Child's Name _____

Class/ Age Group: _____

For Youth Development
For Healthy Living
For Social Responsibility

* Must be Filled Out

2026-2027 Learning and Caring Registration

STEP 1: Please mark the programs your child will be attending **weekly**.

Infants (6 wks-12 months)

		Weekly Rate
☐	5 Days per Week	$ 235.00
☐	3 Days per week	$ 150.00
☐	2 Days per week	$ 105.00

Young Toddler (12-24 months)

		Weekly Rate
☐	5 Days per Week	$ 220.00
☐	3 Days per week	$ 140.00
☐	2 Days per week	$ 100.00

Older Toddler (24-36 months)

		Weekly Rate
☐	5 Days per Week	$ 215.00
☐	3 Days per week	$ 135.00
☐	2 Days per week	$ 95.00

3/4/5 Year olds- Pre-School/Pre-K

		Weekly Rate
☐	5 Days per Week	$ 205.00
☐	3 Days per week	$ 130.00
☐	2 Days per week	$ 90.00

STEP 2: The following fees must be paid at the time of registration

1st Week _____
Membership Dues _____
Total Paid _____

Office Use:
Starting program on:
___/___/___
MSR Initials _____
CCD 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 for 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 participate 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 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.

Pocono Family YMCA
REGISTRATION FORM

CHILD'S INFORMATION

* **Child's Full Name:** _____ ***Birthdate:** _____ * **Age:** _____

* **Grade Completed:** _____ ***School:** _____

* **Home Phone #:** _____

***Street:** _____ ***St:** _____ ***Zip:** _____

***City:** _____

PARENT/GUARDIAN INFORMATION

***Parent/Guardian #1:** _____ ***Authorized to pick up: YES / NO**

***Birthdate:** _____ (Circle one CELL / HOME / WORK

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

Alternate Phone#: _____

Parent/Guardian #2: _____ **Authorized to pick up: YES / NO**

Birthdate: _____ (Circle one CELL / HOME / WORK

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

Alternate Phone#: _____

*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

CHILD'S NAME *	**BIRTHDATE** *
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	* ADDRESS	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 Disabilites (IF ANY)	ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATION, SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS *	POLICY NUMBER (REQUIRED) *

PARENTS 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

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.)

Childcare

Snack

Homework Help

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON(S) DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
Late Fee: $20.00	PER MIN-HR **15 Minutes**	

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. (S 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. (S 3270.124, 3280.124, 3290.124)

PERIODIC REVIEW

SIGNATURE-OPERATOR	DATE	* SIGNATURE-PARENT OR GUARDIAN	DATE

DATE OF CHILD'S ADMISSION

DATE OF WITHDRAWAL

SIGNATURE-PARENT OR GUARDIAN 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:_____

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

CHILD HEALTH QUESTIONNAIRE

*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: _____

809 Main Street
Stroudsburg PA 18360
570-421-2525

Pocono Family YMCA Agreement and Waiver Child Care Updated 7.30.26

The safety and security of our members and those we serve is our number one priority. It is for this reason the YMCA conducts regular sex offender screenings on all members, participants, and guests. If a sex offender match occurs, the YMCA reserves the right to cancel membership, end program participation, and remove visitation access.

Should I/we participate in the YMCA Nationwide Membership Program, I/we understand that we must agree to release the National Council of Young Men's Christian Associations of the United States of America, and its independent and autonomous member associations in the United States and Puerto Rico, from claims of negligence for bodily injury or death in connection with the use of YMCA facilities, and from any liability for other claims, including loss of property, to the fullest extent of the law.

The YMCA recommends doctor's approval to exercise if you or participating family members are experiencing any medical conditions or are using any medications.

Liability Release:
NOTICE: THIS IS A LEGALLY BINDING AGREEMENT. Read this document carefully and in entirety. By signing this agreement, you give up your right to bring a court action to recover compensation or obtain any other remedy for any personal injury or property damage however caused arising out of your participation with the Pocono Family YMCA, now or at any time in the future.
Pocono Family YMCA Membership and/or Program Participant Waiver of Liability and Indemnity Agreement
PLEASE READ CAREFULLY. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND IS LEGALLY BINDING. BY SIGNING THIS AGREEMENT YOU ARE RELEASING THE POCONO FAMILY YMCA FROM ALL LIABILITY AND FOREVER GIVING UP ANY CLAIMS THEREFORE Assumption of Risk I acknowledge and agree that any use of the Pocono Family YMCA facilities, services, equipment and premises (Facilities) and any participation in the Pocono Family YMCA programs and activities (Programs) comes with inherent risks including, but in no way limited to: (1) moderate and severe personal injury, (2) property damage, (3) disability, (4) death, and (5) sickness or disease. I voluntarily accept and assume full responsibility for these risks as well as any and all other risks of the use of Facilities and participation in Programs.

I agree that I have full knowledge of the nature and extent of all such risks and am not relying on all such risks being described in this document. Waiver, Release, Indemnification & Covenant Not to Sue In consideration of the use of Facilities and participation in Programs I, the undersigned, agree that the Pocono Family YMCA, it's officers, directors, agents, employees, volunteers, insurers and representatives Releasees will not be liable for any personal injury, property damage, disability, death, sickness or disease incurred by myself, my family members, dependents, or guests, including minors, however occurring including, but not limited to the negligence of Releasees. I understand that I will be solely responsible for any loss or damage, including personal injury, property damage, disability, death, sickness or disease sustained from the use of Facilities and participation in Programs. I further agree, on behalf of myself and any and all legal successors and proxies, to release and HEREBY DO RELEASE, WAIVE AND COVENANT NOT TO SUE Releasees from any causes of action, claims, suits, liabilities or demands of any nature whatsoever including, but in no way limited to, claims of negligence, which I and any and all legal successors and proxies may have, now or in the future, against Releasees on account of personal injury, property damage, disability, death, sickness, diseases or accident of any kind, arising out of or in

*Parent/Guardian Signature: _____ Date: _____

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._____ Routing No. _____

C.C. Account No. _____ Expiration Date:_____ CVV:_____

* 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.