



**FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

**WILSON-GRAY YMCA
Youth and Family Center**
444 Albany Avenue, Hartford, CT 06120
WilsonGrayYMCA.org
860-241-9622

Dear YMCA Family,

Thank you for choosing the Wilson-Gray Youth and Family Center YMCA for your before and/or after school enrichment needs. We are excited to welcome you and your family to our program and look forward to a great year and beyond!

The Y's focus is on youth development, healthy living, and social responsibility. At the YMCA of Greater Hartford our child development programs aim to nurture young people by providing a safe place to learn foundational skills, develop healthy, trusting relationships, and build self-confidence. While doing so, our programs follow the State of Connecticut requirements and regulations for child development programs, and collaborate with local and state organizations to offer the highest quality enrichment experiences for your child.

Please review this registration packet carefully. Complete and accurate information helps us to provide the best possible care for your child throughout the year and in the event of an emergency. If you have questions or need any additional information now or throughout the year, please feel free to call or email any of us with the contact information below.

In order to complete your registration, a 25% deposit is required and will be automatically scheduled for 8/1/2020. Deposits are applied to June of 2021 and are non-refundable. Financial Assistance is available for all YMCA programs.

Sincerely,

Melody Santiago
Child Development Director

Please check which site your child will attend:

- | | | |
|---|--|---|
| <input type="checkbox"/> Annie Fisher School | <input type="checkbox"/> Capital Prep. School | <input type="checkbox"/> Noah Webster School |
| <input type="checkbox"/> Betances ERL School | <input type="checkbox"/> Hartford Pre-K 1 School | <input type="checkbox"/> R. J Kinsella School |
| <input type="checkbox"/> Breakthrough II School | <input type="checkbox"/> Hartford Pre-K 2 School | |

Please check what options you are requesting for child care:

- | | | | | | |
|---------------|---------------------------------|----------------------------------|------------------------------------|-----------------------------------|---------------------------------|
| Before School | <input type="checkbox"/> Monday | <input type="checkbox"/> Tuesday | <input type="checkbox"/> Wednesday | <input type="checkbox"/> Thursday | <input type="checkbox"/> Friday |
| After School | <input type="checkbox"/> Monday | <input type="checkbox"/> Tuesday | <input type="checkbox"/> Wednesday | <input type="checkbox"/> Thursday | <input type="checkbox"/> Friday |

Rates

- | | | |
|----------------|---------------------------|------------------------|
| Before School: | After School: | Before & After School: |
| 5 Days: \$249 | 3 Days: \$328 | 5 Day: \$397 |
| | 5 Days: \$360 | |
| | 5 Day Pre-k: \$397- \$402 | |

Contacts

Melody Santiago Child Development Director 860-241-9622 ext. 117 Melody.santiago@ghymca.org	Valencia Mack Child Care Registrar 860-241-9622 ext. 103 Valencia.mack@ghymca.org
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- Families with more than one child enrolled in a YMCA School Aged Childcare program are given a 5% discount on the lower program (for the 2nd and each additional child).
- Before school programs open at 7 AM, and after school programs close at 5 or 6 PM depending on the school site, unless noted otherwise.
- A Health Assessment Record (physical) and immunization record will also be required and must be up to date per school timeline. Depending on your child's health information, additional paperwork may be needed.
- For tax purposes, our Tax ID number is # 06-0881325.



**FOR YOUTH DEVELOPMENT®
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OFFICE USE ONLY

Enroll Date: _____
Start Date: _____
Approved by: _____
Withdraw Date: _____
Reason: _____

2020-2021 APPLICATION FOR ENROLLMENT

(Please write clearly and complete all spaces provided)

CHILD INFORMATION

Child's Name: _____ DOB _____ Male _____ Female _____

Address: _____
Street Town Zip

ENROLLMENT INFORMATION

Name of person(s) responsible for payment and tuition with whom financial information/issues should be discussed:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

PARENT/GUARDIAN INFORMATION

Parent/Legal Guardian Name: _____ DOB: _____ Relationship to child: _____

Address: _____
Street Town Zip

Employer Name: _____ Dept. _____

Employer's Address: _____
Street Town Zip

Work Phone: (_____) _____ Ext. _____ Cell: (_____) _____

EMAIL: _____ Work Hours: M T W R F _____ to _____

Parent/Legal Guardian Name: _____ DOB: _____ Relationship to child: _____

Address: _____
Street Town Zip

Employer Name: _____ Dept. _____

Employer's Address: _____
Street Town Zip

Work Phone: (_____) _____ Ext. _____ Cell: (_____) _____

EMAIL: _____ Work Hours: M T W R F _____ to _____

I agree that the above information is current and accurate _____
(parent/guardian signature)

CHILD'S HEALTH INFORMATION

INSURANCE: Husky #: _____ Private Insurance _____ Medicaid #: _____

Allergies: Yes No (if yes, list type) _____

Asthma: Yes No Medications required: _____

Dietary Restrictions (other than food allergies): Yes No

If yes, explain: _____

Special Needs: Yes No (if yes, explain) _____

Is your child on any routine or emergency medications? Yes No (if yes, please provide info below)

Type: _____ Frequency: _____

Reason for medication: _____

Child's Physician's Name: _____ Phone: (____) _____

Child's Dentist's Name: _____ Phone: (____) _____

EMERGENCY CONTACTS/ALTERNATE PICK-UP

I give my permission to the Greater Hartford YMCA Staff to contact and release my child to one of the following individuals listed. Please notify the center if emergency contact people will pick-up your child on any given day.

Name _____ **Relationship:** _____ **DOB:** _____

Work Phone: (____) _____ Cell: (____) _____ Home: (____) _____

Name _____ **Relationship:** _____ **DOB:** _____

Work Phone: (____) _____ Cell: (____) _____ Home: (____) _____

Name _____ **Relationship:** _____ **DOB:** _____

Work Phone: (____) _____ Cell: (____) _____ Home: (____) _____

Custody: Yes No

Is there a court order or restraining order in effect which limits access to your child by a parent, family member or other individual? (If yes, note that a copy of the order should be provided to the center for your child's file in order for the order to be enforced.)

Handbook: _____ I acknowledge that I have received and carefully read the Greater Hartford YMCA Parent Handbook

Behavior Management: _____ I have been provided with the opportunity to review, discuss and ask questions regarding the YMCA's Behavior Management Plan/Policy with the staff (in Parent Handbook).

ADDITIONAL PERMISSIONS

- To take my child for walks on the grounds of YMCA location and to participate in child development related activities and events held in the YMCA facility/on YMCA grounds or facilities including transportation in YMCA van;
- To include my child in vision, hearing, & developmental screening and assessments conducted by the staff and shared with child's pediatrician;
- To transport my child via ambulance to the nearest medical facility;
- For my child to be treated by emergency medical personnel in the event of an emergency;
- For staff that hold the appropriate certifications to administer first aid and CPR as needed;
- For staff that hold the appropriate certifications to administer non-prescription medication, topical medications, lotions and creams as per my written consent.
- To allow my child to eat all of the snack and food provided from YMCA according to USDA food guidelines; unless documented food restriction and care plan.
- To provide the following individuals and/or agencies access to my child's enrollment, health, and other information in my child's file on an as needed basis (office/classroom staff, consultants, public school personnel, emergency medical personnel, OEC, NAEYC, & DCF.)

My signature below grants the Greater Hartford YMCA staff permission to the above approvals.

Parent Signature

Date

**YMCA OF GREATER HARTFORD
RELEASE and WAIVER OF LIABILITY and INDEMNITY and PHOTO/TALENT RELEASE AGREEMENT**

IN CONSIDERATION of being permitted to utilize the facilities, services and programs of the YMCA for any purpose, including, but not limited to observation or use of facilities, or equipment, or participation in any off-site program affiliated with the YMCA, the undersigned, for himself or herself, or on behalf of a minor child under age 18, and for any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has, inspected and carefully considered, or will immediately upon entering and/or participating, inspect and carefully consider, such premises and facilities or the affiliated program. It is further warranted that such entry into the YMCA constitutes an acknowledgement that that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use, or participation.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE YMCA FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY OFF-SITE PROGRAM AFFILIATED WITH THE YMCA, **THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING ON HIS OR HER BEHALF AND/OR BEHALF OF HIS/HER CHILDREN OR GUESTS** (herein referred to as "the undersigned"):

1. MEMBER CONDUCT I agree to abide by all rules and regulations of the YMCA of Metropolitan Hartford (hereafter "YMCA"), and I understand that failure to act in accordance with the rules may result in expulsion from the YMCA and cancellation of membership.
2. INSURANCE I understand that the YMCA does not provide any accident or health insurance for its members or participants and it is my responsibility to provide such coverage.
3. PROPERTY LOSS I understand that the YMCA is not responsible for personal property lost, damaged, or stolen while using YMCA facilities or participating in YMCA programs.
4. ASSUME FULL RESPONSIBILITY I hereby assume full responsibility for and risk of bodily injury, death, or property damage while in about or upon the premises of the YMCA and/or while using the premises, or any facilities or equipment thereon or participating in any program affiliated with the YMCA.
5. PHOTO/TALENT RELEASE I hereby irrevocably release, consent and allow the YMCA and its agents to use my photograph, likeness, voice, as it pertains to my participation with the YMCA, in any manner for promotional efforts without expectation of any reimbursement for its use. (My initials here revoke photo/talent release_____).
6. RELEASE, WAIVE, DISCHARGES I hereby release, waive, discharge and covenant not to sue the YMCA, its directors, officers, employees, and agents (hereinafter referred to as "releases") from all liability to the undersigned, his personal representatives, assigns, heirs, and next of kin for any loss or damages, and any claim or demands therefore on account of injury to the person or loss of property while the undersigned is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with the YMCA.
7. INDEMNIFY AND SAVE AND HOLD HARMLESS I hereby agree to indemnify and save and hold harmless the releases from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about the YMCA premises or in any way observing or using any facilities or equipment of the YMCA or participating in any program affiliated with the YMCA.
8. MEDICAL RELEASE I authorize the YMCA, as my agent, to give consent to medical treatment by a licensed physician or hospital when such treatment is deemed necessary by the physician, and I am unable to give such consent. I authorize a qualified YMCA staff member to administer CPR or first aid if necessary. I understand that it may be necessary for me to provide a release form from my physician regarding my current health status.
9. THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of Connecticut and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding continue in full legal force and effect.
10. THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AND PHOTO/TALENT RELEASE AGREEMENT, and further agrees that no oral representations, statement, or inducement apart from the foregoing written agreement have been made. I HAVE READ THIS RELEASE.

Date: _____ Printed Name of Participant _____

Printed Name of Parent/Guardian _____

Signature of Participant or Parent/Guardian _____

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YMCA of Greater Hartford Electronic Payment Form
One week of tuition is a required non-refundable deposit at the time of enrollment

Billing Name: _____ Child's Name: _____

Address: _____ Town: _____ State: _____ Zip: _____

Home: (____) _____ Work (____) _____ Cell (____) _____

TERMS AND CONDITIONS

It is my complete understanding that if I terminate my child's enrollment I must submit a letter in writing canceling my Electronic Payment giving the YMCA **TWO (2) weeks written notice** prior to my child's withdrawal date. I understand that paying under the Electronic Payment method, I am subject to fee increases periodically by the Board of Directors, and the YMCA may adjust the monthly rate applicable to my child's enrollment category. I will be notified 30 days in advance of any increases. I understand that the monthly debit to my account is a continual draft for ten (10) months equal to the school calendar. Should any pre-authorized electronic payment not be honored by my financial institution when received, I agree that the payment is to be made by me in the amount of said payment, and I agree that I am responsible for that payment plus a service charge (contact your branch for current fees). This service charge does not include possible fees imposed by my financial institution. I understand that if two electronic payments are rejected my child's enrollment will be terminated.

I, the undersigned, have read and agree to the above Terms and Conditions.

Parent/Guardian Signature: _____ Date Signed: _____

ELECTRONIC FUNDS TRANSFER (EFT) OR CREDIT CARD AUTHORIZATION

I authorize the YMCA of Greater Hartford to debit my account as indicated below on a monthly basis. Should any preauthorized EFT or Credit Card payment not be honored by my financial institution at the time of the draft, I understand and agree to the YMCA re-submitting, at their discretion, the request for payment.

CREDIT/DEBIT CARD

Card Type: Visa MasterCard AMEX Discover Expiration Date: _____

Name on Card (print) _____

Card Number _____

I agree the monthly payment amount debited will be \$ _____ and will draft on the 1st day of each month.

My first draft will begin on _____ (date).

Authorized Signature _____ Date _____

EFT

Financial Institution Name _____

Address _____

Name on Account (print) _____

Checking Account Savings Account

Routing Number (9 digits) _____ Account Number _____

I agree the monthly payment amount debited will be \$ _____ and will draft on the 1st day of each month.

My first draft will begin on _____ (date).

Authorized Signature _____ Date _____

Office Use Only: Deposit Payment \$ _____ Receipt Number _____
Form Entered by _____ Date Entered _____
System Account # _____

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State of Connecticut Department of Education Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	<input type="checkbox"/> Black, not of Hispanic origin
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> White, not of Hispanic origin
	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian/Pacific Islander
		<input type="checkbox"/> Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance?	Y N	If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have dental insurance?	Y N	

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Rm visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)			Y	N	Diabetes	Y	N	
Any immediate family members have high cholesterol			Y	N	ADHD/ADD	Y	N	

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height _____ in. / _____% *Weight _____ lbs. / _____% BMI _____ / _____% Pulse _____ *Blood Pressure _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

Screenings

*Vision Screening			*Auditory Screening			Lead:	Date
Type:	<u>Right</u>	<u>Left</u>	Type:	<u>Right</u>	<u>Left</u>		
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass			
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail	*HCT/HGB:		
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made		Other:		

TB: High-risk group? No Yes PPD date read: _____ Results: _____ Treatment: _____

***IMMUNIZATIONS**

Up to Date or Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma No Yes: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced
If yes, please provide a copy of the Asthma Action Plan to School

Anaphylaxis No Yes: Food Insects Latex Unknown source

Allergies *If yes, please provide a copy of the Emergency Allergy Plan to School*

History of Anaphylaxis No Yes Epi Pen required No Yes

Diabetes No Yes: Type I Type II

Other Chronic Disease:

Seizures No Yes, type: _____

This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____

Daily Medications (*specify*): _____

This student may: participate fully in the school program
 participate in the school program with the following restriction/adaptation: _____

This student may: participate fully in athletic activities and competitive sports
 participate in athletic activities and competitive sports with the following restriction/adaptation: _____

Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? Yes No I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number
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Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx _____
of above (Specify) (Date) (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____
 Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
 Polio: At least 3 doses. The last dose must be given on or after 4th birthday
 MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
 Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
 Hep B: 3 doses
 Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6 DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
 Students who start the series at age 7 or older only need a total of 3 doses
 Polio: At least 3 doses. The last dose must be given on or after 4th birthday
 MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
 Hep B: 3 doses
 Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12 Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
 Polio: At least 3 doses. The last dose must be given on or after 4th birthday
 MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
 Hep B: 3 doses
 Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

_____ Initial/Signature of health care provider MD / DO / APRN / PA	_____ Date Signed	_____ Printed/Stamped Provider Name and Phone Number
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