



# Edison Y

1775 Oak Tree Road, Edison NJ 08820 732-494-3232  
www.ymcaofmewsa.org

FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## School Age Child Care Registration 2018-2019

Please Print Clearly: Child's Name \_\_\_\_\_

Grade in Sept. 2017 \_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_M \_\_\_F

Child's Street Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (H)( \_\_\_\_\_ ) Email \_\_\_\_\_

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 \_\_\_\_\_

### 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.

Name \_\_\_\_\_

Cell ( \_\_\_\_\_ ) Relationship to Child \_\_\_\_\_

Name \_\_\_\_\_

Cell ( \_\_\_\_\_ ) Relationship to Child \_\_\_\_\_

### FEES

- Fees are paid by check, cash, or credit card to the **Edison Y** by the 15<sup>th</sup> of the month prior. Credit card draft is available. Cards are drafted the 1<sup>st</sup> of the month. Payments are collected in the month before the service period.
- A \$20 late fee will be automatically applied after the 10<sup>th</sup> of the month.
- A 3% discount will be applied to your payment if you have a current Family Membership to the Community Campus.
- A 10% sibling discount will be applied to all siblings enrolled full time in SACC.
- A written notice before the first day of your last month is needed for withdrawal. No transfers or refunds allowed.
- Drafting occurs on the 1<sup>st</sup> day of the previous month for which you are paying.

Parents are required to keep this information current by contacting the Edison Y with changes.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

- Please charge my credit card on file with the Edison Y automatically when SACC payments are due. (Please specify with Director if more than one card on file.)

Parent Signature \_\_\_\_\_ Amount due \_\_\_\_\_

### Plan A

(After School Care *not including* snow days/holiday care)

Follows Edison Public Schools calendar ONLY.

\$370 p/month, 5 days p/week

\$490 per month with Morning Care

### Plan B

(After School Care *including*

half days, snow days and holiday care)

Follows Edison Public Schools calendar ONLY.

\$420 per month, 5 days per week

\$540 per month with Morning Care

Morning Care only is available for \$170 p/month.

### Please Check Appropriate School & Program(s):

- Plan A  Plan A with Morning Care
- Plan B  Plan B with Morning Care
- Morning Care only

- James Madison Primary
- Woodbrook School
- Martin Luther King School
- Menlo Park School (after care only)
- James Madison Intermediate
- John Adams Middle School
- Woodrow Wilson Middle (after care only)

**All SACC participants are required to have a Community Campus membership.**



**Edison Y**

1775 Oak Tree Road, Edison NJ 08820 732-494-3232  
www.ymcaofmewsa.org

FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

**Edison Y School Age Child Care  
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. \_\_\_\_\_ *initial*

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

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 program specific instructions and permission. \_\_\_\_\_ *initial*

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. \_\_\_\_\_ *initial*

Emergency treatment for my child will be obtained in my absence by the Y 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. \_\_\_\_\_ *initial*

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. \_\_\_\_\_ *initial*

I have read the registration agreement above and agree to abide by said policies. \_\_\_\_\_ *initial*

I have read and received the center's Information To Parents Document. \_\_\_\_\_ *initial*

I have read and received the center's expulsion policy. \_\_\_\_\_ *initial*

**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*

**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