



Avenel Learning Center

238 Avenel St., Avenel, NJ 07001 (732) 636-1100

AvenelCCC@ymcaofmews.org

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

School Age Child Care Registration 2018-2019

Please Print Clearly: Child's Name _____

Start Date _____

Grade in Sept. 2018 ___ Date of Birth ___/___/___ Sex ___M ___F

School attending in Sept. 2018 _____

Does your child have any special needs that we should know about to provide you with the best service possible? no yes please describe _____

Child's Street Address _____

City _____ Zip _____

Phone Number (H)(_____) Email _____

Child resides with: Mom, Dad, both parents, other: _____

Parent #1 Name _____

Phone Number (H)(_____) (W)(_____)

Company Name _____ Cell Number(_____)

Job Title _____ Email _____

Parent #2 Name _____

Phone Number (H)(_____) (W)(_____)

Company Name _____ Cell Number(_____)

Job Title _____ Email _____

Address (if different from child's) _____

Emergency Contacts & Pick-Up Authorization

In addition to the parent(s) who have signed below, the following person(s) are authorized to pick up the child or to be contacted in case of an emergency if neither parent is available to assume responsibility for the child. **2 names required by NJ State Law**

Name _____

Cell (_____) Relationship to Child _____

Name _____

Cell (_____) Relationship to Child _____

Parents are required to keep this information current by contacting Avenel Learning Center with changes.

TUITION POLICY

- Fees are paid by check or credit card to the **YMCA** by the 15th of the prior month (ie. September payment will be due by August 15th).
- Credit/debit card or checking account draft is available. Accounts are drafted on the 15th of the month. If you would like to set this up, please check the box below and call the office with your credit card information.
- A \$20 late fee may be applied to any tuition payments made after the due date.
- A 5% sibling discount will be applied to the combined payment of siblings enrolled in full time (5 days) programs (SACC, KED or Child Care).
- A nonrefundable \$50 deposit is due at the time of registration and will be applied to your first month's payment.
- In order to withdraw from the program or make any changes, please provide notice before the 15th of the month prior to payment. No refunds or credits will be issued for days not used; switching days is not permitted. There will be a \$20 change fee for any schedule/program changes.

Please charge my credit card automatically when payments are due

Parents Signature _____ Date _____

Before School Care

7:00-9:00am

(not including snow days and holiday care)

Follows Woodbridge Public Schools calendar ONLY

180 days of care

\$207p/month, 5 days p/week

\$175p/month 4 days p/week

\$140p/month 3 days p/week

\$104/month 2 days p/week

After School Care

3:30-6:30pm

(not including snow days and holiday care)

Follows Woodbridge Public Schools calendar ONLY

180 days of care

\$235p/month, 5 days p/week

\$197p/month 4 days p/week

\$157p/month 3 days p/week

\$118/month 2 days p/week

***All rates are averaged out and based on 180 days of school. Snow Days and Holidays are not included.

Please check off appropriate days if less than 5 days a week.

Monday Tuesday Wednesday Thursday Friday

FINANCIAL ASSISTANCE

The state subsidy program, Community Child Care Solutions, offers assistance with payment, and it is best to contact them initially. They can be reached at 732-324-4357.

If you do not qualify for them, the YMCA's Financial Assistance Applications are available online at www.ymcaofmews.org. They take a minimum of 2 weeks to process and must be submitted to The Center's office.



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Permission/Informed Consent Agreement & Health History

PERMISSION/AUTHORIZATION (please initial where indicated)

As the parent/guardian of _____, I give permission for my child to participate in Y programs, including any trips taken during the camp day. I understand that transportation will be provided by school bus. I further acknowledge and am aware that these activities may involve inherent risks and that I assume for my child whatever risk of injury or loss which may exist, and further certify that my child is in good physical condition in order to take on these activities. _____

I hereby permit, consent and authorize photographs and/or videos made of my child while at the Y as an individual or part of a group, with or without text in YMCA publications. _____

Prescription medication will be given to my child by the staff at specific times. I understand that I must sign a statement at each illness, giving the specific instructions and permission. _____

An accident or sudden illness to my child will be treated on the premises of the Y by the staff with emergency first aid procedures. I understand that I will be notified immediately, and will be required to pick up my child or send a reliable person in my place to be responsible for taking my child from the Y to a designated place determined by me. _____

Emergency treatment for my child will be obtained in my absence by YMCA staff and its agents or whatever kind is deemed necessary and in his/her interest to protect the life, health and well-being of said son/daughter. I understand that any cost of service not reimbursable by insurance coverage shall be the responsibility of the parent/guardian. Transportation by any necessary means to obtain such medical care of assistance for my child, as circumstances may require in the discretion of the YMCA staff, its employees or agents, is hereby authorized. _____

I have received a copy of the Information to Parents document as well as the program's Expulsion Policy. _____

I understand that the YMCA shall provide appropriate chaperones on all trips, as well as the above mentioned transportation. Prior notice will be given wherever possible. _____

I have read the registration agreement above and agree to abide by said policies in both the handbook, and registration form. _____

HEALTH HISTORY:

Allergies: _____ Treatment: _____

Allergies: _____ Treatment: _____

Dietary modifications _____

Disabilities _____

Chronic/recurring illnesses _____

Current medications _____

Activity limitations _____

Any other known physical or mental conditions _____

Name of physician _____ Phone () _____

Date of last physical examination _____

This Health History is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. _____ *initial*

Pediatrician Name: _____

Pediatrician Address: _____

Pediatrician Phone Number: _____

Emergency Authorization: I hereby give permission to medical personnel to order X-rays, routine tests, and treatment for me/my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, and/or surgery for me/my child as named above. This form may be photocopied.

Signature of Parent/Guardian

Date