



FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## Y's Owls Preschool Program

Sanford-Springvale YMCA

1 Emile Levassuer Drive

Sanford Me, 04073

207-324-4942

Registration Form

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name/Names \_\_\_\_\_

Date of Application \_\_\_\_\_

THE FOLLOWING ITEMS **MUST** BE COMPLETED BEFORE CHILD CAN START:

Please place a check  when each requirement is complete

1. EMERGENCY CONTACT FORMS \_\_\_\_\_
2. CHILD PROFILE / INFORMATION FORM \_\_\_\_\_
3. FEE AGREEMENT CONTRACT \_\_\_\_\_
4. RELEASE AND FIELD TRIP PERMISSION /  
MEDICAL EMERGENCY RELEASE \_\_\_\_\_
5. IMMUNIZATION RECORDS \_\_\_\_\_
6. PARENT STATEMENT OF UNDERSTANDING  
CHILD ABUSE POLICIES AND PROCEDURES \_\_\_\_\_
7. FAMILY TOUR, PROGRAM VISIT, PROGRAM TRIAL \_\_\_\_\_

By my signature and of my own free will, I do hereby agree to indemnify and save harmless the Sanford-Springvale YMCA from any and all claims or demands, cost or expenses arising out of any damage sustained to my child or any party I am responsible for.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

**Y's Owls Preschool Program**  
**Family Information**

*As required by the state please do not leave blanks, completely fill in all sections*

**Child's Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Nickname: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Mother/ Guardian Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Physical Address of Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Father/ Guardian Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Physical Address Employer \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**\*Please make copies of all legal documents regarding custody and/or protection orders. Without this legal documentation we are unable to follow court orders.**

## My Child's Weekly Schedule

Children may not be at the center from open to close. For your child's benefit, please try to limit their day when possible. The state recommends that children not be left in childcare for more than 10hrs a day.

\_\_\_\_\_ My child will attend Full Time (4-5 days)

\_\_\_\_\_ My child will attend Part Time (1-3 days, please circle days of attendance)

**M T W TH F**

Please provide the times you will be dropping off and picking up your child. We understand that these times may fluctuate 15 minutes either way. Please be as accurate as you can so proper staffing can be arranged if necessary.

Monday	_____	to	_____
Tuesday	_____	to	_____
Wednesday	_____	to	_____
Thursday	_____	to	_____
Friday	_____	to	_____

Example: 8 a.m. – 5 p.m., 7 a.m. – 3 p.m., 9 a.m. – 5:30 p.m.

*If you need to change your schedule or level of attendance please get approval from the Director to ensure availability, and then fill out a "status change Form" to complete the process.*

### **Emergency Contact Information (Other than parents, can be friends or relatives)**

Only those listed on this page will be permitted to pick up your child. Emergency contacts and pick ups must be 18 or over unless we have written permission from the parent or guardian and approval form program director.

*Please, do not leave blanks, fill in all information completely*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Physical Address of Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Physical Address of Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Physical Address of Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Other People Authorized To Pick Up Your Child:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Quick Medical Questions:**

**Known Allergies:**

\_\_\_\_\_

**Known Medical Conditions:**

\_\_\_\_\_

## CHILD PROFILE / INFORMATION

My Child is: (describe your child's personality, demeanor, traits)

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My child has: (siblings names & ages)

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What type of activities does your child enjoy?

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What form of discipline is used at home? (redirection, timeout, loss of privileges ect.)

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How does your child get along with others?

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Is this your child's first experience with childcare in a large group setting?      Yes    No  
Does your child have any former childcare/preschool experience?              Yes    No  
Does your child have any friends currently enrolled in our program?          Yes    No  
If so, who? \_\_\_\_\_

How does your child handle these routines at home?

Eating: \_\_\_\_\_  
Sleeping: \_\_\_\_\_  
Toileting: \_\_\_\_\_  
Dressing: \_\_\_\_\_

Has your child shown sensitivity to particular things or circumstances? (nickname, separating from parents, animals, darkness, being alone, loud noises etc)?

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Is there additional information you would like to share regarding your child and his/her family?

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**RELEASE FORM AND FIELD TRIP PERMISSION AUTHORIZATION**

**Child's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- 1. I give permission for the YMCA Child Care Staff to apply sunscreen on my child. Yes No
- 2. I give permission for the YMCA Child Care Staff to apply insect repellent Yes No
- 3. I give permission for the YMCA Child Care Center to photograph/videotape my child for use in the center and marketing and promotional purposes. Yes No
- 4. I give permission for my child to participate in walking field trips away from the Sanford-Springvale YMCA Yes No

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

**MEDICAL EMERGENCY RELEASE**

I, \_\_\_\_\_, hereby authorize the Sanford-Springvale YMCA to arrange for medical examination and/or treatment to my child \_\_\_\_\_ should an emergency arise at the YMCA's Community Child Care Center or on a field trip. It is understood that a conscientious effort will be made by the YMCA to contact me at the emergency numbers I have provided before any medical action is taken. I understand that if the need arises my child will be taken to Goodall Hospital or the closest hospital.

\_\_\_\_\_ Date \_\_\_\_\_

**\*\*This information must be completely filled out. If something does not apply please say so, do not leave anything blank.**

Physician/Pediatrician's Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Physician's Address \_\_\_\_\_

Family Dentist's Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Dentist's Address \_\_\_\_\_

Insurance Provider \_\_\_\_\_ ID # \_\_\_\_\_

My child has the following allergies: \_\_\_\_\_

My child has the following medical conditions: \_\_\_\_\_

My child requires the following medications daily: \_\_\_\_\_

## FEE AGREEMENT CONTRACT

**Child's Name:** \_\_\_\_\_

**Program Start Date:** \_\_\_\_\_

Enrollment Level	Member Rate	Non-Member
Full Time 4-5 Days per week	\$150.00	\$155.00
Part Time 1-3 Days per week	\$110.00	\$115.00

The following is a binding agreement between the Sanford-Springvale YMCA (childcare provider) and \_\_\_\_\_  
(Parent's or Guardian's Name)

I, \_\_\_\_\_ hereby enroll my child \_\_\_\_\_  
(Parent/Guardian's Name) (Child's Name)  
into the Y's Owls Preschool Program. My payment of \$\_\_\_\_\_ will be made no later than the **Friday prior to the week** of service.

**PAYMENTS ARE MADE FOR SERVICES FORTHCOMING, NOT SERVICES RENDERED.** Non-payment of childcare program fees will result in termination of childcare services. If for some reason you feel meeting the payment agreement will be difficult please communicate with the director or billing and enrollment associate.

\*Parents who arrive after 6:00 p.m. will be billed for late fees. Continued late pick ups can result in the loss of child care services. For more information on late pick up fees please see the parent handbook.

\*Parents should also understand that when a child is removed from the program, the slot is gone. If the parent wishes to re-enroll the child at a later date and the slot is available, the child may return but this slot cannot be guaranteed to anyone.

\*It is the parent's responsibility to pay any outstanding balances owed to the Sanford Springvale YMCA **prior** to withdrawal. Failure to do so will result in further collective actions.

**\*A TWO (2) WEEK NOTICE MUST BE GIVEN TO THE PROGRAM DIRECTOR PRIOR TO WITHDRAWAL FROM THE PROGRAM & A STATUS CHANGE FORM MUST BE COMPLETED.**

I have read this child care fee agreement. I understand and accept its terms.

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Program Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SANFORD SPRINGVALE YMCA EFT AUTHORIZATION FORM

Child's Name: \_\_\_\_\_

Childcare Site: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Parent Contact Day Phone Number: \_\_\_\_\_

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

Please fill out the form below if you wish to have your weekly childcare payment withdrawn directly from your checking or savings account, or charged on your debit or credit card. Each week's fee will be withdrawn on Thursday evening and applied toward the next week's fee.

### ELECTRONIC FUNDS (EFT) OR CREDIT CARD AUTHORIZATION

I authorize my bank to honor preauthorized Electron Funds Transfers (or credit card charges) against my account for (membership/program/contribution) payments as indicated below. When the bank honors the EFT (or credit card) by charging my account, such transfer shall constitute notice of payment due and my receipt for the payment. Should any preauthorized EFT (or credit card) not be honored by said bank when received by them, then it is understood that the payment is to be made by me in the amount of said payment plus service charge. It is further understood that if such payment is not honored by the bank (or credit card institution), then the YMCA, at its discretion, may resubmit the amount due for payment on a future date.

#### **Option 1: Drafting from a Checking or Savings Account**

I choose to utilize the EFT option for weekly payment direct debit from my,  
 checking     savings account.

Bank Name: \_\_\_\_\_ Name on Account: \_\_\_\_\_

Routing/Transit Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Attach voided check or photocopy  
here.

#### **Option 2; Drafting from a Credit or Debit Card**

I choose to utilize the EFT option for weekly payment from my credit card or debit card.

Credit Card Type:     Visa                       MC

Card Holder Name: \_\_\_\_\_

Account Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Sanford-Springvale YMCA

## PARENTS STATEMENT OF UNDERSTANDING

### YMCA CHILD ABUSE PREVENTION POLICIES AND PROCEDURES

***The following information is important for the safety and protection of your child. Please read the information and sign.***

*Please keep and refer to your copy of the YMCA Policies & Procedures. Your signature below indicates that you have received and read them.*

I understand the YMCA staff and volunteers are not allowed to baby-sit or transport children outside of the YMCA program at any time without prior authorization from the Executive Director. Immediate disciplinary action toward staff and volunteers will be taken by the YMCA if a violation is discovered.

I understand that I am not to leave my child at the YMCA program site unless a YMCA staff person is there to receive and supervise my child.

I understand that my child will not be allowed to leave the program with an unauthorized person. Any person authorized to pick up my child must be listed with the YMCA and any alternate arrangements will be verified by YMCA staff before approval.

I understand that should a person who appears to be under the influence of drugs or alcohol arrives to pick up my child, staff may have no recourse but to contact the police for the child's safety. Please do not put staff members in a position where they will need to make this judgment call.

I understand that the YMCA is mandated by state law to report to the appropriate authorities for investigation, and any suspected cases of child abuse or neglect.

I have read and understand the Policies and Procedures and the Parent Statement of Understanding above.

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Print Parent/Guardian's name

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Signature Parent/Guardian

**Sanford-Springvale YMCA  
Y's Owls Preschool Program  
PHYSICIAN'S EXAMINATION**

**THIS MUST BE COMPLETED BY YOUR CHILD'S DOCTOR AND RETURNED WITHIN 15 DAYS OF THEIR FIRST DAY OR CARE WILL BE SUSPENDED UNTIL COMPLETE.**  
PLEASE INCLUDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS WHEN SUBMITTING REGISTRATION FORM.

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

ADDRESS \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_

DATE OF PHYSICAL EXAMINATION \_\_\_\_\_

Were there any abnormalities? Yes \_\_\_\_\_ No \_\_\_\_\_

Please specify

\_\_\_\_\_

Tuberculin Test? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_ Result \_\_\_\_\_

Lead screening Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_ Result \_\_\_\_\_

Teeth: Decayed Yes \_\_\_\_\_ No \_\_\_\_\_ Filled: Yes \_\_\_\_\_ No \_\_\_\_\_

Missing Yes \_\_\_\_\_ No \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Is child current on immunizations? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please specify restrictions:

\_\_\_\_\_

Does this child require special dietary restrictions for medical reasons? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please specify

\_\_\_\_\_

Known Allergies:

\_\_\_\_\_

Are there medications needed during school hours? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes please give further details:

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Date form completed \_\_\_\_\_

**Please return to: Sanford-Springvale YMCA  
PO Box 249  
Sanford Maine, 04073  
C/O Matthew Ouellette  
Youth and Family Services Director**