



# Colonia Learning Center

400 Inman Ave, Colonia, NJ 07067 732-340-9622

www.ColoniaCCC@ymcaofmews.org

FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## 2019 Preschool Registration Form

Start Date: \_\_\_\_\_

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

Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_M \_\_\_F

Child resides with: Mom, Dad, Both parents, other: \_\_\_\_\_

Does your child have any special needs that we should know about to provide you with the best possible service?  No  Yes please explain

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

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

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

Parent #1 Name \_\_\_\_\_

Phone Number (H)(\_\_\_\_\_) \_\_\_\_\_ (W)(\_\_\_\_\_) \_\_\_\_\_

Company Name \_\_\_\_\_ Cell Number(\_\_\_\_\_) \_\_\_\_\_

Job Title \_\_\_\_\_ Email \_\_\_\_\_

Address (if different from child's) \_\_\_\_\_

Parent Name #2 \_\_\_\_\_

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 Colonia Learning Center with any changes.

### TUITION POLICY

- Fees are paid by check or credit card to the YMCA by the 15th of the prior month (ie. October payment will be due by the 15th of September).
- Credit/debit card or checking account draft is available. Cards are drafted on the 15th of the month. Please check the box below and call the center with your credit card information if you would like this set up.
- A 5% sibling discount will be applied to the combined payment of siblings enrolled in full time (5 days) programs (SACC, KED or Childcare).
- A \$20 late fee may be applied to any tuition payments made after the due date.
- 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 allow 2 or 3 days for change to process.

Please charge my credit card automatically when preschool payments are due.

Parents Signature \_\_\_\_\_ Amount due \_\_\_\_\_

**FULL DAY PRESCHOOL**  
**BETWEEN 7:00AM TO 6:30PM**  
5 FULL DAYS \$862.00 PER MONTH  
4 FULL DAYS \$727.00 PER MONTH  
3 FULL DAYS \$632.00 PER MONTH  
2 FULL DAYS \$431.00 PER MONTH

**HALF DAY PRESCHOOL**  
**8:30AM TO 12:30PM**  
5 HALF DAYS \$575.00 PER MONTH  
4 HALF DAYS \$479.00 PER MONTH  
3 HALF DAYS \$383.00 PER MONTH  
2 HALF DAYS \$287.00 PER MONTH

### If Part-Time, Please Check Appropriate Days:

- Monday  Tuesday  Wednesday  
 Thursday  Friday

\*Please note, the rates are due to change annually. There will be an increase beginning in January. You will be issued a new form to fill out.

A non-refundable, full month's tuition, is due at the time of registration and will be applied to your first month.



## Preschool Permission & Informed Consent Agreement

### 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 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 center's 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 or assistance for my child, as circumstances may require at the discretion of the YMCA staff, its employees or agents, is hereby authorized. \_\_\_\_\_

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. \_\_\_\_\_

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

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

### 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 ( ) \_\_\_\_\_

Address of physician \_\_\_\_\_

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*

**PLEASE HAVE CHILD'S DOCTOR FILL OUT THE UNIVERSAL CHILD HEALTH FORM**

***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.

**PLEASE SUBMIT A  
 CURRENT COPY OF  
 YOUR CHILD'S RECORD  
 OF IMMUNIZATION.**

Signature of Parent/Guardian

Date

\_\_\_\_\_