Summer Starts here at the Y!

Pocono Family YMCA

School Age Day Camp 2026

Dates: TENTATIVE 8AM-4PM

Ages: 5YRS - 12YRS

*Must have already completed Kindergarten

**Before & Aftercare Additional fee

$180/ Per Camper WEEKLY

FREE THREE MONTH YOUTH MEMBERSHIP

WE ACCEPT Early Learning Resources Center Funding!

Ask us about our Scholarship Program as well

Register Today!

Fill out our application at www.poconoymca.org /childcare/

For more info, email childcareadmin@poconoymca.org

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

809 Main St. Stroudsburg PA 18360 570-421-2525 www.poconoymca.org

Camper Information – Registration Form

2026

the YMCA

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Date of Birth: _____

Phone Number: _____

Email Address: _____

Select Weeks Attending

Camp hours are 8:00am - 4:00pm

☐ **Week 1: June 9–June 12 — School's Out for Summer (Spirit Week)**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 2: June 15–June 19 — Outer Space**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 3: June 22–June 26 — Hawaiian**
- ☐ M–F ($180)
- ☐ M/T/W ($120)
- ☐ T/TH ($90)

☐ **Week 4: June 29–July 3 — Red, White, & Blue**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 5: July 6–July 10 — Wet-n-Wild**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 6: July 13–July 17 — Superheroes**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 7: July 20–July 24 — Super Spy Training**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 8: July 27–July 31 — Wacky Science**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 9: August 3–August 7 — We Got Talent**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 10: August 10–August 14 — Carnival**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 11: August 17–August 21 — Safari Explorers**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

☐ **Week 12: August 24–August 28 — We Are Family (Wrap Up Summer)**
- ☐ M–F ($180)
- ☐ M/W/F ($120)
- ☐ T/TH ($90)

Please select if you need extended care

M - F ☐ 6:30am - 8:00am ($30) ☐ 4:00pm - 6:30pm ($35) ☐ Both - AM/PM care ($65)

M/W/F ☐ 6:30am - 8:00am ($20) ☐ 4:00pm - 6:30pm ($25) ☐ Both - AM/PM care ($45)

T/THRS ☐ 6:30am - 8:00am ($10) ☐ 4:00pm - 6:30pm ($15) ☐ Both - AM/PM care ($25)

[ ] I confirm my child's good health and willingness to follow normal discipline for a successful group experience.
[ ] I acknowledge that failure to pay the balance before care may cancel my registration.
[ ] I understand that I will be responsible for the balance if I don't provide 30 days' written notice for cancellation.
[ ] I approve my child's participation in program activities.
[ ] I waive any claims against the Pocono Family YMCA for injuries.
[ ] I have read and agree to these terms, including the use of my child's image in YMCA materials.
[ ] I agree to adhere to the Code of Conduct.

Parent/Guardian Signature Signature: _____ **Date:** _____

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 Starting Week

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

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
		*See emergency contact
LATE FEE $ 20.00	PER (MIN) HR 15 starting 6:35	

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)

L. Braithwaite
SIGNATURE-OPERATOR DATE

SIGNATURE-PARENT OR GUARDIAN DATE

DATE OF CHILD'S ADMISSION
6.9.2026

DATE OF WITHDRAWAL

PERIODIC REVIEW

SIGNATURE-PARENT OR GUARDIAN DATE

CY 321 - 12/99

03892A

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), 3290.181 & .182

CHILD'S NAME	DATE OF BIRTH
ADDRESS	
PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER ( )
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
ADDRESS	
PARENT'S NAME/LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
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	

SPECIAL DISABILITIES (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL 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 _____

WHITE COPY (Original) **YELLOW COPY** (Child Care Space) **PINK COPY** (Excursion)

CY 867 10/22

the Y

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.

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:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ 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:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

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