

Program Rates & Times

Albany City Schools
 (Dismissal - 5:45PM)

- Full Time
 Y Member: \$200/mo
 Non-Member: \$250/mo
- Part Time (Circle up to 3 days)
 Y Member: \$145/mo
 Non-Member: \$165/mo

Mon Tue Wed Thurs Fri

- Pine Hills
- T.O.A.S.T.
- Eagle Point
- Eagle Point (Pre-K Only)

New Scotland Schools
 (Dismissal - 5:45PM)

- Full Time
 Y Member: \$165/mo
 Non-Member: \$200/mo
- Part Time (Circle up to 3 days)
 Y Member: \$135/mo
 Non-Member: \$170/mo

Mon Tue Wed Thurs Fri

- New Scotland
- New Scotland (Pre-K Only)

A non-refundable \$50 deposit is due at the time of registration. The balance for September is due by August 1, 2016.

- Sibling Discount (\$10/mo)

Name _____

Child's Information

First Name _____ Last Name _____

DOB ____/____/____ Male Female Emergency Contact (____) ____ - ____

Address _____

City _____ State _____ Zip _____

Billing Party Information (all correspondence will be delivered to this party)

- Capital District YMCA Member Non-Member Capital District YMCA Staff

First Name _____ Last Name _____

DOB ____/____/____ Male Female

Address _____

City _____ State _____ Zip _____

Home (____) ____ - ____ Work (____) ____ - ____ Cell (____) ____ - ____

Email _____

Billing Payment Information

- Cash: Due monthly at your local YMCA
- Online Payment: Accessible at www.cdymca.org *Manage My Account*
- Check: Due monthly at your local YMCA or by mail. Made payable to CDYMCA.
 (Childcare Billing, Capital District YMCA, 465 New Karner Rd., Albany NY, 12205)
- Automatic Withdrawal: Credit Card charge or Direct Bank withdrawal (ACH)

Credit Card (If account information is on file, please write just the last 4 digits)

Name on Card _____ Card Type _____

Card Number _____ Exp ____/____

Address _____

City _____ State _____ Zip _____

Bank Withdrawal (ACH) (If account information is on file, please write just the last 4 digits)

Name _____

Bank Name _____

Routing Number (9 Digits) _____ Checking Savings

Account Number _____

Terms: I authorize my financial institution to honor pre-authorized debit/charges initiated by the YMCA on my account for childcare payments. Should any payments not be honored by the above financial institution, I understand that in addition to the regular payment, I will be charged a \$20 NSF (Non-Sufficient Funds) fee. I also authorize a second attempted charge on my card/account if the first payment declines.

Signature (I have read and understand the terms of this draft authorization) _____ Date _____

Financial Assistance

- Department of Social Services (attach DSS approval letter)
- YMCA Scholarship
- Third Party

Payments are due by the 1st of each month. Payments received after the 8th will incur a \$25 late fee. If payment is not received by the 15th, your child will be subject to removal from our care. Please print your child's name in the memo section of your check. When you provide a check as payment, you authorize a one-time EFT (Electronic Fund Transfer) from your account to process the payment. Errors found must be reported within 90 days to ensure the appropriate amount is refunded.

[OFFICE USE ONLY] Staff Signature _____ Date _____ Receipt # _____

Payment Attached Y N Scholarship Percentage _____ Executive Signature _____

Child's Enrollment Information

First Name _____ Last Name _____ DOB ____/____/____

Male Female Sibling's Name(s) & Age(s) _____

Primary Street Address _____

City _____ State _____ Zip _____ Main Contact (____) _____ - _____

School Attending _____ Grade In Fall _____

Parent/Guardian #1

First Name _____ Last Name _____ DOB ____/____/____

Contact Information: Primary Contact (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____

Email _____ Relationship to Child _____

Parent/Guardian #2

First Name _____ Last Name _____ DOB ____/____/____

Contact Information: Primary Contact (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____

Email _____ Relationship to Child _____

Medical Information

Medications Child Is Currently Taking _____

Allergies _____

Does your child have disabilities? Hearing Speech Vision Seizures Other _____

Please Describe _____

Physical Handicaps _____

Services Received Through School _____

Special Needs Requiring an Individual Health Care Plan _____

A child with a special health care need means a child who has a chronic physical, developmental, behavioral, or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Emergency Contacts

Primary Care Physician _____ (____) _____ - _____

Child's Medical Care Facility _____

Family Dentist _____ (____) _____ - _____

Specialist Required _____ (____) _____ - _____

Consent to Release/Emergency Contact Information

Please list secondary individuals who may pick up your child

1. First Name _____ Last Name _____ Relationship _____

Address _____ City _____ State _____ ZIP _____

Contact Information: Main (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____

2. First Name _____ Last Name _____ Relationship _____

Address _____ City _____ State _____ ZIP _____

Contact Information: Main (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____

3. First Name _____ Last Name _____ Relationship _____

Address _____ City _____ State _____ ZIP _____

Contact Information: Main (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____

Custody Information

Parent's Marital Status: Married Divorced Separated Single Widowed

If divorced or separated, who has legal custody? _____

Note: Court orders are needed if a parent is denied access to the child

Parental Agreement

Please read and Initial each statement, then provide your signature at the bottom of the page

- _____ I agree to the policies and procedures set forth by the childcare program
- _____ I understand that the YMCA Parent Handbook is available online at cdymca.org
- _____ I understand that the YMCA does not carry health and accident insurance and that I am responsible for Health/Accident Incurred costs
- _____ I agree to notify YMCA staff if my child is going to be absent from the program
- _____ I agree to give the YMCA written notice 30 days in advance if I choose to remove my child from the program
- _____ I agree to keep registration forms updated throughout the year
- _____ I agree to pay fees as stated on page 1
- _____ I give permission for the Capital District YMCA to take video and/or photographs of myself and/or my child(ren) for the purpose of promoting YMCA programs
- _____ I give permission for my child to be released from YMCA care with the individuals listed on the prior page. I understand that the people listed are required to show identification for a child to be released. I also agree to notify YMCA staff in advance when I will not be picking up my child.
- _____ In the event that I/we cannot be reached to make arrangements for emergency medical attention, I/we, being the parent(s) legal guardian(s) of the named minor, do hereby appoint the YMCA staff to act on my/our behalf in authorizing emergency medical, dental, or surgical care and hospitalization in my/our absence for the named minor.
- _____ I, the legal guardian/parent of the enrolled child, give the Capital District YMCA personal permission to speak with School personnel (teacher) regarding my child.

Parent/Guardian Signature (I have read and understand each of the above statements)

Date

Please keep a copy of this form for your records. Thank you.