Baxter YMCA Preschool Program
2016-2017 Registration Form

Tuition is due the 1st of the month with ***a $10.00 late fee added on after the 5th.*** **Automatic Withdraws** come out on the 1st day of the month only.

Child's Name

First _____ Middle _____ Last _____ Birth date ___/___/_____Gender □M □F Age _____

Name Child goes by _____

Race _____ Address _____ City_____ State _____ Zip _____

Parent(s)/Guardian(s) Information ***Information will be used for accounting questions, emergencies and pick-up verifications***

Parent/Guardian #1 _____ Relationship to Child _____Birth date___/___/___ (required)

Home Phone (____) _____ Mailing Address _____ City _____ State ____ Zip _____

Business Phone (____) _____ Business Name _____

Cell Phone (____) _____ E-Mail Address _____

Parent/Guardian #2 _____ Relationship to Child _____Birth date___/___/___ (required)

Home Phone (____) _____ Mailing Address _____ City _____ State ____ Zip _____

Business Phone (____) _____ Business Name _____

Cell Phone (____) _____ E-Mail Address _____

Health Data/History

Operations or serious injuries (dates): _____

Chronic/recurring illness or medical condition: _____

Dietary restrictions: _____

Current Medications: _____

Name of Physician: _____Physician's Phone: _____

Name of Child's Dentist: _____Dentist's Phone: _____

Insurance Company Name: _____ Policy/Group #_____

Special Needs: _____

Child Pick-up Information Please list additional names and phone numbers of people (minimum of 2) to contact in an emergency and/or names of persons authorized to pick up your child/children. This needs to include yourself, and, if applicable, the child's other parent or legal guardian) who is authorized to pick up your child. Anyone picking up your child must be 18 years of age or older and a photo identification is required. Changes to this list must be done in writing and may only be done by the parent/guardian whose signature appears on this registration form.

Name_____ Relationship_____Phone (__ _) _____Cell Phone (__ _)_____

Name_____ Relationship_____Phone (__ _) _____Cell Phone (__ _)_____

Name_____ Relationship_____Phone (__ _) _____Cell Phone (__ _)_____

Name_____ Relationship_____Phone (__ _) _____Cell Phone (__ _)_____

Signature of Parent or Legal Guardian

_____

Printed Name

_____

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the YMCA staff to order X-rays, routine tests and treatment for me or my child, and, in the event I am not able to communicate or cannot be reached in an emergency, I hereby give permission to the physician selected by the YMCA Director to hospitalize, secure proper treatment for, and order injection(s) and/or anesthesia and/or surgery for me or my child as named above. I will be fully responsible for any costs of such treatment, even if not covered by insurance. **Parent Initial:** _____

PARENT AUTHORIZATION: I hereby do declare my child to be physically sound, having medical approval to participate in the activities of the YMCA. This information is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities except as noted. I certify that my child is amenable to behavior management and free from habits or attitudes which would make him/her unable to appropriately participate. I have studied the brochure and fees and understand the contents thereof. **Parent Initial:** _____

In consideration of my child's participation in the activities of the Young Men's Christian Association of Greater Indianapolis (YMCA), I do hereby agree to hold free from any and all liability the YMCA and its respective officer's, employees and members and do hereby for myself, my heirs, executors and administrators, waive, release and forever discharge any and all rights and claims for damages which I may have or which may hereinafter accrue to me arising out of or connected with my child's participation in any of the activities of the YMCA. **I certify that I am the parent or legal guardian of this child and I have the legal authority to make the representations and grant the authorizations contained herein.** **Parent Initial:** _____

I understand the YMCA of Greater Indianapolis does not allow YMCA employees to provide care to enrolled children outside of the approved YMCA activities. This would include babysitting, outings or trips. I understand that all YMCA staff have been informed of this policy and have signed a statement in agreement with the policy. **Parent Initial:** _____

2016-2017 Preschool Rates

School Year: August 15, 2016 – May 9, 2017
Tuition is due the 1st day of each month beginning August 1, 2016
Deposit Fee: $50 (all families)
Automatic Withdraw is Available

2/3 Combo (must be 2 by 8/1/2016)	**M/W/F 9-11:30am** ____ **T/TH 9-11:30am** ____	2-DAY FACILITY MEMBER.....$116/month PROGRAM MEMBER.....$155/month 3-DAY FACILITY MEMBER.....$152/month PROGRAM MEMBER.....$188/month
3/4 Combo (must be 3 by 8/1/2016)	**M/W/F 9-11:30am** ____ **M/W/F 12:15-2:45pm** ____ **T/TH 9-12pm** ____	2-DAY FACILITY MEMBER.....$116/month PROGRAM MEMBER.....$155/month 3-DAY FACILITY MEMBER.....$152/month PROGRAM MEMBER.....$188/month
Pre-K (4/5) (must be 4 by 8/1/2016)	**M/W/F 9-11:30am** ____ **M/W/F 12:15-2:45pm** ____ **M-TH 9-11:30am** ____ **T/TH 9am-1pm** ____ **T/TH 1:30pm- 4 pm** ____	2-DAY/4 HOUR FACILITY MEMBER.....$175/month PROGRAM MEMBER.....$217/month 3-DAY FACILITY MEMBER.....$152/month PROGRAM MEMBER.....$188/month 4-Day FACILITY MEMBER.....$175/month PROGRAM MEMBER.....$217/month
Pre-K Plus (must be 5 by 2/1/2017)	**M-F 9-11:30am** ____	5-DAY FACILITY MEMBER.....$205/month PROGRAM MEMBER.....$237/month

HEALTH RECORD
State Form 23923 (R3/7-03)

Please have your child's medical provider complete this form prior to the first day of enrollment.

Child's Name _____ **Birth Date** ___/___/___
(Last) (First)
Admission Date ___/___/___

Street Address _____ **City** _____ **Zip** _____

Child lives with _____ **Name** _____ **Phone** _____

MEDICAL HISTORY

Communicable Diseases	Month/Year	Condition	Explain if Present
Measles	___/___	Allergies: _____	_____
Rubella (German Measles)	___/___	_____	_____
Chickenpox (Varicella)	___/___	_____	_____
Mumps	___/___	_____	_____
Scarlet Fever	___/___	Physical Limitations:	_____
Whooping Cough	___/___	_____	_____
Hepatitis B	___/___	_____	_____
Other: _____	___/___	Other:_____	_____

PHYSICAL EXAMINATION

Date of Exam _____ **Age of Child** _____

Skin	Heart
Lymph Nodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth & Mouth	Other

Note any unusual findings: _____

_____

_____

Does this child have any health condition that would be hazardous to him/herself or the other children in a group setting as a result of participation in normal activities (including sports)? No _____ **Yes** _____. **If "Yes," what modification of normal activities would be necessary to protect the child and his/her classmates?** _____

_____

_____

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? No _____ **Yes** _____ **Explain:** _____

_____

_____

(Over)

HISTORY OF IMMUNIZATIONS (Indicate month/day/year)

	1	2	3	4	5
DTaP/DT/Td/DT					

	1	2	3	4
OPV, IPV				

	1	2	3	4
Hib				

	1	2	3
Hepatitis B			

	1	2
Measles		

	1	2
Mumps		

	1	2
Rubella		

	1	2
Varicella		

	1	2	3	4
PCV7				

Name of Physician Completing Form: _____ Phone Number: _____
(Please Print)

Physician's Signature: _____

ADDITIONAL NOTES AND INSTRUCTIONS