



Tri-County YMCA

2010 - 2011 AFTERSCHOOL REGISTRATION FORM

PLEASE CHOOSE SITE LOCATION:

Jasper _____ **Santa Claus** _____ **Ferdinand** _____

Tri-County YMCA Member: _____ **OR** **Program Participant:** _____

CHILD'S NAME: _____ **SEX:** M _____ F _____

SOCIAL SECURITY #: ___ - ___ - ___ **SCHOOL ATTENDED:** _____

BIRTHDAY: ___ / ___ / ___ **AGE:** _____ **GRADE:** _____

ADDRESS: _____

CITY _____ **STATE** _____ **ZIP** _____

IMMUNIZATION HISTORY

A copy of your child's shot records are needed before his/her first day of AfterSchool Care.

HEALTH HISTORY

ALLERGIES (include medication): _____

CHRONIC DISORDERS (epilepsy, diabetes, asthma, etc.): _____

CURRENT MEDICATION: _____

NAME OF CUSTODIAL PARENT OR LEGAL GUARDIAN: _____

MARITAL STATUS: SINGLE _____ DIVORCED _____ MARRIED _____
WIDOWED _____ SEPERATED _____

FATHER'S NAME: _____ **PHONE (H):** _____

ADDRESS: _____

EMPLOYER: _____ **POSITION:** _____ **PHONE (W):** _____

MOTHER'S NAME: _____ **PHONE (H):** _____

ADDRESS: _____

EMPLOYER: _____ **POSITION:** _____ **PHONE (W):** _____

MEDICAL INFORMATION

If I, the parent, am not available in an emergency, please contact:

1. NAME: _____ PHONE (H): _____

EMPLOYER: _____ PHONE (W): _____

2. NAME: _____ PHONE (H): _____

EMPLOYER: _____ PHONE (W): _____

PICK-UP RELEASE

The below mentioned people may pick up my child(ren) **(please list yourself and print legibly):**

1. NAME: _____ PHONE: _____

RELATION TO CHILD: _____ DL#: _____

RESTRICTIONS: _____

2. NAME: _____ PHONE: _____

RELATION TO CHILD: _____ DL#: _____

RESTRICTIONS: _____

3. NAME: _____ PHONE: _____

RELATION TO CHILD: _____ DL#: _____

RESTRICTIONS: _____

4. NAME: _____ PHONE: _____

RELATION TO CHILD: _____ DL#: _____

RESTRICTIONS: _____

5. NAME: _____ PHONE: _____

RELATION TO CHILD: _____ DL#: _____

RESTRICTIONS: _____

Signature of Parent or Guardian

Date Signed

*****FOR OFFICE USE ONLY*****

NAME CHANGE/REASON FOR ACTION: _____

Signature of Parent or Guardian

Date Signed

Signature of Counselor/Witness

Date Signed

FIELD TRIP RELEASE

My child, _____, has my permission to go on any scheduled field trips under the auspices of the AfterSchool program. I understand that these trips may include riding in a bus or vehicle leased by the Tri-County YMCA. This authorization is for the duration of the 2010-2011 school year.

Signature of Parent or Guardian

Date Signed

TALENT RELEASE FOR PHOTOGRAPHY, VIDEOTAPE, AND AUDIO PRODUCTIONS

I hereby release the AfterSchool Program from any forms of remuneration involving the current or future use of photographs, videotapes, or audio recordings for which I have performed.

This statement is hereby acknowledged and agreed upon by me with the full understanding that any photographs, video, or audio tapes will be freely used by the AfterSchool Program for public display in either printed or electronic material for the purpose of furthering the business interest of the AfterSchool Program.

If the subject is a minor, a parent or legal guardian has signed below indicating the same understanding and authorization.

Signature of Parent or Guardian

Date Signed

EMERGENCY MEDICAL CONSENT FORM

If your child needs medical care, the law requires that you, the parent or legal guardian, give your permission to treat the child. In case of an emergency, we will try to contact you. If time does not permit or we are unable to reach you, this form will allow us to have your child receive the attention he/she needs.

I, the parent or legal guardian of _____ hereby grant my permission for the AfterSchool Program and its employees to seek medical care for the above-named child when the child is attending the AfterSchool Program as they deem it necessary. The medical care shall cover illnesses, accident, and/or injury. In the event of treatment when consultation or follow up care is required, it is my desire that our doctor, (name) _____ be contacted at, (phone) _____.

The Tri-County YMCA carries liability insurance but does not carry accident insurance for the participants of this program. **I understand that without this consent, no treatment will be given to the above-named child.**

Signature of Parent or Guardian

Date Signed

Medical Insurance Carrier: _____

Group or Policy Number: _____

Name of Insured: _____

ATTENDANCE

On average, my child plans to attend the AfterSchool program:

1 day a week: _____ 2 days a week: _____ 3 days a week: _____ all week (4 or 5 days): _____

PAYMENT & FEES

The AfterSchool program fee structure is as follows:

YMCA Member:	\$33.00/week
	\$9.00/day
Program Participant:	\$47.00/week
	\$12.00/day

The Tri-County YMCA requires the first week's payment at the time of registration.

Please make checks payable to: Tri-County YMCA.

Please mail your registration form along with payment to:

Tri-County YMCA
c/o Stephanie Bolling
P.O. Box 171
Ferdinand, IN 47532