



FLAGSTAFF FAMILY YMCA 2020/2021 EARLY LEARNING REGISTRATION

Child's name _____ Birth date _____ M / F _____ Age _____

Parent's name _____ Birth date _____ (Required for registration)

Address _____ City _____ AZ Zip code _____

Primary Phone (C) or (H) _____ Work _____

Parent's E-mail address _____ (Required for registration)

Start Date: _____ Are you re-enrolling? Yes ___ No ___

Full Day Early Learning Program in session August 1, 2020 through July 31, 2021 * New session starts August 1st

6:30 AM until 6:30 PM Monday – Friday (excluding holidays)	Draft on the 1st & 15th of every month (circle rate)	
	Member	Non-Member
Toddlers		
Ages 12 + months and walking	\$ 435	\$ 490
Early Learners		
Ages 2 years and turning 3 during the school year	\$ 403	\$ 458
Preschool		
Ages 3 years and turning 4 during the school year	\$ 390	\$ 448
Pre – K		
Ages 4 years by September 1st and Potty Trained	\$ 378	\$ 433

For part time and part week availability please contact kyle.gambino@vosymca.org

PROGRAM CLOSED:

- Labor Day
- Veteran's Day
- Thanksgiving Day and day after
- Christmas Day
- New Year's Day
- Martin Luther King Day
- Presidents Day
- Good Friday
- Memorial Day

Any other days will be posted if needed

REGISTRATIONS WILL NOT BE ACCEPTED WITHOUT THE FOLLOWING ATTACHED:

Signed registration form Completed emergency card Immunization record Best of Care form

DUE AT TIME OF REGISTRATION:

\$35 or 0	Child Care Registration Fee/per child or waived with Family Membership	For office use only	
\$	First month childcare payment (if registration not received 10 days prior to the 1st)	ID #	
Total due today: _____	Paid by:	Date	Staff Initials
	<input type="checkbox"/> Check # _____ <input type="checkbox"/> CASH <input type="checkbox"/> CREDIT CARD	Comments:	
Cardholder's Name _____			
Draft Begins on: / 01 /			

OUR BILLING IS BASED ON TUITION MULTIPLIED BY 2 FOR 24 DRAFTS DONE ON THE 1ST AND THE 15TH MONTHLY. REGARDLESS OF THE NUMBER OF DAYS ACTUALLY OCCURRING IN THAT MONTH. THE Y DOES NOT GIVE CREDITS FOR ILLNESSES, HOLIDAYS OR FAMILY VACATIONS TAKEN DURING SCHOOL DAYS. ALL PLANS USE THE ATS BANK DRAFT (CREDIT/DEBIT CARD) SYSTEM AND ARE WITHDRAWN ON THE 1ST AND THE 15TH OF EACH MONTH.

IF YOUR PAYMENT IS RETURNED BY YOUR FINANCIAL INSTITUTIONS FOR ANY REASON, THE ITEMS WILL BE RE-PRESENTED ELECTRONICALLY AND YOU WILL BE CHARGED A \$25 PROCESSING FEE. IF YOU ARE LATE IN PICKING UP YOUR CHILD (REN) A DOLLAR PER MINUTE LATE FEE WILL BE APPLIED TO YOUR ACCOUNT. YOU MAY DISENROLL WITH A 30 DAY PRIOR WRITTEN NOTICE. THIS NOTICE MUST BE TURNED INTO THE YMCA.

DUE DATES/BANK DRAFT DATES:

2020 8/1 & 15 9/1 & 15 10/1 & 15 11/1 & 15 12/1 & 15
 2021 1/1 & 15 2/1 & 15 3/1 & 15 4/1 & 15 5/1 & 15 6/1 & 15 7/1 & 15

Check here if you would like to have our Statement of Services emailed to you. Please refer to Statement of Service for all policies

I have read, understand, and agree to adhere to the YMCA child care program Parent Handbook, payment policies, and give the YMCA permission to use photographs of my child, in a group setting, for YMCA promotional materials.

My signature acknowledges my understanding and agreement to the above.

Parent/Guardian's Signature _____

Date _____

Financial Assistance is available upon request. You must fill out, attach a Financial Assistance form and provide proof of income. DES participants must attach your Certificate of Authorization to this form.



CDC/SGH# or name: 15151

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

Is child allergic to food or other substances? If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	No	Yes
Is child usually susceptible to infections and if so, what precautions need to be taken? If yes, list precautions:	No	Yes
Is child subject to convulsions and what should be our procedure if one occurs? If yes, specify procedure:	No	Yes
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.)? If yes, list precautions:	No	Yes
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:
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FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

EARLY LEARNING CENTER: BEST OF CARE FORM

This confidential form is to help your childcare provider support the growth and development of your child while creating a safe, stable, and healthy environment for all children. By providing complete information about your child, you will be assisting us in creating a positive experience for your child while in our care.

Child's Name _____ DOB: _____ Nickname _____

Parent/Guardian completing this form: _____

What is your preferred method of communication? Phone call _____ Text _____
Email _____ Note in sign in book _____ In person _____

Please list all the adults living in your child's household:

Name	Relationship	Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all the children in the family, along with their ages and gender.

Name	Age	Gender
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child's Ethnicity:

Caucasian Hispanic or Latino Black or African American
 Asian Native American two or more Races
 Native Hawaiian or other Pacific Islander Other

Has your child attended child care in the past? No _____ Yes _____

If yes, what type of setting(s) was your child in? (Family childcare, center childcare, relative, etc.) _____

What did you like most about your child's previous childcare setting? _____

What did you like least? _____

What is important to you about your child's care? _____

Does your child prefer to play alone or with other children? Alone _____ With Others _____

Does your child have a favorite toy or comfort object? No _____ Yes _____ if Yes, what? _____

What is your child's current sleep schedule? _____



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Does your child fall asleep easily? No ___ Yes ___

What is his/her mood upon awaking? _____

Special things you say or do to comfort your child are: _____

How do you know when your child is:

Happy _____

Sad _____

Mad _____

Tired _____

Other _____

How does your child react when:

Something unexpected happens _____

Something happens he/she doesn't like _____

He/She is scared _____

Other _____

Describe your family's cultural holidays, celebrations and or practices.

How do you discipline your child?

Does your child help out at home and how do they help?

Does your child participate in any enrichment activities? (i.e. gymnastics, swimming)

What kind of activities does your child like to do at home and with the family?

Describe your child's feelings about school?

Please describe any recent family events or changes (i.e. new sibling, moving, divorce, death).



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Is your child completely potty trained, including naptime? If not, what strategies are you using to work on this?

How does your child get along with other children?

What are your child's strengths/weaknesses?

Does your child have any health issues? (i.e. as a result of premature birth, surgery, asthma, seizures) No____ Yes____
If yes, please explain:

Is there anything else you would like to share about your child that you feel would help us create a positive environment and relationship with your child?

Parent/Guardian Signature_____ Date: _____

Parent/Guardian Decline to Complete