



SCHOOL'S OUT HOLIDAY PROGRAM REGISTRATION 2011

**INFORMATION— PLEASE PRINT ALL INFORMATION; COMPLETE ONE FORM PER CHILD**

Already enrolled in Live Y'ers? **Yes - complete Child's Name section only & circle dates needed**
 No - complete all pages (registration fee of \$30 applies)

CIRCLE DATES NEEDED:

<u>Thanksgiving (Friday Frenzy)</u> Nov 25	<u>Martin Luther King Celebration Day:</u> Jan 16
<u>Fall Break</u> Oct: 24/25/26/27/28	<u>Presidents Day</u> Feb 20
<u>Thanksgiving Day - Nov 24 Y closed</u>	<u>Spring Break</u> Mar: 26/27/28/29/30
<u>Winter Break</u> Dec: 19/20/21/22/23 26/27/28/29/30	

Child's Name: _____ **Name Child Goes by:** _____
Home Address: _____ (home ph) _____ (cell ph) _____
City: _____ State: _____ Zip Code: _____ E-Mail: _____
Birth date _____ M/F _____ Child's age: _____ Grade: _____ Ethnicity: _____

Allergies: _____
Receives Medic Aid: Yes/No _____
Behavioral challenges: _____

Speech, language, hearing, vision: _____

Family Information—Please print all information

Mother/Guardian: _____ **Same address as child**
Date of birth: _____ **Drivers license/State I.D. #:** _____
Home Address: _____ (home ph) _____ (cell ph) _____
City: _____ State: _____ Zip Code: _____ E-Mail: _____
Place of Employment: _____ Work ph: _____

Father/Guardian: _____ **Same address as child**
Date of birth: _____ **Drivers license/State I.D. #:** _____
Home Address: _____ (home ph) _____ (cell ph) _____
City: _____ State: _____ Zip Code: _____ E-Mail: _____
Place of Employment: _____ Work ph: _____

Emergency Information

Person to be reached if parents or guardians cannot be reached:
Name: _____ (home #) _____ (other #) _____
Name: _____ (home #) _____ (other #) _____
Name: _____ (home #) _____ (other #) _____

Doctor's name: _____ (w) _____ Address: _____
City: _____ State: _____ Zip Code: _____

Child release for pick-up

Persons authorized to pick up:
 Parents listed above
 Emergency contacts listed above

Additional:
Name: _____
Name: _____
Name: _____

Persons NOT authorized to pick up:

Name _____
Name _____
Name _____
Name _____
Name _____



YMCA OF GRANT COUNTY EMERGENCY INFORMATION, WAIVER, AND MEDICAL AUTHORIZATION

Print Parent/Guardian Name: _____ **Date:** _____

Child's Information: Complete one form for each child.

First Name: _____ Last Name: _____ Age: _____

Birth Date: _____ Male Female

Are immunizations current? No Yes

Has the child been hospitalized or had operations, serious injuries, fractures, etc. in the past five years?

No Yes

Does he/she have any disability, special needs, chronic or recurring illness or conditions?

No Yes

Does he/she have any physical problems, mental health disorders, or developmental disabilities?

No Yes

Name current medication (s) and give instructions: _____

List allergies: _____

If you answered YES to any of the question above, please give details: _____

Health Insurance Information:

Physician's Name: _____ at (hospital/clinic/office): _____

Initial Emergency Contact:

Parent/Guardian to be contacted first: _____ **Phone:** _____

If the initial emergency contact cannot be reached, we will attempt to reach (Please include at least one relative and one available neighbor):

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Parent/Guardian Authorization:

I certify that in advance of participation in YMCA programs, I have received any and all information which I deem necessary or important in making an informed choice regarding my child/ward's participation in such activity or program. I acknowledge the risks inherent in my child's participation in activities. In consideration of the Grant County YMCA allowing my child/ward to participate in such activity or program, I hereby voluntarily agree to assume all risks of his/her participation in such program or activity.

IN EXCHANGE FOR ALLOWING MY CHILD TO PARTICIPATE IN YMCA PROGRAMS AND SERVICES, I HEREBY RELEASE AND HOLD HARMLESS the YMCA, its employees, officers, directors and volunteers, from any loss, liability, claim of bodily injury or death or property damage, or costs which may arise due to my use of the YMCA's facilities and my child's participation in YMCA programs, including claims arising out of negligence of the YMCA and its employees and volunteers. The use of all YMCA facilities shall be undertaken at the undersigned's own risk. This agreement shall be governed by the laws of Indiana.

Authorization of Treatment:

I _____, Parent/legal guardian of the above said minor child, consent to medical treatment by authorized Y Child Care staff for my child, if necessary. I also release and hold harmless the Y Child Care and Grant County YMCA from any liabilities or claims arising from medical care provided.

Acknowledgement of Policies and Guidelines:

By signing below, I acknowledge that I have read the above information, and that I understand the policies of the program and I agree to abide by them. Should I have any questions or concerns, I will contact the Child Care Director. I understand that the staff makes every effort to provide a quality program, but additionally it is important that participants and parents follow all rules, guidelines and procedures in order for the program to be a successful experience for all.

Signature of Parent/Guardian: _____ **Date:** _____



Y CHILD CARE'S PHOTO POLICY

By registering for the Y Child Care program, you are giving the Grant County YMCA permission to take and publish photos of your child. Please return this authorization to the YMCA Child Care office.

I authorize my child's photo to be taken and published (check one):

- Yes** **No**

SCHOOL: _____

PARENT'S NAME: _____

CHILD NAME _____



Financial Assistance

Do you need financial assistance? Yes No (please note that any previous balances must be cleared completely to qualify)

If yes, complete Community Partners Financial Assistance Application Form (available online or at the Front Desk of the YMCA) and return with proof of earnings, previous year’s tax statement, and copy of letter from the school confirming either free or reduce lunch; to the **Child Care Director**, YMCA. For additional queries, please **call 664-0544, and ask for ext. 109.**

Participation Policy

Participation in the Y Child Care’s Program is a privilege. Y Child Care is provided in this community as a service to working parents and their children. The privilege of participation in our program is dependent upon the fulfillment of certain student and parental responsibilities.

Your child’s responsibilities:

- To participate with the staff and other children in creating and following rules for behavior in the Y Child Care’s program.
- To report immediately to Y Child Care after school. If I am staying to help a teacher or for another activity, I will let Y Child Care’s staff know immediately before reporting to the teacher or activity.
- To respect staff and other children.
- To remain with the program staff at all times, to notify staff if they need to go to another area, and to respect school property.
- To treat others gently, both physically and emotionally.

As a registered child, I have read or have had these policy statements read to me, and I understand my responsibilities to be in the Y Child Care’s program.

Child’s signature or parent’s signature

Date

Your responsibilities:

- To pay fees on time.
- Pick up children on time.
- Sign children in/out each day.
- To follow the policies about illness/medication as outlined in the parent handbook.
- To be open to communication from staff about child’s behavior, and to work with staff to an agreeable solution to any problems that might occur.
- To keep Y Child Care’s staff informed of any changes in phone numbers and locations where parents can be reached in emergency situations.

As a parent or guardian of these registered children, I have read and understand the above policy statements. I further understand that a Parent Handbook is available to me in which details the Y Child Care’s program philosophy, operational procedures, health concerns, standards of conduct, and disciplinary procedures.

Parent or guardian signature

Date



Grant County Family YMCA

123 Sutter Way · Marion, Indiana 46952
Phone (765) 664-0544 · Fax (765)664-0548

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

COMMUNITY PARTNERS SCHOLARSHIP APPLICATION

Scholarship Requested for:

Membership Type _____

Program _____

Child Care _____

Day Camp _____

Family- A married couple living together (one is the householder/person in whose name the housing unit is owned or rented) and all IRS allowable tax dependants related by birth or adoption including college students up to the age of 24.

Single-Parent Family (SPF) – A single parent and all IRS allowable tax dependants related by birth or adoption, including college students up to the age of 24.

Senior Citizens- Any individuals 65 years and older.

College- Students up to the age of 24 with 12 or more credit hours.

Youth- Any student under the age of 18 years or still in high school.

Marital Status (circle one) _____ Married Divorced Separated Single

Date: _____

Applicant: _____

Date of birth: _____ Drivers license/State I.D. #: _____

Spouse : _____

Date of birth: _____ Drivers license/State I.D. #: _____

Address: _____

City/State _____ Zip _____

Home phone: _____ Cell phone: _____ Cell phone: _____

Email address: _____

Place of employment: _____ Tel: _____

Spouse's place of employment: _____ Tel: _____

Relative not living with you: _____

Relationship: _____ Phone number: _____

TOTAL GROSS MONTHLY HOUSEHOLD INCOME	
<i>Proof of income verification is required to process the application</i>	
Paycheck: \$	ADC/AFDC: \$
Child Support: \$	Social Security: \$
Food Stamps: \$	Unemployment: \$
Other Income: (please list) \$ \$	<i>A wage inquiry is required for unemployed. An inquiry can be obtained by contacting Work One. 850 Miller Ave. Marion In 46952 (765) 668-8911</i>

List all people living in the home. Attach a separate paper if additional space is required.

Scholarship Request	Name Place a check <input checked="" type="checkbox"/> beside names for which the scholarship is requested.	Date of Birth
	1.	
	2.	
	3.	
	4.	
	5.	
	6.	
	7.	

The above information is certified to be true.

Applicant: _____ Date: _____

Spouse: _____ Date: _____

**All required documentation must be presented with application.
Allow 5 to 7 business days for processing.**

OFFICE USE ONLY:

Date received: _____ Initials: _____

Date processed: _____ Initials: _____

Date notified: _____ Initials: _____