2020 Emergency Care Registration Form
YMCA Learning Centers

*EMERGENCY CARE RATE: **$45.00 per day***

Updated 3/20/2020

1. Child Info

Child's Legal Name	Birthdate (ex: 04-22-2010)	Gender ☐ Male ☐ Female

Child's Age:	Site Location: (determined by YMCA staff)	Date Starting:

2. Primary Contact

Name of Contact — Payer on the Account? ☐ Yes ☐ No		Relationship to Child	Birthdate (ex: 6-30-1981)	
Current Address		City	State	Zip
Cell Phone Number	Name of Cell Provider	Text OK? ☐ Yes ☐ No	Lives With? ☐ Yes ☐ No	
Work Phone	Name of Employer	E-mail Address		

3. Secondary Contact

Name of Contact — Payer on the Account? ☐ Yes ☐ No		Relationship to Child	Birthdate (ex: 6-30-1981)	
Current Address		City	State	Zip
Cell Phone Number	Name of Cell Provider	Text OK? ☐ Yes ☐ No	Lives With? ☐ Yes ☐ No	
Work Phone	Name of Employer	E-mail Address		

4. Emergency Contacts (other than parents/guardians)

Name of Contact	Relationship	Phone Number	check all that apply
			☐ Emergency Contact ☐ May Pick Up ☐ Under 18 Years Old
Name of Contact	Relationship	Phone Number	☐ Emergency Contact ☐ May Pick Up ☐ Under 18 Years Old

a. Authorization for Medical Treatment

1. I hereby authorize the YMCA Learning Center personnel to secure emergency medical treatment for my child listed on this form. In case of an emergency, I hereby give authorization to call any qualified emergency services. I understand the YMCA Learning Center personnel will attempt to contact me before requesting medical treatment, if possible.

Parent Signature: _____ Date: _____

5. Schedule: Hours of Operation: M-F 6:30am-6:00pm

Days attending: Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐

Other Schedule Info:

I understand that I will be charged for the days I sign up for whether i attend or not.

Signature:_____ Date:_____

Office use Only

Date paperwork received:

PARENT'S STATEMENT ON HEALTH OF CHILD

ND DEPARTMENT OF HUMAN SERVICES/CFS
SFN 847 (Rev. 11-2008)

INSTRUCTIONS: This form must be completed annually for any child enrolled in a licensed early childhood facility.

Full Legal Name of Child:	Birth Date:	Enrollment Date:	Please check one: ☐ FT ☐ PT ☐ Drop-in ☐ B/A School	
Full Legal Name(s) of Parent or Guardian:			Relationship:	
Address:		City:	State:	ZIP Code:
Home Telephone Number:	Work Telephone Number:	Family Dentist:		
Family Physician:		Clinic:	Telephone Number:	
Hospital:			Telephone Number:	
Last Visit to Doctor:	Child's Height:		Child's Weight:	

Does The Child Have Any food, medication or environmental allergies: ☐ Yes ☐ No

If Yes, List Allergies: Describe Allergy Reaction: Usual treatment:

Please Check If Any Of The Following Conditions Exist:

☐ Asthma ☐ Diabetes ☐ Vision Impairment ☐ Heart Condition ☐ Seizure Disorder
☐ Hearing Impairment ☐ Behavioral Issues ☐ Frequent Earaches ☐ Other Conditions (please specify):

_____

Please Explain All Checked Items:

Is the Child Under Current Medical Treatment? ☐ Yes If yes, please list:
☐ No

Are There Any Medications That The Child Takes Daily? ☐ Yes If yes, please list:
☐ No

Describe Any Limitation Your Child May Have For Participation in An Early Childhood Program:

Is There A Health Care Plan For Your Child? ☐ Yes If yes, please list:
☐ No

INSURANCE:

Liability insurance is not a requirement for a license to provide family or group child care. Please review with your child care provider the liability coverage that is presently in place.

CERTIFICATION:

I certify that the above information is true to the best of my knowledge. Parent or Guardian's Signature:

Signature	Date

Tuition Express Payment Form

Choose 1 of the 3 Convenient Payment Options Below

We are excited to offer **Tuition Express®** - a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or debit/credit card.

Name	Child *(Only one name required)*		Site Attending
My Email (Required)	Driver's License Number and State		Phone Number
Billing Address	City	State	Zip Code

I (we) hereby authorize the YMCA of Cass and Clay Counties to initiate debit entries to my (our) Checking or Savings Account or debit card below. A bank draft cannot be stopped without proper notice from the parent. To properly effect the cancellation of this agreement, I (we) are required to give **10 days' written notice.**

☐ **Option 1:** I want to be **automatically** bank drafted for the billed amount **on the due date**. Please fill out banking information below and attach a voided check on bottom of form.

☐ **Option 2:** I want to make tuition payments **online**, **on my own schedule**, using my **bank account**. I understand that after three late payments, my account will be drafted and I will be required to change to automatic bank drafts. Please fill out banking information below and attach a voided check. Please note if you use a debit/credit card instead of your bank account, fees will apply as in option 3 below.

Bank or Credit Union	Bank or C.U. Address	City	State	Zip Code
Routing Transit Number	Account Number			☐ Checking ☐ Savings
Authorized Signature				Date

I would like my first two weeks of payment to be drafted from the above account for $_____

☐ **Option 3:** I want to make tuition payments **online**, **on my own schedule**, using a **debit/credit card**. I understand that I will be charged an account maintenance fee of *$2.50/child per bill period*. I understand that after 3 late payments, my account will be drafted and I will be required to provide information to change to automatic bank drafts. Please note using the bank account above (option 2) is free.

Account Number	Expiration Date	Cardholder Signature	Date

I would like to be CALLED at the number listed on this form to have my card charged for my first two week of payment for $_____.

YMCA of Cass and Clay Counties
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