

Dear Parent/Guardian:

Thank you for choosing the Scottsdale/PV YMCA as your preschool choice. We look forward to teaching and mentoring your child on their path to Kindergarten. Please make sure that you have everything you need to register.

Registration Check List:

- _____ Registration Form (along with fees: registration fee, membership, 2 week payment)

- _____ Blue Card (**please make sure everything is completed on card, nothing should be left blank!**)
 - ___ Child's info (name, address, birthdate, sex, phone)
 - ___ Mother/Father or Guardian info (name, address, work address, phone, signature of both, please do not leave blank!)
 - ___ Doctor (name, address, phone)
 - ___ Hospital (name, address, phone)
 - ___ Signature on bottom
 - ___ At least 2 emergency contacts outside the home completed (name, address, phone)
 - ___ any medical information
 - ___ any court documents if needed

- _____ Immunization Records (must be a copy from medical center/doctor)

- _____ Signed Statement of Services

- _____ ATS Form (for bank draft purposes. If not using bank draft, must supply a credit card as a security deposit)

Please keep for your records:

Statement of Services
Preschool brochure
Copy of ATS form
Copy of receipt

**Need help with registration?
FAQ's**

Blue Card: This information is required to participate in all State licensed child care programs. It is essential for emergencies and for medical information.

Single Parent: If you are a single parent and do not have another parent to list, please cross out other parent and put "not available".

Custody issue: if there is a parent or person who is not allowed to pick up, you must turn in custody papers for us to enforce it. Otherwise anyone listed anywhere on the blue card will be allowed to pick up.

Doctor: A doctor name, complete address, and phone number is required for blue card to be complete. You may use your primary physician and can call information or use our internet access to retrieve this information. If you do not currently have a primary physician you may use "Doctor on duty" at one of the listed hospitals below. Or check your immunization records for Pediatric Information.

Hospital: A hospital name, complete address, and phone number is required for blue card to be completed. Below is a list of hospitals in our area:

Meridian Point Hospital
9630 E Shea Blvd, Scottsdale 480.661.0100

Province Health Care Inc
8320 n Hayden Rd Ste B111, Scottsdale 480.609.1826

Scottsdale Healthcare
9003 Shea Blvd, Scottsdale 480.860.3000

Emergency Contacts: two contacts outside the household is required for blue card to be complete. Please take a few minutes to call and get all information. A name, address, and phone number is required. All contacts will be authorized to pick up. Below is a list of suggested contacts:

Grandparents	Aunts/Uncles	Cousins
Friends	Neighbors	Co-workers
Employer	Secretary	Babysitter

Medical Information: Please list any allergies (food, bee stings, meds, etc), any past medical problems or major surgeries, constant ear infections or bloody noses, and any other information that may help us in the proper care of your child.

Immunization Records: immunization records are required to participate in all state licensed child care programs. Please contact your Physician or school to have them fax them to Marcia Leach at 480.951.9663.

Other Important information: DO NOT LEAVE SOMETHING BLANK. If it does not apply to you (ie: business name and you work at home) please put "n/a". For in case of injury or illness please put who you would want us to contact first (911 will be contacted if there is an emergency regardless).

If anything is left blank your registration will be incomplete and therefore your child will not be able to attend until all information is retrieved.

Scottsdale/Paradise Valley YMCA 2009-2010 Registration

Child's name _____ Birthdate _____ Age _____
 Parent's name _____ Address _____
 City _____ AZ Zip code _____ Parent's E-mail address _____
 Home # _____ Work # _____ Cell # _____

2009-2010 year: August 10th –May 28th

Bank Draft:
 The monthly fees listed below will be divided into equal payments; paid twice per month. Payments are automatically deducted from your checking/credit card account on the 5th and the 18th of each month. **The first 2 weeks must be paid in full at time of registration.** First month will be prorated, depending on start date.

Starting Date: _____ **Ending Date:** _____

We will also need a credit card to put down as a security deposit. Your card will only be charged if a payment is past due or a bank draft comes back insufficient. You will receive one courtesy phone call before collection is taken.

Card # _____ Exp Date _____ Card holder's Name _____

Preschool Program Options (Check One)

Facility Members	Program Members
_____ 2-3 year olds Part Time Only (9:00-1:00) choose one below _____ 5 Days (M-F) \$425/month _____ 3 Days (MWF) \$305/month _____ 2 Days (TTh) \$190/month	_____ 2-3 year olds Part Time Only (9:00-1:00) choose one below _____ 5 Days (M-F) \$475/month _____ 3 Days (MWF) \$355/month _____ 2 Days (TTh) \$240/month
_____ 3-4 year olds _____ 4-5 year olds Part Time (9:00-1:00) 5 Days (M-F) \$425/month	_____ 3-4 year olds _____ 4-5 year olds Part Time (9:00-1:00) 5 Days (M-F) \$475/month
_____ 3-4 year olds _____ 4-5 year olds Full Time (7:00-6:00) 5 Days (M-F) \$625/month	_____ 3-4 year olds _____ 4-5 year olds Full Time (7:00-6:00) 5 Days (M-F) \$675/month
_____ Daily Lunches (monthly) \$45/month	_____ Prepaid Lunch card \$30 (10 lunches)

●Closed: Labor Day, Thanksgiving Day, Christmas, New Years, Memorial Day, Independence Day, any other days will be posted

WHERE DID YOU HEAR ABOUT OUR PROGRAM? _____

<p align="center"><u>Due at the time of Registration</u></p> <p><u>Current Membership</u> Program Members: \$35 (Annual Fee) Facility Members: Prices Vary</p> <p><u>Preschool Registration Fee</u> \$35 Facility and Program Members</p>	<p><u>Payment:</u> \$35/\$0 Program/Facility Membership</p> <p>\$35 Registration Fee</p> <p>\$ _____ First Payment (1/2 of monthly fee)</p> <p>_____</p> <p>\$ _____ Total Payment due Today</p>
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I have read, understand, and agree to adhere to the YMCA Preschool program payment policies, and **give the YMCA permission to use photographs of my child, in a group setting, for YMCA promotional materials.**

Parent/Guardian's signature _____

Date _____



Emergency Information and Immunization Record Card

Child's Name: _____ Date of Enrollment: _____ Updated: _____

Street Address: _____ Date of Disenrollment: _____

City, State & Zip Code: _____ Date of Birth: _____ Sex: Male Female

Mother or Guardian: Name: _____
Home Address: _____
Hm. Ph: _____ Cell Ph: _____
Business Name: _____
Business Address: _____
Wk. Ph: _____
Signature: _____

Father or Guardian: Name: _____
Home Address: _____
Hm. Ph: _____ Cell Ph: _____
Business Name: _____
Business Address: _____
Wk. Ph: _____
Signature: _____

If Medical Care is Necessary, Call:

DOCTOR: _____
Name _____ Address _____ Phone _____

HOSPITAL: _____
Name _____ Address _____ Phone _____

In case of injury or sudden illness, _____ will be called first. I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of an emergency, or if I cannot be contacted to pick up my child, I hereby authorize the following person(s) to pick up my child.

Name: _____ Name: _____

Address: _____ Address: _____

Ph: _____ Cell Ph: _____ Ph: _____ Cell Ph: _____

Name: _____ Name: _____

Address: _____ Address: _____

Ph: _____ Cell Ph: _____ Ph: _____ Cell Ph: _____

The following person(s) may not remove my child from the facility:

Name: _____ Name: _____

Custody papers have been provided and are on file at the facility. yes no

This Emergency Information and Immunization Record Card is accurate and complete, front and back, and was provided by:

Parent or Guardian printed name: _____

Signature: _____ Date: _____

Immunization Information

PHOTOCOPY Must be Medical Copy

Age	Required Vaccine Doses By Age					
	DtaP	Polio	Hib	Hepatitis B	Hepatitis A	MMR
< 2 months				#1		
2 - 3 months	#1	#1	#1			
4 - 5 months	#2	#2	#2	#2		
6 - 11 months	#3		#2 - #3 ¹			
12 - 14 months		#3	#1 - #4 ²	#3		#1
15 - 59 months	#4				#1 - #2 ³	
24 - 71 months				3	2	
School Age	#4 or #5 ⁴	#3 or #4 ⁵				

¹ Hib if Pedvax or Comvax vaccine given
² at least 1 Hib after 12 months of age
³ Maricopa County only

⁴ 4 doses satisfy requirement if 3rd dose after 4th birthday
⁵ 3 doses satisfy requirement if 3rd dose after 4th birthday

Check one

- Copy of current official documented immunization record attached
- Religious Beliefs exemption form signed by parent/guardian attached
- Medical Exemption form signed by physician and parent/guardian attached
- Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s): / / / / / /
 MO/DAY/YR MO/DAY/YR MO/DAY/YR

Updated immunizations received and attached / / / / / /
 MO/DAY/YR MO/DAY/YR MO/DAY/YR

Medical Information

Is child allergic to food or other substances? (If so, name foods or substances to be avoided and procedure to follow if reaction occurs.)

Is child usually susceptible to infections and if so, what precautions need to be taken?

Is child subject to convulsions and what should be our procedure if one occurs?

Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)?

Additional comments: _____

Other special instructions: _____

**VALLEY OF THE SUN YMCA
CHILD CARE AGREEMENT**

Automatic Transfer System (ATS)

FOR OFFICE USE ONLY

NAME:

COURIER DATE:

I understand that the information below will be used to transfer payment from my account.

CHILD'S FULL NAME (Please Print)						
ADDRESS						
CITY, STATE, ZIP & ZIP EXTENSION						
PHONE	(HOME)	*		(WORK)		
MEMBER # Branch, Group & Family #	160-					
DRAFT DAY / BEGIN DATE	/					
DRAFT DESCRIPTION	Program Code:			Site:		
ACCOUNT TYPE: (Circle One)	Checking	Savings	MC	VISA	AmEx	Amount \$
CREDIT CARD #	EXP Date:		CC Holder's Name:			

1. I understand that this transfer will occur twice monthly on the fifth (5) and eighteenth (18) of each month for checking/savings and credit card drafts.
2. I understand that should I choose to terminate or change Bank Accounts, Banks, Account Types, or Child Care Plan in anyway, I must provide the YMCA with at least a thirty (30) day written notice prior to my transfer date.
3. I understand that the YMCA may, upon thirty (30) days written notice, adjust child care rates, which would result in a change in my semi-monthly transfer rate.
4. I understand that if my payment is returned NSF for any reason, the item(s) will be re-presented electronically and I understand I will be charged a processing fee. I am also responsible for all other recovery costs.

Authorized Bank Account Signature _____

DATE _____