



FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

### New Rochelle YMCA School Age Child Care Child Information

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M \_\_\_ F \_\_\_  
Child's School: \_\_\_\_\_ Grade: \_\_\_ Bus# \_\_\_ Site: Webster \_\_\_ Y \_\_\_  
Home Address: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
Guardian's Name: \_\_\_\_\_ Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
Email (parent #1) \_\_\_\_\_ Email (parent #2) \_\_\_\_\_  
Child Lives with: Mother \_\_\_ Father \_\_\_ Both \_\_\_ Other \_\_\_\_\_

\*\*If one parent retains sole legal custody, for the protection of the child a copy of the court order must accompany this form.

**(M – F) \$255.00 per month / Must Sign a monthly Credit/Debit Card Contract**  
**\$30 per ½ day (11:30-3pm) – If your child is enrolled to attend ON THAT DAY**

#### Alternate Emergency Contacts

List two additional emergency contact persons, who may pick up your child. We will not release your child to anyone, other than persons stated unless specified in writing prior to pick up. Telephone approval is not acceptable. I understand and agree that once my child is released into the custody of any of the above or below named individuals, the YMCA and its staff no longer has any responsibility for my child. We strongly recommend that you establish a secret password with your child to be used in an emergency situation.

Name: \_\_\_\_\_ Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Name: \_\_\_\_\_ Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Monthly Credit/Debit Card Contract

I authorize the New Rochelle YMCA to keep my signature on file and to charge my credit card account, on an ongoing basis for amounts I owe. I understand that this authorization is valid for the duration of my child's enrollment and that I may cancel the authorization at any time through a 30 day written notice. I also agree to contact the merchant if there are any changes to my credit card account information. Account will be charge on the 1<sup>st</sup> of every month school is in session.

Cardholder Name: \_\_\_\_\_

Cardholder Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Monthly charges are:

5 days / week \$255.00 \_\_\_\_\_

**Payments received after the 10<sup>th</sup> of the month will be charged a \$25.00 late fee**

All information on this form is correct as far as I know. I understand that the YMCA reserves the right to refuse an application, or terminate enrollment of any child based upon disciplinary difficulties or lack of payment.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### WITHDRAWAL PROCEDURES

All withdrawals must be made in writing only. Withdrawals must be sent directly to the **YMCA** located at **50 Weyman Avenue, New Rochelle, NY 10805**. Monthly enrollment fees will be charged until the director receives notification of withdrawal in writing. You are paying for your child's space in the SACC program; therefore, supervision has been planned for the entire month, whether your child attends or not. Please plan accordingly... all payments received are final. NO REFUNDS.



## Permission Form

I hereby grant permission for my child to use all the play equipment and participate in all of the activities of the center.

I hereby grant permission for my child to be included in evaluations and pictures connected with the child care program.

I hereby grant permission for the director or acting director to take whatever steps may be necessary to obtain emergency medical care if warranted as stated on the Emergency Medical Authorization Form.

I understand expenses incurred in obtaining medical treatment are my responsibility.

I understand and give permission for the YMCA to add my email address to the email blast via constant contact.

I understand that the center is not responsible for anything that might happen as a result of false information given by a parent or guardian.

I understand that the YMCA and the center will not assume responsibility for a child who had not been signed in when he/she arrives for the day, if enrolled in the before school program.

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Child's Name: \_\_\_\_\_ School/Site: \_\_\_\_\_

Parent/Guardian  
Signature:

\_\_\_\_\_ Date \_\_\_\_\_

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**CHILD IN CARE MEDICAL STATEMENT**

**To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner**

Name of Child:	Date of Birth:	Date of Examination:
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**Immunizations required for entry into day care**

Yes  No

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	5 <sup>th</sup> Date
Polio (IPV or OPV)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Haemophilus influenzae type B (Hib)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date OR 1 <sup>st</sup> Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Hepatitis B	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date		
Measles, Mumps and Rubella (MMR)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			
Varicella (also known as Chicken Pox)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			

**Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A**

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

**Tests**

Tuberculin Test Date: \_\_\_ / \_\_\_ / \_\_\_ Mantoux Results:  Positive  Negative \_\_\_\_\_ mm  
 TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.  
 If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: \_\_\_ / \_\_\_ / \_\_\_  
 Attach lead level statement  
**Lead Screening (Include All Dates and Results)**

1 year \_\_\_ / \_\_\_ / \_\_\_ Result: \_\_\_\_\_ mcg/dL  Venous  Capillary  
 2 years \_\_\_ / \_\_\_ / \_\_\_ Result: \_\_\_\_\_ mcg/dL  Venous  Capillary

**Most recent date of lead screening (if different from above):**  
 \_\_\_ / \_\_\_ / \_\_\_ Result: \_\_\_\_\_ mcg/dL  Venous  Capillary

**Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.**  
 If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

*(Continued on reverse side)*

**CHILD IN CARE MEDICAL STATEMENT** *(continued)*

Health Specifics	Comments
Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Summary of Physical Exam**

Include special recommendations to child day care providers

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On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care.  Yes  No

Signature of Examiner	Address
Please Print Name	City, State, Zip
Title	(      ) Phone
	Date

**Religious Exemptions**

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.



