FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

# DROP-IN DAILY CHILDCARE & CAMPS

## VALLEY OF THE SUN YMCA

### REGIONAL CARE CENTER: LEGACY FOUNDATION CHRIS-TOWN YMCA

Child's Name _____ Birth Date _____ Grade (2017/18) _____

Parent's Name _____ Birth Date _____ (Required for registration)

Address _____ City _____ Zip Code _____

Home # _____ Work # _____ Cell # _____

Parent's E-mail Address _____

**PLEASE COMPLETE:**

DATE(S) CARE IS PROVIDED: _____

**DAILY RATE:** $30 (MEMBERS) / $50 (NON-MEMBERS)
*CURRENT BEFORE/AFTER SCHOOL PARTICIPANTS RECEIVE AN ADDITIONAL $10 OFF PER DAY

**CAMP DAY INFO:**

- Payment for care will be processed upon drop-off each day. Payment must be made prior to leaving the building.
- Camp runs from 6:30AM to 6:30PM for ages 5-13
- Morning and afternoon snacks are provided by the YMCA
- Please provide a non-perishable lunch for your child
- All participants are to be dropped off and picked up at the YMCA; with a parent, guardian or authorized adult signing them in and out of the program.

**REGISTRATIONS MUST INCLUDE:**

☐ Signed Registration Form (This Form)
☐ AZ DHS Emergency Card (Blue Form)*
☐ *AZ Best of Care Form* (Please submit within 24 hours of enrollment)*
☐ *Immunization Records (Please submit within 24 hours of enrollment)*
*Current Before and After school participants do not need to submit new emergency cards, immunization records, or Best of Care form

I have read, understand, and agree to adhere to the YMCA child care program Statement of Services, 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*

| PAYMENT INFORMATION | | | | OFFICE USE ONLY | |
|---|---|---|---|---|---|
| $35 / $0 | YMCA Licensed Childcare Registration Fee, paid once per school-year per child. *WAIVED WITH YMCA FAMILY MEMBERSHIP* | | | DAXKO ID # | |
| $ | **TOTAL DUE CAMP DAYS** | | | Date In / / | |
| $ | **TOTAL DUE TODAY** | | | Staff Name | |
| Payment: | ☐ CASH | ☐ CHECK (EFT) | ☐ CREDIT/DEBIT CARD | | |
| Name on Card | | Card # | | EXP DATE | |

DES accepted; authorization must be received prior to starting the program.
Financial Assistance may be available to those that qualify.

CDC/SGH# or name:_____

**Arizona Department of Health Services**
**Bureau of Child Care Licensing**

# Emergency, Information and Immunization Record Card

| | | |
|---|---|---|
| **Child's Name:** | **Date Enrolled:** | Updated: |
| **Home Address (#, Street, City, State, Zip Code):** | | **Date Disenrolled:** |
| **Home Phone:** | **Date of Birth**: | **Sex:** ☐ **male** ☐ **female** |

| | |
|---|---|
| **Parent or Guardian Name**: | **Home Address (#, Street, City, State, Zip Code):** |
| Cell Phone (optional): | **Contact Telephone Number:** |

| | |
|---|---|
| **Parent or Guardian Name**: | **Home Address (#, Street, City, State, Zip Code):** |
| Cell Phone (optional): | **Contact Telephone Number:** |

**I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted: (Pursuant to R9-5-304.B, at least two contact persons are required.)**

| | |
|---|---|
| **Name**: | **Contact Telephone Number**: |
| **Name**: | **Contact Telephone Number**: |
| Name: | Contact Telephone Number: |
| Name: | Contact Telephone Number: |

If Medical care is necessary, call:

| | | |
|---|---|---|
| **Health Care Provider*** | **Name**: | **Contact Telephone Number**: |

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

| | |
|---|---|
| **In case of injury or sudden illness, I request that this individual be called first:** | |

The following individual(s) may NOT remove my child from the facility:

| |
|---|
| Name(s): |

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

Telephone Authorization Code (optional):_____

## Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:
**www.azdhs.gov/phs/immun/index.htm** or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

| | |
|---|---|
| ☐ | 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? ☐ **No** ☐ **Yes**<br>**If yes**, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs: |
| Is child usually susceptible to infections and if so, what precautions need to be taken? ☐ **No** ☐ **Yes**<br>**If yes**, list precautions: |
| Is child subject to convulsions and what should be our procedure if one occurs? ☐ **No** ☐ **Yes**<br>**If yes**, specify procedure: |
| 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.)? ☐ **No** ☐ **Yes**<br>**If yes**, list precautions: |
| Additional comments: |
| Other special instructions: |

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

| **Parent/Guardian PRINTED Name**: | **SIGNED Name**: | **DATE:** |
|---|---|---|
| | | |