

# Westwood YMCA - Child Care Registration

2093 Harkney Hill Rd., Coventry, RI 02816  
(401) 397-7779 - Fax (401) 397-3930



Child's Name: \_\_\_\_\_ DHS # (if applicable): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Female [ ] Male [ ] School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Are you a member? Yes [ ] No [ ] Ethnicity: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_ Father/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

In case of emergency list parent to call 1st: \_\_\_\_\_ Phone: \_\_\_\_\_

Is there any court order relating to the child's custody or release? Yes [ ] No [ ]  
If yes, please provide a copy of the court order. Start Date: \_\_\_\_\_

## CHILD'S PARTICIPATION SCHEDULE

Washington Oak / Western Coventry Coventry Grades K - 6 (Elementary)	Metcalf Exeter/West Greenwich Grades K - 6 (Elementary)
<input type="checkbox"/> Before and After School	<input type="checkbox"/> After AM Kindergarten
<input type="checkbox"/> Before School Only	<input type="checkbox"/> Before PM Kindergarten
<input type="checkbox"/> After School Only	<input type="checkbox"/> Extended Kindergarten (½ day plus 3-6pm)
	<input type="checkbox"/> After School
	<input type="checkbox"/> Before School
	<input type="checkbox"/> Before and After School

Minimum of 2 days - Circle days for part time **ONLY**  
M T W TH F

## EMERGENCY CONTACT INFORMATION

**SIGN OUT AUTHORIZATION / EMERGENCY CONTACTS** - The following individuals have my **unrestricted** permission to sign the above named child out from the YMCA school - age child care program and should be contacted when I cannot be reached. (Minimum of two required)

Name	Phone #1	Phone #2	Relationship to Child

The following individuals are **restricted** from signing out my child due to a court - issued restraining order (A certified copy of the official court documentation must be kept in child's YMCA file).

Name	Name
Name	Name

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Important:** Please be aware that the signatures on this application are the only persons authorized to make changes. This includes adding or deleting pick - up names.

OFFICE USE ONLY:	Reg Fee _____	Membership _____	Pymt Agrmt _____	YN _____	ST _____
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## ENROLLMENT AGREEMENT

### Please carefully read and sign below.

- I understand that I am committing my child to participation in the School Age Child program for the current school year unless unforeseen events make withdrawal necessary. In that event, I will give written notification to the program director 10 days in advance.
- I understand that I am financially responsible for the services of care regardless if my child actually attends the program, even in the event of illness.
- I understand that my child will not be released to any person(s) not listed on the enrollment form. In case of an emergency an emergency release plan will be followed.
- I understand that my child must be signed in and out daily by myself or my designee (as listed on the enrollment form).
- I understand that my child will not be released to any person(s) who seem to be under the influence of drugs or alcohol.
- If my child is experiencing problems in the program, a conference will be arranged between the parent, program director and executive director. The YMCA reserves the right to terminate child care services if the problem(s) are not rectified.
- I understand that in the event that school is cancelled or dismissed early due to unfavorable conditions (such as bad weather, water main break, etc.), the YMCA services will also be cancelled. There is **no refund** for services due to unforeseen school cancellations or unscheduled dismissals.
- If I choose to participate in vacation weeks I must register in advance and pay in full and all accounts should be up to date.
- All information provided at the time of enrollment is complete and accurate.
- False or incomplete information may lead to termination of services.
- I understand that if any information on my child's enrollment forms changes, it is my responsibility to notify both the YMCA Branch and the program site director in writing immediately.
- **I have received, read, and agree to abide by all policies, procedures, and fee requirements as outlined in the parent handbook. I will make all authorized individuals aware of the policies and procedures as stated above and in the parent handbook.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTH HISTORY (to be filled out by parent)

1. Please list any medications your child is currently taking, including the dose and reason: \_\_\_\_\_
2. Please list all known allergies: \_\_\_\_\_
3. Please list the date and nature of any operations or serious injuries: \_\_\_\_\_
4. Please describe any disability or chronic or recurring illness: \_\_\_\_\_
5. Please list any activities encouraged or limited by the physician: \_\_\_\_\_
6. Please describe any dietary modifications or considerations: \_\_\_\_\_

***IMPORTANT: Please include a copy of your child's immunization record with this form***

## AUTHORIZATION FOR EMERGENCY TREATMENT

In consideration of admittance, I hereby authorize the Westwood YMCA to arrange for Medical examination and/or treatment of my child, should an emergency arise at the child care site or on a field trip. It is also understood that a conscientious effort will be made by the staff to contact me at the emergency numbers I have provided below before any medical action is taken.

I would prefer to have my child taken to the following hospital if the need arises: \_\_\_\_\_.

I understand the choice of hospital may be limited by the service of local rescue squad.

Print Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Health Insurance Coverage: \_\_\_\_\_ Policy Number: \_\_\_\_\_

This health history is correct, as far as I know, and the person herein described has permission to engage in all prescribed activities excepted as noted. I hereby give my permission to the medical personnel selected by the child care director to order routine tests, x-rays, treatment and necessary transportation for the individual named above.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# EMERGENCY CLOSURE - EARLY DISMISSAL FORM

Child's Name	Grade	Teacher's Name	School Name
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In the event that school should dismiss early due to an emergency closure, such as inclement weather, power failure, water main break, etc., the school age child care program will be canceled. Also, if the school calls for an early dismissal not previously scheduled in the current school calendar, the YMCA school age child care program will be canceled.

Please complete the section below:

If there is an emergency school closure or unscheduled early dismissal, my child:

- Will be picked up by \_\_\_\_\_ Phone: \_\_\_\_\_.
- Other \_\_\_\_\_.

If there is any change in the above procedure, please notify in writing your site director and the YMCA branch at once!

I understand that it is my responsibility to ask the school office about their procedure for emergency closure/dismissal. I have discussed these procedures with my child, and my child understands what he/she should do in the event of an emergency school closing or early dismissal.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



YMCA

We build strong kids,  
strong families, strong communities.



# WESTWOOD YMCA

## FAMILY MEMBERSHIP

Family Last Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Ethnic Origin \_\_\_\_\_

Father's Place of Business \_\_\_\_\_ Work# \_\_\_\_\_  
Email Address \_\_\_\_\_ Cell# \_\_\_\_\_

Mother's Place of Business \_\_\_\_\_ Work # \_\_\_\_\_  
Email Address \_\_\_\_\_ Cell # \_\_\_\_\_

### **Members: Must reside in the same household**

1. Father's Name _____	Birth Date _____
2. Mother's Name _____	Birth Date _____
3. Child's Name _____	Birth Date _____
4. Child's Name _____	Birth Date _____
5. Child's Name _____	Birth Date _____
6. Child's Name _____	Birth Date _____
7. Child's Name _____	Birth Date _____
8 Child's Name _____	Birth Date _____

How did you hear about the YMCA?

(Please check one)

- Direct Mail
- Newspaper
- Friend
- YMCA
- Drive by - Live in area
- Other \_\_\_\_\_



### OFFICE USE ONLY

_____	_____	_____	_____	_____	_____
Date	Amount	MemberST	Car Passes	Guest Passes	Program Book

School Name & Address:

Health Care Provider Name and Address:

**STATE OF RHODE ISLAND  
SCHOOL PHYSICAL FORM**

Phone:

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Address: Street	Apt #	City	State	Zip Code
				Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript). The requested information is in accordance with the State of Rhode Island Rules and Regulations for: Immunization and Testing for Communicable Disease, School Health Programs, and Lead Poisoning Prevention. Website: [www.rules.state.ri.us/rules](http://www.rules.state.ri.us/rules)

IMMUNIZATIONS					
Hepatitis B	___/___/___	___/___/___	___/___/___		
Diphtheria-Tetanus- Pertussis DTP/DTaP	___/___/___ Check <input type="checkbox"/> if DT	___/___/___ Check <input type="checkbox"/> if DT	___/___/___ Check <input type="checkbox"/> if DT	___/___/___ Check <input type="checkbox"/> if DT	___/___/___ Check <input type="checkbox"/> if DT
Pneumococcal Conjugate PCV	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	<input type="checkbox"/> IPV or <input type="checkbox"/> OPV	<input type="checkbox"/> IPV or <input type="checkbox"/> OPV	<input type="checkbox"/> IPV or <input type="checkbox"/> OPV	<input type="checkbox"/> IPV or <input type="checkbox"/> OPV	
Haemophilus Influenzae Type B Hib	___/___/___	___/___/___	___/___/___	___/___/___	
Measles-Mumps-Rubella MMR	___/___/___	___/___/___			
Varicella	___/___/___	___/___/___	<input type="checkbox"/> Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis Tdap	___/___/___				
Tetanus-Diphtheria Td	___/___/___	___/___/___	___/___/___		
Meningococcal	___/___/___	___/___/___			
Immunization Exemption: Medical <input type="checkbox"/> Religious <input type="checkbox"/>					
<input type="checkbox"/> Hepatitis B <input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> Hib <input type="checkbox"/> PCV <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Td/Tdap					
PHYSICAL EXAMINATION					
Date of PE ___/___/___		Height _____	Weight _____	BP _____	
Please note any health problem, chronic health condition, or disability that may affect behavior or health at school:					
ASTHMA: No <input type="checkbox"/> Yes <input type="checkbox"/>		DIABETES: No <input type="checkbox"/> Yes <input type="checkbox"/>		OTHER: _____	
Significant Systems Findings: _____					
ALLERGIES: No <input type="checkbox"/> Yes <input type="checkbox"/> (Please explain) _____		EPINEPHRINE AUTO-INJECTOR REQUIRED: No <input type="checkbox"/> Yes <input type="checkbox"/>			
Treatment Plan: _____					
MEDICATION (REQUIRED AT SCHOOL): No <input type="checkbox"/> Yes <input type="checkbox"/> (Please list) _____		Other medication(s) that may affect behavior or health at school: _____			
RESTRICTIONS: Can participate in physical education:		Fully <input type="checkbox"/>	With limitation <input type="checkbox"/>	_____	
Can participate in sports:		Fully <input type="checkbox"/>	With limitation <input type="checkbox"/>	_____	
LEAD SCREENING (Required for children < 6 years of age only) Student is in compliance with lead screening requirements: Yes <input type="checkbox"/> No <input type="checkbox"/>		VISION SCREENING (Required for children entering kindergarten) <input type="checkbox"/> Pass <input type="checkbox"/> Failed and referred for comprehensive exam <input type="checkbox"/> Not screened and referred for comprehensive exam		SCOLIOSIS SCREENING Yes <input type="checkbox"/> No <input type="checkbox"/>	
TUBERCULOSIS (if required by school district) Date of TB test: ___/___/___		___/___/___	___/___/___	___/___/___	___/___/___

HEALTH CARE PROVIDER SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_