MUST HAVE TO REGISTER FOR SACC:

- ☐ Registration Forms
- ☐ Registration Fee ($30)
- ☐ First week payment
- ☐ Immunization Records
- ☐ Parent Handbook
- ☐ DCN Number (if applicable)

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
CHILD'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about military-related services in Missouri or visit www.dese.mo.gov/veterans-services.

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY OTHER THAN PARENT (AT LEAST ONE EMERGENCY CONTACT IS REQUIRED)

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ Yes ☐ No	CHILD'S RELATION TO CHILD CARE PROVIDER

ETHNIC AND RACE INFORMATION (YOU ARE NOT REQUIRED TO ANSWER THIS SECTION)

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

What is your race? (Select one or more.)	☐ American Indian or Alaskan native	☐ Asian	☐ Black or African American	☐ Native Hawaiian or other Pacific Islander	☐ White

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

Will child attend: ☐ Full time ☐ Part time Check what days your child will attend.		When does your child usually arrive each day?	When does your child usually leave each day?	Describe any changes or variations in usual attendance, including shift changes.
Monday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Tuesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Wednesday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Thursday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Friday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Saturday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Sunday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	

MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack ☐ None

HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ New Year's Day	☐ Easter	☐ Labor Day
☐ Martin Luther King, Jr.'s Birthday	☐ Truman Day	☐ Columbus Day
☐ Lincoln's Birthday	☐ Memorial Day	☐ Veterans Day
☐ Washington's Birthday	☐ Juneteenth	☐ Thanksgiving Day
	☐ Independence Day	☐ Christmas Day

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in the event of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make the necessary arrangements, or in a critical emergency requiring medical care, I authorize

_____

(CHILDCARE FACILITY NAME)

to contact the following:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGMENTS

A	I have received a copy of this facility's policies pertaining to the admission, care, and discharge of children.	PARENT/GUARDIAN INITIALS
B	I have been informed that a copy of the licensing rules for child care home or the licensing rules for group child care homes and centers is available at this facility for review.	PARENT/GUARDIAN INITIALS
C	The provider and I have agreed on a plan for continuing communication regarding my child's development, behavior, and individual needs.	PARENT/GUARDIAN INITIALS
D	When my child is ill, I understand and agree that s/he may not be accepted for care or remain in care.	PARENT/GUARDIAN INITIALS
E	I understand that, before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations or exemption from immunizations.	PARENT/GUARDIAN INITIALS
F	I ☐ do ☐ do not give permission for field trips/excursions. I understand that I will be notified in advance when they are planned.	PARENT/GUARDIAN INITIALS
G	I ☐ do ☐ do not give permission for the facility to transport my child.	PARENT/GUARDIAN INITIALS
H	I have been informed and have received a copy of the facility's safe sleep policy when enrolling a child less than one (1) year of age.	PARENT/GUARDIAN INITIALS
I	I have been notified that I may request notice at initial enrollment or at any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.	PARENT/GUARDIAN INITIALS

PARENT/GUARDIAN SIGNATURE	DATE

CACFP REQUIREMENT			
	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-05080002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW Washington,
   D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

SCHOOL-AGE CHILD HEALTH REPORT

IDENTIFYING INFORMATION	
CHILD'S NAME	BIRTHDATE

HEALTH STATEMENT (CHECK ONE)

☐ My child is in good health, is able to participate in group care, has no special health or medical requirements.

☐ My child is able to participate in group care but has special health or medical requirements as listed below.

SCHOOL-AGE CHILD'S SPECIAL HEALTH OR MEDICAL REQUIREMENTS

PLEASE LIST ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS (SUCH AS ASTHMA, SEIZURES), BEHAVIORAL DISORDERS, SPECIAL NEEDS, ETC.

PARENT OR LEGAL GUARDIAN SIGNATURE	DATE

TO BE FILED IN CHILD'S RECORD AT CHILD CARE FACILITY.

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

MEDICATION AUTHORIZATION

SAVE
PRINT
RESET

MEDICATION REQUIREMENT

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

I AUTHORIZE CHILD CARE PERSONNEL TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD:

(PROPER NAME OF MEDICATION)

CHILD'S FULL NAME	DATE MEDICATION TAKEN FROM	UNTIL

DOSAGE	TIME(S) OF DAY

POSSIBLE SIDE EFFECTS

SIGNATURE OF PARENT(S) OR GUARDIAN	DATE

RECORD OF ADMINISTRATION

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME

FORM TO BE RETAINED IN CHILD'S RECORD

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

CACFP ENROLLMENT FORM FOR CHILD CARE CENTERS

CENTER'S INFORMATION

NAME OF CHILD CARE CENTER	PHONE NUMBER

CENTER CONTACT PERSON'S NAME	CHILD'S DATE OF ENROLLMENT (FIRST DATE ATTENDING THIS CENTER)

CHILD'S INFORMATION

CHILD'S FULL NAME	DATE OF BIRTH

PARENT OR GUARDIAN NAME	STREET ADDRESS

CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER

ETHNIC AND RACE INFORMATION (YOU ARE NOT REQUIRED TO ANSWER THIS SECTION)

ARE YOU OF HISPANIC OR LATINO ORIGIN?

☐ Yes ☐ No

WHAT IS YOUR RACE? (SELECT ONE OR MORE)

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

IN THIS COLUMN, CHECK THE DAYS YOUR CHILD USUALLY ATTENDS DAY CARE:		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM
MON		AM PM	AM PM
TUES		AM PM	AM PM
WED		AM PM	AM PM
THURS		AM PM	AM PM
FRI		AM PM	AM PM
SAT		AM PM	AM PM
SUN		AM PM	AM PM

WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION:

CHECK WHEN YOUR CHILD IS IN CARE AT THIS CENTER

☐ FULL DAY CARE
☐ HALF DAY - MORNING
☐ HALF DAY - AFTERNOON
☐ BEFORE SCHOOL CARE
☐ AFTER SCHOOL CARE
☐ BEFORE AND AFTER SCHOOL CARE
☐ EVENING CARE
☐ OVERNIGHT CARE

CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS CENTER

☐ BREAKFAST
☐ MORNING SNACK
☐ LUNCH
☐ AFTERNOON SNACK
☐ SUPPER
☐ EVENING SNACK

CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS CENTER

☐ NEW YEARS DAY
☐ MARTIN LUTHER KING'S BIRTHDAY
☐ LINCOLN'S BIRTHDAY
☐ WASHINGTON'S BIRTHDAY
☐ EASTER
☐ TRUMAN DAY
☐ MEMORIAL DAY
☐ JUNETEENTH
☐ INDEPENDENCE DAY
☐ LABOR DAY
☐ COLUMBUS DAY
☐ VETERAN'S DAY
☐ THANKSGIVING DAY
☐ CHRISTMAS DAY

SIGNATURE OF PARENT OR GUARDIAN	DATE

NOTE: DEPARTMENT OF HEALTH AND SENIOR SERVICES OFFICIALS OR A SPONSORING ORGANIZATION REPRESENTATIVE MAY CONTACT YOU TO VERIFY INFORMATION.

ANNUAL UPDATES: THE PARENT OR GUARDIAN SIGNING THIS FORM CERTIFIES THAT THE ENROLLMENT INFORMATION IS CORRECT. IF INFORMATION HAS CHANGED, THE PARENT OR GUARDIAN HAS WRITTEN THE APPROPRIATE CHANGES ON THE FORM AND INITIALED THE CHANGE. IF THERE ARE MANY CHANGES, PLEASE COMPLETE A NEW FORM

FIRST ANNUAL UPDATE	PARENT SIGNATURE	DATE
SECOND ANNUAL UPDATE	PARENT SIGNATURE	DATE
THIRD ANNUAL UPDATE	PARENT SIGNATURE	DATE

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https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:** U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or

2. **fax:** (833) 256-1665 or (202) 690-7442; or

3. **email:** program.intake@usda.gov

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
CHILD AND ADULT CARE FOOD PROGRAM (CACFP)

INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the child care center.

PART 1: CHILDREN ENROLLED AT THE CHILD CARE CENTER

Complete information below for children enrolled at the center. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number **for all of the children listed in Part 1.**

NAME (first and last)	FOSTER CHILD	BIRTH DATE	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER
		/ /		
		/ /		
		/ /		
		/ /		

PART 2: HOUSEHOLD AND INCOME INFORMATION

List all members of the household not including the children listed in Part 1. Indicate source and amount of current monthly gross income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months. Foster children may be eligible regardless of household income. Contact the center for more information.

INCOME BASED ON (CHECK ONE) ☐ YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3: RACIAL ETHNIC INFORMATION (You are not required to answer this section)

Are you of Hispanic or Latino origin? ☐ YES ☐ NO

What is your race? (Select one or more)

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE

PART 4: SIGNATURE

I hereby certify that all information provided is correct. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal laws.

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER (LAST 4 DIGITS ONLY)	DATE
	XXX-XX-	/ /
PRINTED NAME OF ADULT	**ADDRESS**	**PHONE NUMBER**
		( ) -

Section 9 of the National School Lunch Act requires that, unless your children's SNAP or Temporary Assistance case number is provided, you must include the last four digits of a social security number of the adult household member signing the application or indicate that the household member signing the application does not possess a social security number. Provision of the last four digits of a social security number is not mandatory, but if the last four digits of a social security number are not provided or an indication is not made that the signer has none, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the accuracy of information stated on the application. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR CENTER USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ☐	MONTH ☐	2 X A MONTH ☐	EVERY 2 WEEKS ☐	WEEKLY ☐	SNAP (Food Stamp) ☐	TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Free ☐ Reduced ☐ Paid

SIGNATURE OF CENTER REPRESENTATIVE	DATE

SCHOOL AGE CHILD CARE PROGRAM
FEE SCHEDULE

Child's Name: _____ Birthdate:_____

School Attending: _____

DCN # _____ (if applicable)

Please Check One	✓	Part Time (1-2 Days) Members	✓	Part Time (1-2 Days) Community Participant	✓	Full Time (3 Days or more) Members	✓	Full Time (3 Days or more) Community Participant
Before School		$24.00		$36.00		$30.00		$42.00
After School		$30.00		$46.00		$38.00		$53.00
Before & After School		$45.00		$67.00		$56.00		$84.00

Payment Terms:

- Registration Fee: $30 per family, due at registration, along with first week's tuition.
- Weekly fees are paid on Wednesday by electronic funds transfer (EFT) from a specified checking/ savings account, credit or debit card for the current week of service. Should any EFT or charge not be honored, the Y will attempt to redraft the payment. If the EFT or charge is not honored on the redraft, another form of payment must be provided, plus a $10 service charge.
- **Failure to notify the Y a week in advance of any changes to your child's schedule or enrollment will result in the bank draft being processed on the Wednesday of the current week. No refunds will be issued.**

_____ _____

Parent Signature Date

ACCOUNT ACCESS AUTHORIZATION

I authorize the following to have access to my child(ren)'s account in the event that the named person(s) is paying the account. I understand by listing the person(s), that they will have access to the account balance for my child(ren). If a person has not been authorized, information about my child(ren)'s account should not be provided.

_____
Name

_____
Name

EXTRA CURRICULAR ACTIVITIES

I give my permission for my child _____, to participate in
Name of Child

_____. The program will run from_____
Name of Program Start Date

to _____, and they will meet every _____ from _____ to _____.
End Date Day of the Week Start Time End Time

_____ My child WILL return to the School Age Child Care program after the activity.

_____ My child WILL NOT return to the School Age Child Care program after the activity.

_____ _____
Parent Signature Date

PARENT INFORMED CONSENT AGREEMENT

Name of Child:_____

_____ 1. I give permission for my child to participate in activities, field trips, and swimming.

_____ 2. I give permission for my child to be given CPR and First Aid treatment by qualified YMCA staff as necessary until emergency personnel arrives. In the event hospitalization is required, I give consent for my child to be taken to a hospital and to be treated by a qualified physician. I agree to assume financial responsibility for such treatment.

_____ 3. I give permission for my child to be transported by emergency vehicle.

_____ 4. I give permission for my child's photograph/video to be printed and/or used in promotional materials such as Facebook for the YMCA.

_____ 5. I've read the Parent Handbook and agree to abide by all rules and regulations stated. All information is correct and current.

_____ 6. I understand that registration is not complete unless the registration fee and the payment of the first week's tuition accompanies this form.

_____ 7. I understand that these agreements are subject to updates and revisions.

SCHOOL AGE CHILD CARE PROGRAM
STATEMENTS OF UNDERSTANDING

____ Payments are processed every **Wednesday** for the current week of care.

____ The total cost of running a 9-month program is divided equally among 9 months. The tuition remains the same each week regardless of out of school breaks or the number of half-weeks, or school closings due to inclement weather.

____ I will call to inform the Site Director when my child will not be attending on any day for which he or she is signed up.

____ In the event that any of the work numbers, home numbers, or emergency contact numbers that are listed for my child(ren) should change, I will immediately inform the Site Director. I will also make sure that the emergency contacts I list for my child(ren) are aware that they may be called if I cannot be reached.

____ In order to change my child(ren)'s schedule, I must provide 1 week written notice, using the Change Form, to the Youth Development Director. I understand that my account must be at a zero balance before I can make any changes.

____ In order for this registration to be processed in accordance with the Missouri State Licensing Department, all information requested on the following registration forms must be completed at this time.

____ I may disenroll my child earlier than May with written notice (a minimum of one week prior to child's final attendance). I am responsible for payment through my child's last day.

____ Credits or refunds will not be given for days missed due to illness, school closings due to inclement weather, (without 1 week's written notice), or suspensions from the program.

____ A non-negotiable Late Pick-Up Fee of $25 will be assessed for all incidents of late pick-up (defined as 6:01 p.m. or after). This fee will automatically be drafted from the bank account or credit card you have on file. Continuous late pick up may result in my child's dismissal from the program.

____ A copy of my child's immunization record has been turned in with this packet.

____ I have read, understand, and will adhere to the policies and procedures set forth in the School Age Child Care Program Policy and Procedures Parent Handbook.

____ I attest that my child is in good health and is able to participate in all YMCA activities. The last physical check up date for my child was_____.

I, _____, have read, understand, and will adhere to the
(Parent's Name)

policies and procedures set forth in the School Age Child Care Policy and Procedures.

Parent Signature _____Date _____

SCHOOL AGE CHILD CARE BANK DRAFT FORM

School name: _____

First Name	MI	Last Name	M/F	Birth Date

Telephone	Cell	Email

Billing Address

Street	City	State	Zip

Payment Terms & Conditions

■ In order to provide for convenient School Age Child Care payments to the YMCA of St. Joseph, we authorize electronic funds transfer (EFT) from this specified checking/savings account, credit or debit card. We will provide a one week written notice for any changes to our account. Please Initial _____

■ Should any EFT or charge not be honored, we understand that the Y will attempt to redraft the payment. If the EFT or charge is not honored on the redraft, we will be required provide another form of payment plus a $10 service charge. Please Initial _____

Failure to notify the Y a week in advance of any changes to your child's schedule or enrollment will result in the bank draft being processed on the Wednesday of the current week. No refunds will be issued. Please Initial _____

Payment Options

Electronic Funds Transfer (EFT): $. beginning (MMYY)

A. ☐ Checking ☐ Savings Bank Name:_____

Account Number

Routing Number

Please attach a voided check

B. Debit/Credit Card: ☐ Visa ☐ MC ☐ Discover ☐ AMEX

Expire Date

I have read and agree to all terms of the YMCA payment terms and conditions.

Signature of Responsible Party	Date

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF ST. JOSEPH THIRD PARTY RESPONSIBILITY AGREEMENT

This form must be signed and submitted at time of registration.
Only parents with third party billing of DFS/Voc Rehab need to fill out this form.

The YMCA of St. Joseph accepts payment from DFS (Division of Family Services)/Voc Rehab. It is important that you read the fee schedule so you are aware of the rates you will be charged for any YMCA services used which are not covered by your third party funding. This agreement is **REQUIRED** for all families who are subsidized by DFS/Voc Rehab, Third Party agencies, or other individuals. Please read the following carefully.

As a parent or legal guardian of **(child's name)**, I understand and agree to the following:

- I am responsible for payment of the **full weekly tuition fee, due every Wednesday (paid by EFT) for the current week of service,** until official notice of DFS/Voc Rehab qualification is received. I have read the **Parent Handbook and Fee Schedule,** including payment policies, and understand that I am responsible for any fees not covered by DFS/Voc Rehab or third party, **including the $30 per family registration fee.**

- Initially I am responsible for **payment at the full fee for any care I use that is not authorized by DFS/Voc Rehab.**
  This includes, but is not limited to:
  1. Any care that occurs before or after the dates authorized by DFS/Voc Rehab.
  2. Care used on days/times not authorized by DFS/Voc Rehab.
  3. Late pick-up fees
  4. Late payment fees
  5. **ANY** other fees as indicated in YMCA documents including the Parent Handbook.

- I will **contact DFS/Voc Rehab and the YMCA immediately, in writing, if my situation changes (employment status, hours of work or enrollment in school, class schedule, custody issues, living arrangements, change of address).**

- I will provide my caseworker with documentation at least **two weeks before my contract expiration date.** This gives your caseworker time to process your information and provide a new authorization to the Y before your current contract expires.

- Cancellation/Expiration of DFS/Voc Rehab funds **does not automatically cancel or change** my childcare with the YMCA. **I am responsible for completing change/cancellation forms** according to YMCA policies. **If your DFS/Voc Rehab expires,** you will be charged **as a full paying family** until the Y receives a change/cancellation form.

- I understand that **YMCA financial assistance may be available** if I have applied, but do not qualify for DFS/Voc Rehab. Financial assistance **is not retroactive**.

- **I understand that failure to make payments as scheduled can/will result in termination of my care and will result in lack of DFS/Voc Rehab benefits for future providers. Failure to pay all fees in a timely manner may result in disenrollment from the program and your account being sent to collection.**

Expiration Date: _____

Weekly Amount due from parent $_____

Child's Name: _____

Program Location: _____

DCN #_____

Parent/Guardian Name *(please print)*_____

Parent/Guardian Signature: _____

Date: _____

DVN Numbers

- **Eugene Field –** 000177017
- **Hyde –** 001800028
- **Parkway –** 001800073
- **Pershing –** 001800082
- **Pickett –** 001993231
- **Oak Grove –** 002487385
- **Skaith –** 003003743
- **Carden Park –** 003018531

YMCA OF ST. JOSEPH, MO

READ CAREFULLY BEFORE SIGNING – INITIAL EACH PARAGRAPH

___ INITIALS **I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my participation at** YMCA of St. Joseph, MO. On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless YMCA of St. Joseph, MO, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of YMCA of St. Joseph, MO, its employees, agents, and representatives.

___ INITIALS I represent that I have adequate insurance to cover any injury or illness I may suffer or cause while participating in this activity, or else I agree to bear the costs of such injury or illness myself. I further represent that I have no medical or physical condition which could interfere with my safety in this activity, or else I am willing to assume – and bear the costs of – all risks that may be created, directly or indirectly, by any such condition.

___ INITIALS In the event that I file a lawsuit, I agree to do so in the state where YMCA of St. Joseph, MO is located, and I further agree that the substantive law of that state shall apply. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

___ INITIALS **I have had sufficient time to read this entire document and, should I choose to do so, consult with legal counsel prior to signing.** Also, I understand that this activity might not be made available to me or that the cost to engage in this activity would be significantly greater if I were to choose not to sign this release, and agree that the opportunity to participate at the stated cost in return for the execution of this release is a reasonable bargain. **I have read and understood this document and I agree to be bound by its terms.**

___ INITIALS If I have signed a separate general waiver of liability connected to my participation at YMCA of St. Joseph, MO, I agree that the terms of that waiver are wholly incorporated into this document and that the terms of this document are incorporated into the separate general waiver.

Signature_____Print Name_____Telephone (___)_____

Address_____ City_____ State_____ Zip_____Date _____

PARENT OR GUARDIAN ADDITIONAL AGREEMENT (Must be completed for participants under the age of 18)
In consideration of minor's name being permitted to participate in this activity, I further agree to indemnify and hold harmless Releasees from any claims alleging negligence which are brought by or on behalf of minor or are in any way connected with such participation by minor.

Minors' Names

Print Name_____Print Name_____Print Name_____

Parent or Guardian_____ Print Name_____ Date_____

Acknowledgement of Receipt of YMCA School Age Child Care Parent Handbook

I acknowledge I have received a copy of the YMCA School Age Child Care Parent Handbook. I agree to abide by the policies and procedures outlined in this handbook.

_____ _____

Parent's Signature Date