/guardian of the above stated, hereby give my approval to participate in any program activities. I hereby waive, release, absolve, indemnify and agree to hold harmless the Pocono Family YMCA and employees from any claim rising out of injury to my child. I have read, understood and agree with this in its entirety. I authorize the use of the above named child's image in YMCA materials. I agree to be bound by the Code of Conduct of the Pocono Family YMCA.

Parent Signature _____

Date _____

STEP 4:

Releases: Please sign each release for which you give permission for your child.

Transportation - The YMCA has my permission to transport my child on ALL YMCA trips

Movie Release - I give permission for my child to view movies rated G or PG

Emergency Medical Care - I give permission for the YMCA to obtain any emergency medical care for my child

Minor First-Aid - I give permission for the YMCA to administer minor first-aid care to my child.

Parents Signature

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| |

Walking/Trips - I give permission for my child to attend walking field trips with the YMCA

Wading Release - I give permission for my child to wade at the YMCA or outdoor areas we may visit

Swimming Release - I give permission for my child to swim at the YMCA or outdoor areas we may visit

Parents Signature

| |
|--|
| |
| |
| |

STEP 5:

Child's Full Name _____ Male _____ Female _____

Birth Date _____ Age _____

Address _____

City _____ State _____ Zip _____

Primary Guardian _____

Cell Number _____ Work Number _____ Home Number _____

Email _____

*Please list a valid email address to receive special notices

Secondary Guardian _____

Cell Number _____ Work Number _____ Home Number _____

Email _____

*Please list a valid email address to receive special notices

STEP 6:

If guardians are NOT available in an emergency, please notify:

Name _____ Relationship to child _____

Cell Number _____ Work Number _____ Home Number _____

Name _____ Relationship to child _____

Cell Number _____ Work Number _____ Home Number _____

Child Release Information (Please include emergency numbers)

The following people are authorized to pick up my child from the YMCA:

Name _____ Address _____ Phone Number _____

Name _____ Address _____ Phone Number _____

Attach additional sheet for additional names and numbers

STEP 7:

Name of Child's Physician/Medical Care Provider _____

Address _____

Special Disabilities (if any) _____ Allergies (If any) _____

Medical or Dietary information Necessary in an Emergency situation _____

Medication, Special Situations _____

Additional Information on Special Needs of Child _____

Health Insurance Coverage for Child or Medical Assistance Benefits _____ Policy Number _____

STEP 8:

My signature below verifies that all this information is complete and correct.

Signature of Parent or Guardian _____

Date _____

REGISTRATION AND PAYMENT PROCEDURES

Registration begins on January 1st, 2018 and is accepted on a first-come, first-served basis. All children must be a Member or

Please bring completed registration form(s) to the Member Services Desk. Registration can only be done in person at the YMCA with the Camp Director.

ALL Payments are due **PRIOR TO** attending any childcare programs . If payment is not made, your registration will be canceled and your spot will be opened for the next child on the waiting list. Payments are automatically drafted on the 28th of the month before service

If you need to make changes to your registration, all requests to cancel, add or change days must be done in writing. All requests to cancel registration must be with 30 days written notice. Any cancellations done with less than 30 days written notice will be charged a \$100 cancellation fee.

SICKNESS OR INJURY PROCEDURES

- Children with communicable illnesses are not permitted to attend ANY Childcare programs. They will be sent home if they arrive and
- Whenever it is necessary to contact you due to sickness or emergency, we will first contact the numbers provided and then proceed to the emergency numbers listed on the child's enrollment forms.
- If a minor injury occurs during the day, an injury report will be filled out and the parent/guardian will be notified. If a more severe injury occurs during the day, the parents/guardians will be immediately contacted.

BEHAVIOR & DISCIPLINARY ACTION PLAN

The Y expects all participants and parents to conduct themselves in a manner that reflects the character values of caring, honesty,

The Pocono Family YMCA reserves the right to take disciplinary action based on what it deems to be appropriate in any given situation. All past disciplinary actions will be taken into consideration when addressing a violation. Forms of disciplinary action may include, verbal warnings, time outs, written notice to the parent/guardian, suspension or termination.

My signature below certifies that I have read this information and agree with all of the written plans in place by the YMCA.

Signature of Parent or Guardian _____

Date _____

For questions or information phone the YMCA at 570-421-2525
or visit our website at www.poconoyymca.org

CHILD HEALTH ASSESSMENT

Parents & Child Care Providers fill-in this part. Parents may write immunization dates, health professionals should verify and complete all data.

| | | |
|---------------------------|-------------|------------------|
| CHILD'S NAME: (LAST) | (FIRST) | PARENT/GUARDIAN: |
| DATE OF BIRTH: | HOME PHONE: | ADDRESS: |
| CHILD CARE FACILITY NAME: | | |
| FACILITY PHONE: | COUNTY: | WORK PHONE: |

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at < www.aap.org > or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

| | |
|---|--|
| Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> NONE | Date of most recent well-child exam: _____ |
| Allergies to food or medicine (describe, if any): <input type="checkbox"/> NONE | Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies. |

| LENGTH/HEIGHT | WEIGHT | HEAD CIRCUMFERENCE | BLOOD PRESSURE |
|------------------------|------------------------|------------------------|---------------------------------------|
| _____ IN/CM %ILE _____ | _____ LB/KG %ILE _____ | _____ IN/CM %ILE _____ | (BEGINNING AT AGE 3) _____ / _____ |

| PHYSICAL EXAMINATION | <input checked="" type="checkbox"/> =NORMAL | IF ABNORMAL - COMMENTS |
|-------------------------------|---|------------------------|
| HEAD/EARS/EYES/NOSE/THROAT | | |
| TEETH | | |
| CARDIORESPIRATORY | | |
| ABDOMEN/GI | | |
| GENITALIA/BREASTS | | |
| EXTREMITIES/JOINTS/BACK/CHEST | | |
| SKIN/LYMPH NODES | | |
| NEUROLOGIC & DEVELOPMENTAL | | |

| IMMUNIZATIONS | DATE | DATE | DATE | DATE | DATE | COMMENTS |
|---------------|------|------|------|------|------|----------|
| DTaP/DTP/Td | | | | | | |
| POLIO | | | | | | |
| HIB | | | | | | |
| HEP B | | | | | | |
| MMR | | | | | | |
| VARICELLA | | | | | | |
| MENINGOCOCCAL | | | | | | |
| PNEUMOCOCCAL | | | | | | |
| INFLUENZA | | | | | | |
| HEP A | | | | | | |
| ROTAVIRUS | | | | | | |
| OTHER | | | | | | |

| SCREENING TESTS | DATE TEST DONE | NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL |
|----------------------------------|----------------|--|
| LEAD | | |
| ANEMIA (HGB/HCT) | | |
| URINALYSIS (UA) at age 5) | | |
| HEARING (subjective until age 4) | | |
| VISION (subjective until age 3) | | |
| PROFESSIONAL DENTAL EXAM | | |

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

NONE

NEXT APPOINTMENT - MONTH/YEAR: _____

| | | | |
|------------------------|---------------------------------|-----------------|-------------------|
| MEDICAL CARE PROVIDER: | SIGNATURE OF PHYSICIAN OR CRNP: | | |
| ADDRESS: | | | |
| | PHONE: | LICENSE NUMBER: | DATE FORM SIGNED: |

