Chambersburg Memorial YMCA
23-24 BASFC Registration Form

_____ New Registration _____ Change Form

Student Information					
First Name:		M.I.:	Last Name:		
D.O.B.:	Age:	Grade:	Gender:	Phone Number:	
Street:		City:		State:	Zip Code:

Enrolling Parent/Guardian Information				
First Name:	Last Name:		Relationship to Particpant:	
Home Phone:	Cell Phone:		Work Phone:	
Street:	City:		State:	Zip Code:
Email address:		Employer:		
Employer Address Street:	City:		State:	Zip Code:
Authorized to pick-up				
Name:	Name		Name	
Name:	Name			

Program Attending (After School)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

After School

☐ After School

School Location

☐ Corpus Christi

Start Date: _____ Anticipated Pick-Up Time: _____

Monthly Pricing		
PROGRAM	Part-Time (2 days)	Full Time (3-5 days)
After School	$105.00	$225.00

Payment Amount	
Registration fee:	$30.00
BASFC Payment:	
Monthly Payment	

Payment Type:

☐ Automatic Credit Card (Due 25th of each month prior)
☐ Automatic Bank Draft (Due 25th of each month prior)
☐ ELRC Co-Pay: _____ (Due the Monday of each week)
Caseworker: _____

Prices are subject to change, notification will be given in advance. Second child receives 10% discount.

☐ I received a BASFC Program Guideline Manual
(BASFC Supervised play and homework time including all services listed in the handbook)

Parent/Guardian Signature Date:

Parent/Guardian Signature (6 month review) Date:

Director Signature Date:

Parent/Guardian Signature (9 month review) Date:

Business Office :

55PA CODE CHAPTERS 3270.123 & 181©

Chambersburg YMCA
Emergency Sheet

Student Information			
Student Name:		Birthdate:	
Street:	City:	State:	Zip Code:

Parent/Guardian 1 Information			
Guardian Name:		Relationship to Particpant:	
Home Phone:	Cell Phone:	Work Phone:	
Street:	City:	State:	Zip Code:
Email address:	Employer:		
Employer Address:	City:	State:	Zip Code:

Parent/Guardian 2 Information			
Guardian Name:		Relationship to Particpant:	
Home Phone:	Cell Phone:	Work Phone:	
Street:	City:	State:	Zip Code:
Email address:	Employer:		
Employer Address:	City:	State:	Zip Code:

Emergency Contact Person (list in order to be called)		
Name:	Name:	Name:
Phone Number:	Phone Number:	Phone Number:

Authorized to pick-up		
Name:	Address:	Phone Number:
Name:	Address:	Phone Number:
Name:	Address:	Phone Number:
Name:	Address:	Phone Number:
Name:	Address:	Phone Number:

Health Information			
Physician/Medical Care Provider:		Phone Number:	
Physician Address:	City:	State:	Zip Code:
Special Disabilities: (IF ANY)		Allergies:	
Medical/Dietary Information:		Medication Special Conditions:	
Additional Information on Special Needs of Child:			
Health Insurance Coverage:		Policy Number:	

Parent Signature is Required for Each Item Below to Indicate Parental Consent	
Obtaining Emergency Medical Care:	Walks and Trips:
Admin. Of Minor First-Aide Procedures:	Swimming:
Transportation By the Facility:	Wading:
Photo Consent:	Sunscreen:

Parent/Guardian Signature Date:

Parent/Guardian Signature (6 month review) Date:

Parent/Guardian Signature (9 month review) Date:

Parent/Guardian Signature (12 month review) Date:

Business Office :

55PA CODE CHAPTERS 3270.123 & 181(c)

Chambersburg YMCA Bank/Credit Card Draft Agreement Form

Please check all that apply: ☐BASFC ☐Camp ☐Membership ☐Preschool ☐Swim ☐ARK (☐ weekly or ☐ monthly)

Member ID #_____

Member Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Primary Phone: _____

Credit Card: ☐ Visa ☐ MasterCard ☐ Discover

Card Number:_____

Expiration Date: _____ 3-Digit _____

Name on Card: _____ Zip Code_____

Bank Draft: Bank Name:_____

Bank Routing Number: _____

Account Number: _____

Name on Account:_____

☐ **MEMBERSHIP:** The Chambersburg YMCA Bank Draft/Credit Card is a continuous membership payment plan. I have the right to cancel this agreement by submitting a **"CANCELLATION NOTICE" 14 days prior** to my next due date and returning all membership cards and locker keys.

Member's Initials

I hereby authorize the Chambersburg YMCA to initiate debit entries in the amount of $_____ to my Bank/Credit Card Draft account indicated above to fulfill my membership dues obligation.

In granting this authority, I understand that dues may change, and the monthly amount deducted from my account can change without the necessary of my signing a new authorization. I understand that I will be sent a notice of such changes.

I understand if any draft is denied by the bank/credit card company, I am responsible to make to payment, to maintain a current membership.

☐ **CHILD CARE:** I hereby authorize, the Chambersburg YMCA to initiate debit entries to my account indicated above to fulfill my Swim, Before & After School Fun Club (BASFC), Camp, ARK and/or Preschool fees.

In granting this authority, I understand that the monthly bank/credit card draft amount will not change unless there is a change to my Child Care contract. Any changes in my Child Care contract will not necessitate the need to sign a new credit card draft authorization agreement. I will provide the Chambersburg YMCA with at least two (2) weeks written notice of any change in the status of my account that might affect the monthly transaction.

I understand if any draft is rejected by *CardConex* for any reason, I will be required to pay the Chambersburg YMCA the monthly amount plus a $30.00 service charge before any child/children will be permitted to continue participation in the BASFC, Camp, ARK, Preschool and/or Swim program. I also understand that this event will in no way nullify this agreement.

Date: _____ Signature: _____

Member/Parent copy received by Member/Parent: Member/Parent Initial: _____ Staff Initial: _____

YMCA Office Use Only

Membership type: _____ Group code: _____ Program/Site _____

BD Amount: _____ (Start date_____) Header Completed: _____

Date of Draft: (**Membership**, □ 1st □ 15th); (**BASFC/Camp**, □ 25th); (**Swim**, □ 25th); (**ARK**, □ weekly □ 25th); (**Preschool**, □ 25th)

Type Code: ☐ Prime ☐ Military ☐ Boro ☐ County ☐ Letterkenny ☐ Volvo ☐ Financial Aid ☐ Special/Misc. _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.