2025-2026 NEW ROCHELLE YMCA AFTER SCHOOL REGISTRATION FORM

Please print clearly - One form is REQUIRED for EACH child – We thank you in advance.

Child's Name:			
Birthdate:	**School and Grade:**		**Gender:**
Home Address:	**City:**	**State:**	**Zip:**
Medications: ▢ No ▢ Yes If yes, include in Health History	**Allergies:** ▢ No ▢ Yes If yes, include in Health History		
Parent/Guardian 1: (Authorized Pick up)	**Parent/Guardian 2: (Authorized Pick up)**		
Cell phone:	**Cell phone:**		
Work phone:	**Work phone:**		
Email (for updates & newsletter. Print clearly)	**Email (for updates & newsletter. Print clearly)**		
Parental Custody/Special Arrangements: (Please list here)			

- **Ethnicity** ▢ African American ▢ Hispanic ▢ Caucasian ▢ Asian/Pacific Islander ▢ Native American ▢ Unspecified ▢ Other: _____

For grant purposes

EMERGENCY CONTACTS & PICK UP AUTHORIZATION (May NOT be primary mother/father/guardian)

In an emergency situation, parents will be contacted first and Emergency Contacts will be contacted only if parents/guardians listed above cannot be reached. Please list in order to be contacted. All individuals authorized to pick up your children from the program must be at least 18 years of age. Children will not be released to minors. A license or other positive proof of identification must be shown at pick up. Please make sure that the individuals on this list are aware that they may be called in an emergency to pick up your child.

I give permission for the emergency contact persons listed below to authorize medical treatment or to pick up and/or transport my child from the program in my absence. I understand that persons listed as "Emergency Contacts" are automatically authorized to pick up my child from the program. In emergency situations only, I will give verbal and/or written permission for an individual, who is not on this list to pick up my child. I understand no child will be released without emergency verbal/written permission.

I further understand and agree that once my child is released into the custody of any of the individuals listed below, in addition to the parents/guardians noted above, the YMCA and its staff no longer has any responsibility for my child. We recommend that you establish a secret password with your child to be used in an emergency situation.

Late Pick-Up: If a child is picked-up late, a charge of $1.00 per minute will be applied to your bill. Habitual late pick-ups may result in suspension from the program. Please be on time.

ADDITIONAL AUTHORIZED PICKUP & CONTACTS -Relatives, Friends, Babysitter, etc. (Not parents)

Name:	**Relationship:**	**Cell #:**	**Home/Work #:**
Name:	**Relationship:**	**Cell #:**	**Home/Work #:**
Name:	**Relationship:**	**Cell #:**	**Home/Work #:**

Name:	Relationship:	Cell #:	Home/Work #:
Name:	Relationship:	Cell #:	Home/Work #:

CHILD HEALTH HISTORY INFORMATION

This section is **required** for your camper's care and is mandated by the State of NY.

May participate in all activities (see the camp guide for the full list)

Please restrict from these activities: _____

I am providing my child's immunization records or I will be providing a current copy *within one month* of after school. I understand that my child will not be able to attend after school without these up to date records.

Please describe any past medical treatment that this camper has received or any medical/health/ behavior information helpful to know in a camp setting (attach additional page if needed):	
Insurance Carrier:	**Insurance Policy #:**
Child's Physician:	**Physician's Phone #:**
Child's Dentist:	**Dentist's Phone #:**
Allergies: ▫ No ▫ Yes–If yes, list below:	Medications: ▫ No ▫ Yes–If yes, list below:
Dietary Restrictions:	
What do you find to be the most successful in terms of encouraging positive behavior and discipline?	

ADMINISTRATION OF FIRST AID

These steps may include, but are not limited to the following: contacting parent/guardian; authorized alternate persons; child's physician/dentist.

ABSENT PARENT CONSENT FOR EMERGENCY TREATMENT OF A MINOR

- I hereby authorize the staff of the New Rochelle YMCA to give first aid and CPR to my child as needed. I understand that the staff are trained in the basics of First Aid and CPR.
- In the event of an emergency, I hereby authorize the program staff to have my child transported to the nearest medical facility to secure necessary medical treatment.
- I give permission for the emergency contact persons to authorize medical treatment or to pick up and/or transport my child from the program in my absences
- In the event that I cannot be reached, I hereby authorize any licensed physician to provide proper treatment, order injections, hospitalize, give anesthesia or perform emergency surgery for my child. give permission to the physicians attending to my child to secure and administer treatment as necessary. I understand that this authorization is given prior to any need for medical care, but is given to avoid unnecessary delay in emergency treatment, which the physician may deem advisable.
- I understand that the staff will make every effort to notify me of the emergency immediately.
- I hereby grant permission for the staff to take any steps necessary to obtain medical or dental care if warranted The YMCA shall not be held responsible for anything that may happen as a result of false information given at the time of enrollment.

I **have read, understood and agreed** to the conditions **as stated above.**

Parent Signature:	**Date:**

2025 NEW ROCHELLE YMCA AFTER SCHOOL REGISTRATION FORM PARENT AGREEMENT (PLEASE READ CAREFULLY)

Child's Name:	DOB:

The following information is important for the safety of your child. Please read the information and sign below. Please keep and refer to your copy of the **YMCA** Parent Handbook, which outlines our program Policies and Procedures. Your signature below indicates that you have received them, read them and will adhere to all regulations and requirements.

- I have received and read the parent handbook.
- I understand the New Rochelle YMCA Codes of Conduct for parents and each child and will obey these codes as outlined in the parent handbook. Should we not comply with the codes of conduct, we understand we can be asked to leave the program and the YMCA and forfeit any fees or payments for programs paid.
- I grant permission for my child to use all of the play equipment and participate in all of the activities of the program with the exception of: _____
- I hereby grant consent for my child to participate in swimming in life-guarded places only.
- My child's ability to swim is (select one:) ☐Non-swimmer ☐Beginner ☐Intermediate ☐Advanced
- I grant permission for my child to use all the play equipment and participate in all of the activities of the center.
- I grant permission for my child to walk to nearby parks and use the play equipment under the supervision of YMCA staff.
- I grant permission for my child to leave the program premises under the supervision of a staff member for a field trip, in an authorized vehicle.
- I hereby grant consent and authorize the use of photographs, slides, videotape and film of my child participating in New Rochelle YMCA activities for commercial and art purposes in any medium of advertising, communication, publication or publicity that will promote New Rochelle YMCA programs and services, and/or recognition of participants. I understand that the YMCA is a non-profit organization.
- I understand that YMCA staff and volunteers are ***not allowed to baby-sit*** *or* ***transport children at any time outside of the YMCA program****.* The YMCA may take immediate disciplinary action toward staff and volunteers if a violation is discovered.
- I understand I am not to leave my child at the YMCA or program site unless a YMCA staff or volunteer is there to receive and supervise my child.
- I understand that my child will not be allowed to leave the program with an unauthorized person.
- I understand any person, myself or other parent/guardian included, picking up my child(ren) may ask to verify their identification with a license at any time.
- I understand that should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police.
- I understand that if my child is picked up after dismissal more than 3 times, I may be asked to leave the program.
- I understand that the YMCA is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- I certify that my child has my permission to apply self-supplied sunscreen and bug repellent as necessary.
- I certify that a licensed physician has examined my child in the last 12 months and I have provided the New Rochelle YMCA with documentation with immunization records.
- I understand that the New Rochelle YMCA can suspend any child at any time for inappropriate or dangerous behaviors.
- I understand that only the person that signs this form may make changes to it.
- I understand that fees are nonrefundable.
- I give permission for my child to walk to the **YMCA of New Rochelle** located at 50 Weyman Avenue, New Rochelle, NY 10805 from **Jefferson Elementary School** with the New Rochelle YMCA After-School program.

PARENT STATEMENT OF UNDERSTANDING

The New Rochelle YMCA strongly believes that our after school program will most effectively meet your child's developmental needs by providing continuous care. The YMCA has made a commitment to maintain staff, curriculum and facilities that will enrich your child's learning and growth experiences. We seek a similar commitment from you. In signing this agreement, you have reserved your child's space for the 2024-2025 after school program and you dates you are responsible for full payment. Under no circumstances will the YMCA accept less than 60 days written notice of the withdrawal of your child from the program. The **YMCA** reserves the right to charge for full services throughout the notice period. Registration, deposit, late fees and membership fees are non-transferable and non-refundable if at any time you or the **YMCA** of New Rochelle terminates services.

I **have read, understand and agree to the following:**

- Registration and payment is due before each month. After school fees are nonrefundable.
- My child will not be able to attend YMCA programming until the enrollment form, administration of medication and child's health record are completed, signed by all parties and returned to the Y.
- I have received a copy of the YMCA Parent Handbook with policies and procedures.

Parent Signature:	Date:

NEW ROCHELLE YMCA AFTER SCHOOL **2025 PAYMENT PLAN FORM**

Child's Name:	DOB:

PLEASE CHECK OFF DESIRED AFTERSCHOOL SITE:

AFTER SCHOOL SITE	DAYS PER WEEK	Half Days ($40 additional per ½ day from 11:30 AM – 3:00 PM)
50 WEYMAN AVE, MAIN LOCATION **3:00 PM – 6:30 PM** **CHECK BOX HERE:** ☐	☐ 5 Days Per Week ($150/week) ☐ 3 Days Per Week ($100/week) Tuition is billed monthly on the 1st	☐ November 27th, 2024 ☐ December 5th, 2024 ☐ December 11th, 2024 ☐ January 28th, 2024 ☐ March 17th, 2024 ☐ June 25th, 2024 ☐ June 26th, 2024 ☐ June 27th, 2024
WEBSTER ELEMENTARY SCHOOL **3:00 PM – 6:00 PM** **CHECK BOX HERE:** ☐	☐ 5 Days Per Week ($150/week) ☐ 3 Days Per Week ($100/week) Tuition is billed monthly on the 1st	☐ November 27th, 2024 ☐ December 5th, 2024 ☐ December 11th, 2024 ☐ January 28th, 2024 ☐ March 17th, 2024 ☐ June 25th, 2024 ☐ June 26th, 2024 ☐ June 27th, 2024

$100.00 REGISTRATION FEE REQUIRED

CREDIT CARD/BANK ACCOUNT DRAFT AUTHORIZATION

By signing this form, I agree to pay the amount due by the 1st of the month each month of the school year. It will be my responsibility to notify the New Rochelle Y in the event that I cancel my credit/debit card. I will also notify the Y when I receive a new expiration date on my card. If for some reason a transaction will not post (ie. account closed or suspended, insufficient funds), I understand that I will be charged a $35.00 fee.

I authorize the New Rochelle YMCA to keep my signature on file and to charge my credit card on account, on an ongoing basis for amounts I owe. I understand that this authorization is valid for the duration of my child's enrollment and I may cancel the authorization at any time through a 60-day written notice.

PRIMARY BILLING METHOD: Select CREDIT CARD, BANK ACCOUNT **OR** THIRD PARTY PAYMENT

Account Holder's Name:			
Home Address:	City:	State:	Zip:

☐ CREDIT CARD: ☐Visa ☐Mastercard ☐Amex ☐Discover

Account Number:	Exp Date:	CSC:
Signature:		

☐ BANK ACCOUNT:

Name of Bank:	Account Number:	Routing Number:
Signature:		

☐ THIRD PARTY PAYMENT: ☐DSS ☐Other Approved Program:_____

All information on this form is correct as far as I know. I understand that the New Rochelle YMCA reserves the right to refuse an application, or terminate enrollment of any child based upon disciplinary difficulties or lack of payment.

REFUND POLICY:

Cancelling your participation in the afterschool program requires 60 day's notice. If you will be pulling out of the program, notice is required so we can replace your seat. You will be charged for the next 60 days if you do not give advance notice. **There are no refunds.**

A $30 service fee per occurrence will apply for any returned or disputed payments. Unpaid balances past 30 days will be forwarded for collection.

Parent Signature:	**Date:**

FEELING GRATEFUL AND ABLE TO SHARE THE OPPORTUNITY? SUPPORT CAMPAIGN CONTRIBUTION:

Every year the New Rochelle YMCA helps families afford child care, camp, family memberships and other rewarding and necessary programs for their own development. Your contribution can help a family experience our programs! On behalf of our families, we thank you.

I would like to pledge the following amount to a family in need:

☐ $25 ☐ $50 ☐ $100 ☐ $350 ☐ Other: $_____

Payment Method for this contribution:

☐ I have enclosed a check for $_____

☐ Charge my credit/debit card on file.

☐ Withdraw from my banking account on file.

By providing my signature below I authorize the New Rochelle YMCA to charge/withdraw $_____.

Card Holder Signature: _____ Date:_____

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NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN
FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

***A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally*.**

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

Child Name:	**Child date of birth:** **/ /**
Name of the child's health care provider:	**Physician** **Physician Assistant** **Nurse Practitioner**

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN
FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Program Name:	**facility id number:**	**Program Telephone Number:** **( )**
Child care provider's name (please print):		**Date:** **/ /**
Child care provider's signature: **X**		

I agree this Individual Health Care Plan meets the needs of my child. **Yes** **No**

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. **Yes** **No**

Signature of Parent:

X	**Date:** **/ /**

For Office Use Only

Name of Document	**Completed**	**Not Completed**
New Rochelle YMCA **COMPLETED** Afterschool Application		
Child in Care Medical Statement or Child's 2025-2026 Annual Physical		
Child's Immunization History		
Child's IEP, 504, or Intervention Services Documentation*		
Individual Health Care Plan For a Child with Special Health Care Needs*		
Health Care Needs (ASTHMA AND ALLERGIES INCLUDED)*		
DSS or 3rd Party Approval Letter*		
Signed Parent Handbook and Code of Conduct		
Youth Membership ($200) & Registration Fee Paid ($100)		