



FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# DROP-IN DAILY CHILDCARE & CAMPS

## VALLEY OF THE SUN YMCA

### REGIONAL CARE CENTER: TEMPE 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: \$35 (MEMBERS) / \$55 (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. <i>WAIVED WITH YMCA FAMILY MEMBERSHIP</i>	DAXKO ID #	
\$	<b>TOTAL DUE CAMP DAYS</b>	Date In _____ / _____ / _____	
\$	<b>TOTAL DUE TODAY</b>	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**

<b>Child's Name:</b>	<b>Date Enrolled:</b>	Updated:
<b>Home Address (#, Street, City, State, Zip Code):</b>		<b>Date Disenrolled:</b>
<b>Home Phone:</b>	<b>Date of Birth:</b>	<b>Sex:</b> <input type="checkbox"/> male <input type="checkbox"/> female

<b>Parent or Guardian Name:</b>	<b>Home Address (#, Street, City, State, Zip Code):</b>
Cell Phone (optional):	<b>Contact Telephone Number:</b>

<b>Parent or Guardian Name:</b>	<b>Home Address (#, Street, City, State, Zip Code):</b>
Cell Phone (optional):	<b>Contact Telephone Number:</b>

**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.)**

<b>Name:</b>	<b>Contact Telephone Number:</b>
<b>Name:</b>	<b>Contact Telephone Number:</b>
<b>Name:</b>	<b>Contact Telephone Number:</b>
<b>Name:</b>	<b>Contact Telephone Number:</b>

If Medical care is necessary, call:

<b>Health Care Provider*</b>	<b>Name:</b>	<b>Contact Telephone Number:</b>
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\*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

<b>In case of injury or sudden illness, I request that this individual be called first:</b>	
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The following individual(s) may NOT remove my child from the facility:

<b>Name(s):</b>
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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](http://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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