

CHILDCARE ENRICHMENT PROGRAM 2011-12 SCHOOL YEAR REGISTRATION FORM

PLEASE PRINT LEGIBLY and include your registration fee. Register Online through August 4th at ymcalouisville.org.

Please attach a recent **wallet size photo** and **immunization certificate** for each child.

Program start date	Email address (To receive important program updates and registration information)
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1st CHILD

First name	Middle initial	Last name	Date of birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age
Race <input type="checkbox"/> African American/Black <input type="checkbox"/> Alaskan <input type="checkbox"/> Native Asian/Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other					
Physical conditions/special needs			Medications/allergies		
To better serve your child, please indicate if he/she has been diagnosed with any of the following: <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Convulsions <input type="checkbox"/> Bleeding/Clotting Disorders <input type="checkbox"/> Autism <input type="checkbox"/> Aspergers <input type="checkbox"/> Fragile X <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Tourettes <input type="checkbox"/> Rhett Syndrome <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Chronic Health Problems <input type="checkbox"/> Asthma/Severe Allergies <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Other					
Does this child have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Childcare Enrichment Program Site			School Attending		
Attendance <input type="checkbox"/> 1-3 Days <input type="checkbox"/> 4-5 Days			Grade in School (2011-12)		
Participation <input type="checkbox"/> Before-School Care <input type="checkbox"/> After-School Care <input type="checkbox"/> Before- & After-School Care <input type="checkbox"/> In-Service Day Care <input type="checkbox"/> Snow Day Care					

2nd CHILD

First name	Middle initial	Last name	Date of birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age
Race <input type="checkbox"/> African American/Black <input type="checkbox"/> Alaskan <input type="checkbox"/> Native Asian/Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other					
Physical conditions/special needs			Medications/allergies		
To better serve your child, please indicate if he/she has been diagnosed with any of the following: <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Convulsions <input type="checkbox"/> Bleeding/Clotting Disorders <input type="checkbox"/> Autism <input type="checkbox"/> Aspergers <input type="checkbox"/> Fragile X <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Tourettes <input type="checkbox"/> Rhett Syndrome <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Chronic Health Problems <input type="checkbox"/> Asthma/Severe Allergies <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart defect/disease <input type="checkbox"/> Other					
Does this child have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Childcare Enrichment Program Site			School Attending		
Attendance <input type="checkbox"/> 1-3 Days <input type="checkbox"/> 4-5 Days			Grade in School (2011-12)		
Participation <input type="checkbox"/> Before-School Care <input type="checkbox"/> After-School Care <input type="checkbox"/> Before- & After-School Care <input type="checkbox"/> In-Service Day Care <input type="checkbox"/> Snow Day Care					

1st PARENT/GUARDIAN

Name	Relationship to child	Date of birth / /
Address	City	State Zip
Home phone	Cell phone	Work phone Employer

2nd PARENT/GUARDIAN

Name	Relationship to child	Date of birth / /
Address	City	State Zip
Home phone	Cell phone	Work phone Employer

INSURANCE INFORMATION

Health insurance company	Policy number
Name of physician	Physician phone

PLEASE LIST ANY ADULT OTHER THAN THE ABOVE THAT MAY BE PICKING UP THIS CHILD OR THAT MAY BE CONTACTED IN AN EMERGENCY.

Anyone picking up your child must be at least 18 years of age or older. A picture ID is required at pick-up.

Name	Relationship to child	Phone 1	Phone 2
Name	Relationship to child	Phone 1	Phone 2

- The YMCA has permission for my children to be photographed and/or interviewed for promotional purposes Yes No
 My child(ren) have permission to participate in basic health and fitness evaluations Yes No
 Yes, I would like to make a charitable donation to The Spirit Campaign \$10 \$25 \$50 \$100 Other/please contact me
 Check here if either parent is School partnership employee YMCA employee YMCA family facility member Spirit recipient 4-C recipient
 YES! I would like to learn more about FREE or LOW-COST health insurance for my children and teens.

You must choose one option below to process your registration. Drafts will occur each Wednesday for the current week unless otherwise scheduled through our main office.

- I am currently on draft. Please use the account on file ending in _____. **Authorized account holder signature** _____
 I am authorizing a NEW bank draft from my checking account and I have attached a voided check.
 I am authorizing a NEW credit card draft and I have provided all the information below:

Credit Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover	
Name on card	Authorized cc signature
Card number	Expiration date
Billing street address	Billing zip code

I have the legal authority to sign up the child/children named on this form and to the best of my knowledge the information on this application form is complete and accurate. I understand that my application will not be processed unless it includes the full fee or automatic draft authorization. I understand that the YMCA prohibits staff members from being alone with children they meet in YMCA programs outside of the YMCA. This includes but is not limited to baby-sitting, tutoring, sleep-overs, etc. In the event I cannot be reached in an emergency, I hereby give permission to the director of the program or designee to secure emergency medical services, including transportation and medical care. I also give permission for the attending physician to order injections, anesthesia or surgery for this child as named above. I understand that medical and accident insurance is the responsibility of the parent or guardian. If my child(ren) attend Jefferson County Public Schools, by signing this form I am giving the YMCA permission to communicate and exchange information with JCPS for the purpose of providing and enhancing services to my child(ren). There may also be times when JCPS or the YMCA may take photographs (or other digital images) of students participating in activities. Those images may appear in the YMCA's or JCPS's publications, including electronic publications. By signing this form, I am giving permission to JCPS and the YMCA to use my child(s) image for the purposes listed above. I understand that this release may be revoked by me at any time by written request.

Signature	Date Signed
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