

Child's Name: _____

Class/Age Group: _____

2026 - 2027

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: _____
Regstarts 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 programactivities. 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 authorize 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: _____

****Please complete all forms thoroughly; if not your application will be delayed****

Pocono Family YMCA
REGISTRATION FORM

CHILD'S INFORMATION

Child's Full Name: _____ Birthdate: _____
Grade Completed: _____ Gender: _____ Age: _____
Home Phone #: _____ School: _____
Street: _____ State: _____ Zip: _____
City: _____

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 #2: _____
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), 3290.181 & .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	NAME	TELEPHONE NUMBER WHEN CHILD IS IN CARE
EMERGENCY CONTACT PERSON(S)		
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

CHILD CARE COPY (Child Care Space)

PINK COPY (Excursion)

CY 857 10/22

AGREEMENT

55 PA CODE CHAPTERS 3270.123 & 181(c); 3280.123 & 181(d); 3290.123 & 181(e)

NAME OF CHILD		
FEE AMOUNT \$	PER-DAY <u>WEEK</u>	DAY PAYMENT TO BE MADE <u>Friday Prior to care</u>
Services to be provided as part of the day care fee (examples; transportation, care, meals, etc.)		
- Snack - Childcare - home work help		
CHILD'S ARRIVAL TIME <u>6:30</u>	CHILD'S DEPARTURE TIME <u>6:30</u>	PERSONS DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED <u>See emergency contacts</u>
LATE FEE \$ <u>20.00</u>	PER MINUTE <u>15</u>	
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 minimum. (§ 3270.124, 3280.124, 3290.124)

R. Brathwaite

SIGNATURE-OPERATOR

DATE

SIGNATURE-PARENT OR GUARDIAN

DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

SIGNATURE-PARENT OR GUARDIAN

DATE

the



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 have any known vision difficulties? Yes No

If yes, please explain: _____

Has your child received services for impaired vision? Yes No

If yes, please explain: _____ conducted by? _____

What was the date of the last screening? _____

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.

Bank Draft Acct No. _____

C.C. Account No. _____

Routing No. _____

Expiration Date _____

CW: _____

CHILD HEALTH REPORT

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

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:	COUNTY:	WORK PHONE:
FACILITY 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: IF THE CHILD HAS EVER BEEN SCREENED FOR VISION, HEARING OR LEAD, THE SCREENING WAS A SUCCESS, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT THE FACILITY, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.

VISION (subjective until age 3)

HEARING (subjective until age 4)

LEAD

RECORD DATES OF IMMUNIZATIONS BELOW ON A SEPARATE PHOTO COPY OF THE CHILD'S IMMUNIZATION RECORD						COMMENTS
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	
HEP-B						
ROTAVIRUS						
DTAP/DTP/ID						
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: