



# Bethlehem Area YMCA Childcare Registration

2009-2010 School Year

Office Staff Signature \_\_\_\_\_ Receipt # \_\_\_\_\_  
 Use Reg. Fee: \$ \_\_\_\_\_ /First Month: \$ \_\_\_\_\_ /Last Month: \$ \_\_\_\_\_ ...TOTAL = \$ \_\_\_\_\_  
 Only Credit Card \_\_\_ /Cash \_\_\_ /Check # \_\_\_\_\_ Date: \_\_\_\_\_ Copied \_\_\_\_\_

REGISTRATION INFORMATION (Check all that apply) Start Date: \_\_\_/\_\_\_/\_\_\_

(To be completed by Parent/Guardian and returned with payment.)

\*Registration Fee (non-refundable) \$50.00

\*Program Members pay payment an additional \$50 annual usage fee.

\*First month due by June 1<sup>st</sup>.

\*Last month deposit due by August 15.

(\*Registrations made after August 15 must include registration fee, first month fee, and last month deposit.)

\_\_\_ **Three-year preschool program**...9:00 am to Noon.....M/W/F...\$150/mo (Program Members: \$300)

\_\_\_ **Four-year preschool program**.....9:00 am to Noon....T/TH...\$100/mo. (Program Members: \$200)

BILLING PARTY INFORMATION (Please print clearly) \_\_\_ YCMA Member \_\_\_ Program Member  
(This is the person we will contact for billing concerns.) \_\_\_ Capital District YMCA Employee

Billing Name \_\_\_\_\_ Child's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Place of Work \_\_\_\_\_

BILLING INFORMATION \*Payment Options:

**Payment must be received by the 1<sup>st</sup> of each month. A late fee of \$25 will be added after the 15<sup>th</sup>.  
(If paying by check, please print the child's name in the "memo" portion of the check.)**

\_\_\_ DSS (DSS Approval Letter Required) \_\_\_ YMCA Scholarship (Attach application; available at front desk) \_\_\_ Third Party

\_\_\_ Pay cash/check at the Bethlehem Area YMCA facility front desk.

\_\_\_ Mail payments. Please mail to : Capital District YMCA  
Attn: Child Care Billing  
465 New Karner Road  
Albany, NY 12205

\_\_\_ Automatic Draft (Please complete draft form for child care, available at the front desk)

\*Please Note: When selecting automatic draft, the registration fee and first month payment must be paid in full through another payment option (cash/check/credit card) before the automatic draft takes effect.



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## ENROLLMENT INFORMATION

*(To be completed in full by Parent/Guardian and returned with payment)*

Child's Name \_\_\_\_\_  Male  Female  
 Birth date \_\_\_/\_\_\_/\_\_\_ School Attending: \_\_\_\_\_ Grade in the Fall: \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Sibling's Names \_\_\_\_\_ Ages \_\_\_\_\_

Parent/Guardian #1 \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_ E-Mail \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_ E-Mail \_\_\_\_\_

### **MEDICAL**

Medications child is presently taking \_\_\_\_\_  
 Allergies \_\_\_\_\_  
 In case of Allergic reaction, what action should be taken? \_\_\_\_\_  
 \_\_\_\_\_  
 Date of Child's last Tetanus shot: \_\_\_/\_\_\_/\_\_\_  
 Does your child have any disabilities?  Hearing  Speech  Vision  Seizures  Other  
 Describe other \_\_\_\_\_  
 Physical Handicaps \_\_\_\_\_  
 Services received through school \_\_\_\_\_

### **EMERGENCY**

In an emergency, person to contact first  Mother  Father  Guardian  
 In the event, that I cannot be reached to make arrangements for emergency medical attention, I/We being the parent(s)/legal guardian(s) of the above named minor do hereby appoint the YMCA staff to act on my behalf in authorizing emergency medical, dental, or surgical care and hospitalization in my/our absence for above named minor.

Parent/Guardian Signature #1 \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 Parent/Guardian Signature #2 \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
 Family Dentist \_\_\_\_\_ Phone # \_\_\_\_\_  
 Specialist Requested \_\_\_\_\_ Phone # \_\_\_\_\_  
 \_\_\_\_\_  
 (for pre-existing medical problems)  
 Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

### **Local Emergency Contacts (If Parents can not be reached)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Parent's Marital Status**  Married  Divorced  Single  Widowed

If separated or divorced who has legal custody? \_\_\_\_\_  
 Is child's time divided between parents because of divorce or separation?  Yes  No  
 How is it divided? \_\_\_\_\_

**Note: Court orders are needed if a parent is denied access to the child.**



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## CONSENT TO RELEASE INFORMATION

*I give permission for my child to be released from the YMCA Child Care program with the following people. I further understand that the people listed below must show identification for a child to be released. It is required, whenever possible, that parents notify YMCA staff in advance if someone other than themselves is picking up your child.*

1. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell/pager \_\_\_\_\_
2. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell/pager \_\_\_\_\_
3. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell/pager \_\_\_\_\_
4. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell/pager \_\_\_\_\_

*Staff: Parent's must cross out any deletions, sign and date. Staff should not make changes. Any additions should be added by the parent/guardian and initialed.*

Name and Relationship to Child	Phone Numbers	Date Added
1.		
2.		



Bethlehem Area YMCA 900 Delaware Ave. Delmar, NY 12054
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