



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

DROP-IN DAILY CHILDCARE & CAMPS

VALLEY OF THE SUN YMCA

REGIONAL CARE CENTER: COPPER BASIN FAMILY 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 7:00PM 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. <i>WAIVED WITH YMCA FAMILY MEMBERSHIP</i>	DAXKO ID #	
\$	TOTAL DUE CAMP DAYS	Date In _____ / _____ / _____	
\$	TOTAL DUE TODAY	Staff Name _____	
Payment:	<input type="checkbox"/> CASH	<input type="checkbox"/> CHECK (EFT)	<input type="checkbox"/> 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: <input type="checkbox"/> male <input type="checkbox"/> 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:
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*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:	
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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:

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	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

<p>Is child allergic to food or other substances? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:</p>
<p>Is child usually susceptible to infections and if so, what precautions need to be taken? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Is child subject to convulsions and what should be our procedure if one occurs? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, specify procedure:</p>
<p>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.)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Additional comments:</p>
<p>Other special instructions:</p>

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:
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