Child's Name: _____

Class/Age Group: _____

2025 - 2026

School Aged Child Care (SACC) Registration

STEP 1 :

Please mark the programs your child will be attending weekly.

STROUDSBURG		EAST STROUDSBURG	
5 DAY Weekly Rate		Weekly Rate	
Before and After Care	$150	Before and After Car	$150
Before Care ONLY	$85	Before Care ONLY	$75
After Care ONly	$85	After Care ONly	$95

STEP 2 :

The following fees must be paid at the time of registration

1st Week : _____

Membership Dues : _____

Total Paid : _____

Office use:

Starting program on: ___/___/___

Registarts initials: ____

STEP 3:

I certify that my child is in good health and is amiable to normal discipline necessary for a successful group experience. I understand that the pre-paid membership fees are non-refundable. I also understand that failure to pay the balance prior to care will result in cancellation of my registration. I understand that I will be responsible fo the balance due should I not cancel with a 30 days written notice. I, the parent/guardian of the above stated, hereby give my approval to particiapte in any program activities. I hereby waive, release, absolve, indemnify and agree to hold harmless the Pocono Family YMCA and employees from any claim rising out of injury to my child. I have read, understood and agree with this in its entirety, I authourize the use of the above named child's image in YMCA materials, I agree to be bound by the Code of Conduct of the Pocono Family YMCA.

Parent Signature _____ Date: _____

Pocono Family YMCA
REGISTRATION FORM

CHILD'S INFORMATION

Child's Full Name: _____ Birtdate: _____

Grade Completed: _____ Gender: _____ Age: _____

Home Phone #: _____ School: _____

Street: _____

City: _____ State: _____ Zip: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1: _____

Birthdate: _____ Authorized to pick up: YES / NO

Primary Phone# _____ (Circle one CELL / HOME / WORK

Alternate Phone#: _____ (Circle one CELL / HOME / WORK

Parent/Guardian #1: _____

Birthdate: _____ Authorized to pick up: YES / NO

Primary Phone# _____ (Circle one CELL / HOME / WORK

Alternate Phone#: _____ (Circle one CELL / HOME / WORK

Is the parent a current member of the Pocono Family YMCA: YES / N

Do the child's parents live together: YES /NO

Is there a current custody agreement:YES / No. If yes, please attach supporting documentation.

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124 (a) (b), 3270.181 & 182; 3280.124 (a) (b), 3280.181 & .182; 3290.124 (a) (b), 3280.181 & .182

CHILD'S NAME	DATE OF BIRTH
ADDRESS	HOME TELEPHONE NUMBER ( )
PARENT'S NAME/LEGAL GUARDIAN	
ADDRESS	BUSINESS TELEPHONE NUMBER
BUSINESS NAME	
ADDRESS	HOME TELEPHONE NUMBER
PARENT'S NAME/LEGAL GUARDIAN	
ADDRESS	BUSINESS TELEPHONE NUMBER
BUSINESS NAME	
ADDRESS	
EMERGENCY CONTACT PERSON(S) NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME ADDRESS	TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	TELEPHONE NUMBER
ADDRESS	ALLERGIES (INCLUDING MEDICATION REACTION)
SPECIAL DISABILITIES (IF ANY)	MEDICATION, SPECIAL SITUATION
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST-AID PROCEDURES
WALKS AND TRIPS	SWIMMING
TRANSPORTATION BY THE FACILITY	WADING

PERIODIC REVIEW

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

YELLOW COPY (Child Care Space) PINK COPY (Excursion) CY 857 10/22

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &.181(C); 3280.123 &.181(c); 3290.123 &.181(c)

NAME OF CHILD		
FEE AMOUNT $	PER-DAY/WEEK	DAY PAYMENT TO BE MADE Friday Prior to care

Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)

- Snack
- Childcare
- homework help

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
6:30	6:30	See emergency contacts
LATE FEE $ 20.00	PER MIN/HR 15	

Extra services to be provided at an additional fee if applicable

I, the parent/guardian;

☐ received complete written program information at the time of enrollment. (§ 3270.121, 3280.121, 3290.121)

☐ agree to update the emergency contact/parental consent form information whenever changes occur or every 6 months at a minumum. (§ 3270.124, 3280.124, 3290.124)

R Braithwaite

SIGNATURE-OPERATOR DATE SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION	
DATE OF WITHDRAWAL	SIGNATURE-PARENT OR GUARDIAN DATE

CHILD HEALTH QUESTIONNAIRE

Child's name: _____ DOB: _____ Date of Form: _____

Does your child have any known allergies to any of the following?

a. Food (milk, peanuts, eggs etc.) _____
b. Medicine _____
c. Animals _____
d. Bee/ wasp sting _____
e. Grass, Pollen, dust _____

What is the plan in place to respond if exposure to allergens should occur? _____

_____

Does your child have Asthma? If yes, please also complete an Asthma Control Plan obtained from the Director.

What causes the attack? _____

What is done to treat an attack? _____

What can be done to prevent an attack? _____

What activities have to be limited, if any? _____

What medicine is given, if any? _____

The YMCA requires that the following routine screening are done annually. Normally, your child's Health Care Provider will conduct these assessments.

Does your child have any known speech / language difficulties? Yes No

If yes, please explain: _____

Has your child received speech / language services? Yes No

If yes, by whom? When? _____

What was the date of the last screening? _____ Conducted by? _____

Does your child any known vision difficulties? Yes No

If yes, please explain: _____

Has your child received services for impaired vision? Yes No

If yes, please explain: _____

What was the date of the last screening? _____ conducted by? _____

Does your child wear glasses or contacts? ____ Glasses ____ contacts

Does your child have any known hearing difficulties? Yes No

If yes, please explain: _____

Has your child received services for hearing loss? Yes No

If yes, by whom? When? _____

What was the date of the last screening? _____ Conducted by? _____

Does your child have any dietary needs we should be aware of? Yes No

If yes, please explain: _____

Has your child ever had an eating or appetite problem? Yes No

If yes, please explain: _____

Does your child tend to get a lot of ear infections? Yes No

Does your child take medication regularly? Yes No

If yes, what is the medication and how often is it taken? _____

Has your child been hospitalized or seen in an emergency department? _____

_____

It is expected that the child named on this form be immunized according to the PA Code schedule for immunizations. If the child is not yet fully immunized, please describe why and when the immunizations will be completed. (Children who have not yet reached school age should be immunized according to their age. Please respond only to immunizations that should have been completed to date.)

My child is fully immunized. Yes No

If not, reason immunizations have not been completed: Health Concerns

Religious Beliefs

Other: _____

Does your child have any other "Special Health Needs" that we should be aware of? Yes No

If yes, please complete the "Individual Health Care Plan for Child with Special Health Care Needs".

In accordance with HIPPA laws, your permission is required for the Pocono Family YMCA staff to have access to health information about your child. By signing this form, you understand that the YMCA Administrative Staff and staff working with your child will have access to the information disclosed on this form and other pertinent information required to meet the daily needs of your child.

Parent/Guardian Signature: _____ Date: _____

Parent/ Guardian Releases: (Responsible party must initial each item below)

_____ I, the undersigned, hereby enroll my child in the Pocono Family YMCA Program at 809 Main St. Stroudsburg, PA. I understand the YMCA must have current names and addresses of anyone authorized to pick up my children.

_____ I understand that the YMCA assumes responsibility for my child's wellbeing during the hours of care and will make every effort to contact the parent should any type of emergency arise. I understand that if I cannot be reached that individuals authorized on the emergency pickup will be contacted. Those individuals are authorized to assist in an emergency.

_____ In the event I cannot be reached, I authorized the YMCA staff to act for me according to his/her best judgment in any emergency requiring medical or surgical care. I authorize the physician selected to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child named above. I expect to be notified immediately. I further understand I am responsible for the cost of all medical care.

_____ I have provided and agree to update and keep complete, the child/ infant information sheet and health questionnaire, to update the staff with any pertinent information which may assist the YMCA in caring for my child including but not limited to: allergies, previous or existing illness or condition, skin sensitivity, diet requirements, long term medications, disability or limiting conditions, or emotional, developmental or behavioral difficulties.

Photo Consent

The YMCA uses photographs in "promotional material" (such as, but not limited to, newsletters, social media, advertising, news releases, etc.) throughout the year. By consenting below, you allow any photographs or likeness of your child to be used in such "promotional material."

_____I give consent that any photographs or likeness of my child may be used in promotional materials. I understand that I will not be informed or reimbursed for such photographs.

Health Insurance

_____As a condition of enrollment, The YMCA requires children to be continually covered by health insurance. Coverage information must be provided on the enrollment application and updated as changes occur.

Change of Contact Information

_____ I agree to inform the YMCA in writing of any changes in address, work telephone, emergency numbers, etc., for myself and any emergency contacts listed on the enrollment application.

Fees

Registration Fee:

_____ A current membership is required for child/ren enrolled in our childcare/SACC programs. A Membership fee is charged monthly to your account.

Tuition Fees:

_____ Tuition fees are based on an annual budget; no credit is given for absences. I agree to pay tuition in advance on a _____weekly or _____bi-weekly basis. I understand fees may increase with a minimum of two weeks' notice, and I will be responsible for paying the updated fee. A late fee will be charged for accounts past due. In the event of default of payment by client or dispute between client and the YMCA, client is held responsible for all reasonable collection and attorney fees/expenses.

_____All requests to cancel, add or change days must be done in writing at least 2 weeks prior to changes being made.

My signature acknowledges my understanding of, and agreements to, the above statements.

_____ _____

Parent/Guardian Date

_____ _____

Parent/Guardian Date

_____ _____

Pocono Family YMCA Date

Parent/ Guardian D.O.B: _____

Email: _____

Credit Card & Bank Draft Authorization Agreement
Child Care & Membership

***All registrants MUST complete/ initial this document regardless if they are requesting Auto-draft or not. However, you do not have to include your account information- that can be taken at registration.**

* I hereby give the Pocono Family YMCA permission to charge my credit card for any overdue/program/membership monies on my account to keep my account in good standing.
_____(Initials)

* The YMCA Board of Directors may, at its discretion, adjust the monthly rate applicable to my membership category. I understand that I will receive at least **two weeks' notice** prior to any such change in membership/program dues.
_____(Initials)

*Should any deduction not be honored by my financial institution for any reason, I realize that I am responsible for payment, **plus a service charge of $30.00.** This is in addition to any service charge that my financial institution may charge to my account. I understand that it is my responsibility to notify the YMCA in writing should I change my financial institution or account at any time.
_____(Initials)

*I understand that if I wish to terminate my membership/program fees or change my membership/enrollment in any way, I must give **30 days written notice.** I understand that I must turn in all membership cards upon termination and that I will receive temporary cards for the balance of the time that I have paid. Membership cards remain the property of the YMCA and MUST be surrendered upon request.
_____(Initials)

Office Staff Only

Program: Monthly Fees:

Weekly Assistance/CCIS/ELRC:_____ Staff Initials: Date:

Child Care Auto-draft Payments: Y N Staff Initials: _____ Date:

This authorization to deduct funds to remain in effect until the YMCA has received a 30-day written notification from me indicating my desire to cancel my membership or withdraw from the program.

Member Signature _____ Date

I hereby authorize the Pocono Family YMCA to initiate electronic fund entries by:

☐ Bank Draft ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Membership Draft will be on the 5th/ 14th/ 28th (please circle preference): _____(Initials)

Child Care payments Due on Friday prior to the registered weeks: _____(Initials)

We strongly recommend setting up an auto draft to ensure your payments are paid on time. Please check YES_____ or NO _____ for auto draft payments.

Routing No. ___ _____

Bank Draft Acct No.

Expiration Date _____ CVV:_____

C.C. Account No.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST) (FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH: HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:	WORK PHONE:
FACILITY PHONE: COUNTY:	

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)
☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:

ADDRESS: PHONE:

SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT

TITLE: DATE FORM SIGNED:

LICENSE NUMBER:

Parents may write immunization dates; health professional should verify and complete all data.