Fords Learning Program

400 Inman Avenue, Colonia, NJ 07067 (732)346-9622 (Director's Office)
FordsCCC@ymcaofmewsa.org

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

School Age Child Care Registration 2017-2018

Please Print Clearly: Child's Name_____

Start Date _____

Grade in Sept. 2017___ Date of Birth__/__/__ Sex __M __ F

School attending in Sept. 2016 _____

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 _____

❒ Before School Care

7:00-9:00am
(*not including* snow days and holiday care)
Follows Woodbridge Public Schools calendar
180 days of care
$232p/month, 5 days p/week
$218p/month 4 days p/week
$180p/month 3 days p/week
$116p/month 2 days p/week

❒ After School Care

3:30-6:30pm
(*not including* snow days and holiday care)
Follows Woodbridge Public Schools calendar
180 days of care.
$298p/month, 5 days p/week
$278p/month 4 days p/week
$232p/month 3 days p/week
$150p/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

Please check off appropriate school your child attends.

❒School 25 ❒School 19 ❒School 14 ❒Fords Middle (Aftercare Only)

***Please note, that before and after care is held at Lafayette Estates School 25. Children from Schools 19, 14 and Fords Middle, will be bused to and from School 25 by a YMCA bus.

Parents are required to keep this information current by contacting Fords Learning Program 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 ____/_____/_____

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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 my 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