LEGACY FOUNDATION CHRIS-TOWN YMCA 2021/2022 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: _____

Full Day Early Learning Program in session August 1, 2021 through July 31, 2022 **** New school session starts August 1st***

Early Learning program hours are 8:00 AM – 3:00 PM.
To maximize your experience, all children are asked to be dropped off by 7:45 AM and picked up after 3:15 PM.
The program includes extended child care hours from 6:30 AM – 6:30 PM (excluding holidays).

Draft on the 1st & 15th of every month (circle rate)	**Member****	**Non-Member**
Preschool		
Ages 3 – 5 years and Potty Trained	**$ 400**	**$ 455**
*****12 month memberships will receive an additional 10% reduction on preschool fees.***		

PROGRAM CLOSED ●Labor Day ●Veteran's Day ●Thanksgiving Day and day after ●Christmas Eve/Day ●New Year's Eve/Day ●Martin Luther King Day ●Presidents Day ●Good Friday ●Memorial Day

Any other days will be posted if needed - Minimum attendance required to provide full day care.

REGISTRATIONS WILL NOT BE ACCEPTED WITHOUT THE FOLLOWING ATTACHED:

☐ Signed registration form ☐ Emergency card ☐ Immunization record ☐ Best of Care form ☐ DES Certificate of Authorization (if applicable)

FEES 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)	Date Received: / /
$	**TOTAL DUE TODAY**	Staff Initials:
Draft Begins on: / /		

PAYMENTS AND BILLING:

- All plans use the ATS Bank Draft (credit/debit card) system and are withdrawn on the 1st and 15th of each month.
- Our billing is based on tuition multiplied by 2 for 24 drafts done on the 1st and 15th of each monthly regardless of the number of days actually occurring in that month.
- The Y does not give credits for illnesses, absent days, holidays or family vacations taken during school days.
- Payments returned NSF for any reason will be re-posted electronically and you will be charged a $25 processing fee.
- If you are late in picking up your child(ren) $1.00 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:

2021 8/1 & 15 9/1 & 15 10/1 & 15 11/1 & 15 12/1 & 15
2022 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.

We accept DES. Please list your caseworker's name _____

LEAVE PAGE BLANK

CDC/SGH# or name: 3929

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? **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:**

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

BEST OF CARE

This confidential form is to help your child care 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 child care.

Instructions: This form is to be completed by a parent/guardian and must be on file at the child care facility on or before a child's first day of attendance. If additional space is needed, attach a separate sheet of paper.

CHILD'S NAME	DATE OF BIRTH

PARENT/GUARDIAN COMPLETING THIS FORM	WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION?

PROVIDER/CENTER NAME

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

If yes, what type of setting(s) was your child in? (Family child care, group care, etc.)

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

What did you like least?

Other comments:

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

Who is important to your child?

Does your child prefer to play alone or with other children? ☐ Alone Other children

Does your child have a favorite toy or comfort object? ☐ Yes No

If yes, what?

What is your child's current sleep schedule?

Does your child fall asleep easily? ☐ Yes ☐ No

What is his/her mood upon waking?

What does your child like?

What does your child dislike?

See reverse for EOE/ADA/LEP/GINA disclosures

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?

Does your child have any health issues? Yes No
If yes, please explain:

Does your child have any other special needs? ☐ Yes ☐ No
If yes, please explain:

Events at home often influence a child's behavior, for example: changes in the family, such as a new sibling, separation or divorce, or moving to a new home. Knowing about these transitional times will allow us to provide special attention, understanding, and care that your child needs.

Has anything happened recently in your child's life that might have an effect on him/her? ☐ Yes ☐ No
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 for your child?

☐ Parent/Guardian declined to complete

Parent/Guardian Signature Date

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.