



**FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

ENSURE A BRIGHTER FUTURE

YMCA Licensed Child Care
2011–2012 Returning Participant
Admission Information

RANCHO



MARIN YMCA
1500 Los Gamos Dr., San Rafael, CA 94903
415-492-YMCA • www.ymcasf.org/marin

RANCHO • BILLING SCHEDULE 2011–2012

Tuition Rates (per 4 week session)

| | Morning 6:45–8:30 Program / Facility | Kindie Time 8:30–11:30 or 11:30–3:00 Program / Facility | Afternoon 3:00–6:30 Program / Facility |
|-------------|--|---|--|
| 1 day | \$46 / 41 | \$93 / 88 | \$93 / 88 |
| 2 day | \$77 / 67 | \$155 / 145 | \$155 / 145 |
| 3 day | \$109 / 94 | \$218 / 203 | \$218 / 203 |
| 4 day | \$134 / 114 | \$270 / 250 | \$270 / 250 |
| 5 day | \$166 / 141 | \$331 / 306 | \$331 / 306 |

Additional Tuition Options

| | |
|--|--|
| Program Membership (Annual) | \$50 for individual |
| | \$75 for family |
| Registration Fee (Annual) | \$65 |
| Full Day (7:00–6:30) on No School Days | \$45 |
| Hourly Drop-in | \$10 |
| Late pick-up | \$5 a minute for pick-up after closing |

- Payment is due in advance by the 20th of each month. A \$25 fee will be applied for late payment.
- No credits will be given for holidays, illness, in service days or vacations.
- Registration and Program Membership are non refundable.
- Two week notice for cancellation or decrease in days must be indicated on a status change form and turned into the Site Director.
- Marin Child Care Council, PACE and Cal Works families are responsible for balance of tuition.
- Hourly drop-in days are for non-scheduled day.

| 4 week Session | Session Dates | Payment / Draft Date |
|-------------------------------|------------------------------|-------------------------------|
| Session 1 | August 24–September 2 | July 20th (8 day prorate) |
| Session 2 | September 5–30 | August 20th |
| Session 3 | October 3–28 | September 20th |
| Session 4 | October 31–December 2 | October 20th |
| Thanksgiving Break Camp | November 21–25 | Payment due upon registration |
| Session 5 | December 5–January 13 | November 20th |
| Winter Break Camp | December 19–30 | Payment due upon registration |
| Session 6 | January 16–February 10 | December 20th |
| Mid Winter Break Camp | February 21–24 | Payment due upon registration |
| Session 7 | February 13–March 16 | January 20th |
| Spring Break Camp | April 9–13 | Payment due upon registration |
| Session 8 | March 19–April 20 | February 20th |
| Session 9 | April 23–May 18 | March 20th |
| Session 10 | May 21–June 14 | April 20th |

(Sessions dates are subject to change depending on NUSD budget decisions.)

RANCHO • REGISTRATION FORM 2011–2012

Child's Name _____

Starting Date ____/____/____ Sex: M F Age _____ Home Phone _____

Home Address _____ City _____ Zip _____

Grade _____ School _____ Room Number _____

Responsible Adult Information:

Name _____ Phone (W) _____ Phone (Cell) _____

Relationship _____ Email Address _____ Birthdate _____

Name _____ Phone (W) _____ Phone (Cell) _____

Relationship _____ Email Address _____ Birthdate _____

School-Age Program Fee Schedule for Fall School Year

| Morning Care: | Program / Facility | Days of Week (please circle) | | | | |
|----------------|--------------------|------------------------------|---|---|----|---------------|
| 1 day/wk..... | \$46 / 41..... | M | T | W | TH | F |
| 2 days/wk..... | \$77 / 67..... | M | T | W | TH | F |
| 3 days/wk..... | \$109 / 94..... | M | T | W | TH | F |
| 4 days/wk..... | \$134 / 114..... | M | T | W | TH | F |
| 5 days/wk..... | \$166 / 141..... | M | T | W | TH | F |
| | | | | | | Fee: \$ _____ |

| Kindie Time: | Program / Facility | Days of Week (please circle) | | | | |
|----------------|--------------------|------------------------------|---|---|----|---------------|
| 1 day/wk..... | \$93 / 88..... | M | T | W | TH | F |
| 2 days/wk..... | \$155 / 145..... | M | T | W | TH | F |
| 3 days/wk..... | \$218 / 203..... | M | T | W | TH | F |
| 4 days/wk..... | \$270 / 250..... | M | T | W | TH | F |
| 5 days/wk..... | \$331 / 306..... | M | T | W | TH | F |
| | | | | | | Fee: \$ _____ |

| Afternoon Care: | Program / Facility | Days of Week (please circle) | | | | |
|-----------------|--------------------|------------------------------|---|---|----|---------------|
| 1 day/wk..... | \$93 / 88..... | M | T | W | TH | F |
| 2 days/wk..... | \$155 / 145..... | M | T | W | TH | F |
| 3 days/wk..... | \$218 / 203..... | M | T | W | TH | F |
| 4 days/wk..... | \$270 / 250..... | M | T | W | TH | F |
| 5 days/wk..... | \$331 / 306..... | M | T | W | TH | F |
| | | | | | | Fee: \$ _____ |

Annual Giving Campaign

The demand in our community for the programs and services that Marin YMCA provides has grown significantly, and continues to rise. Thanks to the generosity of donors, we have been able to respond to these needs and are working to preserve their benefits.

A contribution will directly impact the lives of the youth, teens, seniors and families in our community.

Your contribution is tax deductible to the extent allowed by law.

Annual Program Membership Fee \$50 or \$75

Annual Registration Fee \$65

4 Week Session Fee \$_____

I would like to make a Campaign Donation \$_____

TOTAL Due Today \$_____

Applying for Financial Assistance: Yes No

Bank Draft (see page 4): Yes No

Check Number _____ Check Total _____

See page 4 for one time credit card payment information.

Site Director Sig. _____

Date _____

BANK DRAFT FORM

ATTACH BANK DOCUMENTATION HERE

Marin YMCA a branch of YMCA of San Francisco
Continuous Child Care
Authorization for monthly account debit

1. I authorize the YMCA of San Francisco, to initiate debit entries to my credit card account at the bank named below.
2. The YMCA of San Francisco agrees to provide 30 days notification prior to a price increase.
3. I agree to pay for any time block adjustment caused by the usage of additional hours of child care as well as the \$10 transfer fee.
4. I agree that I will keep my HOME ADDRESS and PHONE NUMBER updated with the YMCA at all times.
5. I agree to IMMEDIATELY notify the YMCA if my account information changes.
6. I understand that a service charge will apply to any returns from my account.
7. I agree to provide written notice 30 days prior to the monthly draft date stated below to cancel this agreement.

Member Name _____ Membership Type _____

Child's Name _____ Child Care Site _____

Address _____

City _____ State _____ Zip _____

Account Holders Signature _____ Date _____

One time withdrawal. Not intended for monthly draft.

Beginning ___/ 20 / ___ and every month until ___/ 20 / ___ for monthly child care fees.

PLEASE NOTE: Your account could be drafted up to 5 days before or after this date.

VISA MasterCard

Account Number _____ Expiration Date _____

Member # _____ Received Date _____ Staff Initials _____

MEDICAL HISTORY & CONSENT TO PROVIDE MEDICAL CARE

Child's Medical History and Allergy Information: PLEASE DO NOT LEAVE BLANK.

To help the staff meet your child's needs, please check and give approximate dates for all that apply:

Conditions:

- no significant conditions
- frequent ear infections
- heart defect/disease
- convulsions epilepsy
- diabetes
- bleeding/clotting disorders
- asthma
- ADD/ADHD
- _____

Shots:

- tetanus
- TB
- Hep B
- MMR
- Hib
- DTP
- DT
- IVP
- TD

Diseases:

- no significant diseases
- chicken pox
- mumps
- measles
- _____

Allergies:

- no allergies
- hay fever
- poison ivy/oak
- insect stings
- penicillin
- _____

Swimming Skills:

- Beginner
- Intermediate
- Advanced

Sunscreen Permission:

The YMCA has permission to provide sunscreen to my child. Due to licensing, the YMCA staff is not allowed to apply sunscreen to your child.

Parent Signature

Fieldtrip Permission:

I give permission for my child to participate in YMCA activities and fieldtrips (with advance notice).

Parent Signature

Photo Release:

The YMCA has permission to use pictures taken of my child for future YMCA promotional purpose.

Parent Signature

CONSENT FOR EMERGENCY MEDICAL TREATMENT Child Care Centers

As the parents or authorized representative, I hereby give consent to MARIN YMCA CHILD CARE to obtain all emergency medical or dental care prescribed by a duly licensed physician (M.D.) Osteopath (D.O) or Dentist (D.D.S.) for _____.
(Child's Name)
whatever conditions are necessary to preserve the life, limb or well being of the child named above.

**My child is allergic to the following medication _____

Date _____ Parent/Guardian Signature _____

Home Address _____

Home Phone _____ Work Phone _____

IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

| | | | | | |
|------------------------------|-----------|--------|-------|---------------------------|---------------------------|
| CHILD'S NAME | LAST | MIDDLE | FIRST | SEX | TELEPHONE () |
| ADDRESS | NUMBER | STREET | CITY | STATE | ZIP |
| FATHER'S NAME | LAST | MIDDLE | FIRST | BUSINESS TELEPHONE () | |
| HOME ADDRESS | NUMBER | STREET | CITY | STATE | ZIP |
| MOTHER'S NAME | LAST | MIDDLE | FIRST | BUSINESS TELEPHONE () | |
| HOME ADDRESS | NUMBER | STREET | CITY | STATE | ZIP |
| PERSON RESPONSIBLE FOR CHILD | LAST NAME | MIDDLE | FIRST | HOME TELEPHONE () | BUSINESS TELEPHONE () |

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

| NAME | ADDRESS | TELEPHONE | RELATIONSHIP |
|------|---------|-----------|--------------|
| | | | |
| | | | |
| | | | |
| | | | |

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

| | | | |
|-----------|---------|-------------------------|------------------|
| PHYSICIAN | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE () |
| DENTIST | ADDRESS | MEDICAL PLAN AND NUMBER | TELEPHONE () |

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

| NAME | RELATIONSHIP |
|------|--------------|
| | |
| | |
| | |
| | |
| | |

TIME CHILD WILL BE CALLED FOR

| | |
|--|------|
| SIGNATURE OF PARENT OR AUTHORIZED REPRESENTATIVE | DATE |
|--|------|

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

| | |
|-------------------|-----------|
| DATE OF ADMISSION | DATE LEFT |
|-------------------|-----------|