

**2010-11 AFTER SCHOOL ENROLLMENT FORM**

Information in this packet is mandated by the State of CT Licensing Regulations

Today's Date:

School:

First Day of Attendance:

**CHILD'S INFORMATION**

Child's Name:			Grade in Fall		
Home Address:			Birth date:	Age	Gender
City:	State:	Zip:	/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Home Phone:		Current YMCA Membership:		<input type="checkbox"/> Youth	<input type="checkbox"/> Family

**PARENT/GUARDIAN INFORMATION (in case of emergency, contact first)**

Parent/Guardian's Name:			Primary Language:		
Relation to Child:			Home Phone:		
Home Address:			Cell Phone:		
City:	State:	Zip:	Email:		
Employer:			Work Phone:		
Address:			Work Hours:		

**OTHER PARENT/GUARDIAN INFORMATION**

Parent/Guardian's Name:			Primary Language:		
Relation to Child:			Home Phone:		
Home Address:			Cell Phone:		
City:	State:	Zip:	Email:		
Employer:			Work Phone:		
Address:			Work Hours:		

**SERVICE AGREEMENT**

I wish to enroll my child in the Greenwich Family YMCA After School Program

**TUITION**

<b>Full Time Program</b>	<b>5 days</b>	<b>\$265.00 per month</b>	
<b>ANNUAL FEES (required)</b>		<b>TOTAL PAYMENT ENCLOSED</b>	
<b>YMCA Youth Membership</b>	<b>\$150.00</b>	\$ _____	
<b>Annual Supply Fee</b>	<b>\$20.00</b>		

Enclosed is total payment, which includes deposit, tuition, and membership fees. I understand tuition is based on a monthly fee. The rate will be the same regardless of snow days, school vacations, half days and holidays. I have read and understand all policy and tuition information and agree to comply. In signing this agreement, you have reserved your child's space until 30 days written notice is received upon withdrawal. The YMCA will not accept less than 1 month's written notice of withdrawal of your child from our program. We reserve the right to charge for full services, throughout the notice period. Registration and membership fees are non-refundable and non-transferable if at any time services are terminated by you or the Greenwich YMCA.

<b>Parent/Guardian Printed Name:</b>	<b>Date:</b>
<b>Parent/Guardian Signature:</b>	

**2010 -11 AFTER SCHOOL ENROLLMENT FORM  
EMERGENCY CONTACTS & PICK UP AUTHORIZATION FORM**

**EMERGENCY CONTACTS**

Please list, in order to be contacted, individuals to be contacted in an emergency/non-emergency, if you cannot be reached. Please note that persons listed as "Emergency Contacts" are automatically authorized to pick up your child from the program\*.

Name:	Home Phone:
Relation to Child:	Work Phone:
Address:	DL#:
Name:	Home Phone:
Relation to Child:	Work Phone:
Address:	DL#:
Name:	Home Phone:
Relation to Child:	Work Phone:
Address:	DL#:

**PICK UP AUTHORIZATION**

Please list below individuals who are authorized to pick up your child from the program. These persons are IN ADDITION to those listed under "Emergency Contacts"\*.

Name:	Home Phone:
Relation to Child:	Work Phone:
Address:	DL#:
Name:	Home Phone:
Relation to Child:	Work Phone:
Address:	DL#:

**Please note any special instructions regarding individuals listed:**

\* Parents and legal guardians listed on enrollment forms are automatically authorized to pick up your child unless the program is given a copy of a current court ordered custody agreement or restraining order. All individuals authorized to pick up your child from the program must be at least 16 years of age. A license or other positive proof of identification must be shown at pick up. If you wish to change, add or delete any of these authorizations, you must do so in writing.

**PARENT AGREEMENT**

Initial	Should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, staff may have no recourse but to contact the police. This is for the child's safety.
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**I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS AS STATED ABOVE**

<b>Parent/Guardian Printed Name:</b>	<b>Date:</b>
<b>Parent/Guardian Signature:</b>	

**2010-11 AFTER SCHOOL ENROLLMENT FORM  
MEDICAL INFORMATION & AUTHORIZATION FORM**

**INSURANCE INFORMATION**

Child's Name:	Date of Birth:
Medical Insurance Company:	Policy #:
Other Coverage (Including Dental):	
Child's Physician:	Phone #:
Address:	
Child's Dentist	Phone #:
Address:	

**MEDICAL HISTORY**

*Please write "NONE" if there are none.*

Allergies	Reactions	Treatments

Special Disabilities/Needs/Chronic Health Conditions:

Current Medications:

Emergency Medical/Dietary Information/Religious Restrictions:

Behavioral Issues:

Other Health Concerns:

**MEDICAL TREATMENT CONSENT**

I hereby authorize the staff of the Greenwich Family YMCA to give First Aid and CPR to my child as needed. I understand that the staff are trained in the basics of First Aid and CPR. In the event of an emergency, I hereby authorize the program staff to have my child transported to the nearest medical facility or to \_\_\_\_\_ and secure necessary medical treatment including, but not limited to: hospitalization, injections, anesthesia and/or surgery. In the event that I cannot be reached, I hereby give permission to the physicians attending to my child to secure and administer treatment as necessary. I understand that the staff will make every effort to notify me of the emergency immediately. Any expenses incurred will be the responsibility of the parent/guardian.

Initial	I certify that a licensed physician has examined my child in the last 12 months and I have provided the Greenwich Family Y with proper documentation, clearly stating date of physical & immunization records.
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**I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS AS STATED ABOVE**

Parent/Guardian Printed Name:	Date:
Parent/Guardian Signature:	



## 2010- 11 AFTER SCHOOL ENROLLMENT FORM AUTHORIZATION & CONSENT FORM

### PROMOTIONAL RELEASE

I hereby grant consent and authorize the use of photographs, slides, videotape and film of my child participating in Greenwich Family YMCA activities for commercial and art purposes in any medium of advertising, communication, publication or publicity that will promote Greenwich Family YMCA programs and services, and/or recognition of participants. I understand that the YMCA is a non-profit organization.

**Parent/Guardian Printed Name:**

**Parent/Guardian Signature:**

### SUPPORT STAFF CONSENT

The Greenwich Family YMCA Programs have support staff that consist of childcare resource advisors, family support specialists and social service staff. In addition student interns and/or volunteers may work within the program. I give permission for my child to interact with these support staff

**Parent/Guardian Printed Name:**

**Parent/Guardian Signature:**

### FACILITY USES

I grant permission for my child to use all of the play equipment and participate in all of the activities of the program with the exception of: \_\_\_\_\_

**Parent/Guardian Printed Name:**

**Parent/Guardian Signature:**

### OFF SITE ACTIVITIES

I hereby grant consent for my child to leave the program premises under the supervision of a staff member in an authorized vehicle to the Main YMCA facility. I understand that any other activity destination or field trip will require my written permission.

**Parent/Guardian Printed Name:**

**Parent/Guardian Signature:**

### SWIMMING CONSENT

I hereby grant consent for my child to participate in swimming in life guarded places only.

My child's ability to swim is:     **Non-Swimmer**         **Beginner**         **Intermediate**         **Advanced**

**Parent/Guardian Printed Name:**

**Parent/Guardian Signature:**

### PARENT AGREEMENT

Initial	I understand that YMCA staff and volunteers are not allowed to baby-sit or transport children at any time outside of the YMCA program
Initial	I understand that the YMCA is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation

**I HAVE RECEIVED AND READ THE PARENT HANDBOOK AND CONFIRM THAT ALL INFORMATION GIVEN IS CORRECT. I UNDERSTAND THAT THE GREENWICH FAMILY YMCA SHALL NOT BE HELD RESPONSIBLE FOR ANYTHING THAT MAY HAPPEN AS A RESULT OF FALSE INFORMATION GIVEN AT THE TIME OF ENROLLMENT.**

**Parent/Guardian Printed Name:**

**Parent/Guardian Signature:**

**Date:**







# State of Connecticut Department of Education Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 10th or 11th grade. Specific grade level will be determined by the local board of education.

*Please print*

Name of Student (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity		
(Town and ZIP code)		<input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Other		
Home Telephone Number	School		Grade	
Name of Parent/Guardian (Last, First, Middle)				
Health Care Provider		Health Insurance Company/Number* or Medicaid/Number*		

\* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

## Part I — To be completed by parent

**Important: Complete Part I before your child is examined.  
Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.  
(Explain all "yes" answers in the space provided below.)

- |     | Yes                      | No                       |   |
|-----|--------------------------|--------------------------|---|
| 1.  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)?   |
| 2.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____ |
| 3.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)?  |
| 4.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)?   |
| 5.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?  |
| 6.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.)  |
| 7.  | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.)   |
| 8.  | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.)   |
| 9.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY)  |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have dental insurance?  |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school nurse?   |

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

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I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date