



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

**YMCA OF GREATER SEATTLE**  
Youth Program Registration Form

YOUTH INFORMATION						
Legal First Name	M	Legal Last Name	Preferred Name	Date of Birth	Gender	Ethnicity
Home Address	Apt		City	State	Zip Code	

SPECIFIC MEDICAL, BEHAVIORAL OR DEVELOPMENTAL NEEDS		
Date of Last Physical	Date of Last Dental Exam	Date of Last Tetanus
Depending upon your child's need, additional paperwork and a meeting with a YMCA Director may be required prior to your child's start to ensure your child can best be accommodated. Failure to share information that identifies your child's special care, accommodations or supervision needs may jeopardize the placement of or continued participation by your child in the program. <u>Write "none" if none.</u>		
Dietary Modifications/Allergy	Chronic/Recurring Illness	
Current Medications (medication authorization may be required)	Operations/Serious Injury	
Physical Disability	Behavioral Disorder	
Developmental Delays		
List any activities from which your child should be exempted for health reasons:		

EMERGENCY & INSURANCE INFORMATION			
Child's Physician	Address		Phone Number
Child's Dentist	Address		Phone Number
Local Emergency Contact (other than parent or Dr.)	Phone Number	Out of Area Emergency Contact	Phone Number
It is the responsibility of every individual, their parent or legal guardian, to provide for their own accident and health coverage while participating in all YMCA activities. The YMCA of Greater Seattle does not provide any accident or health coverage for its participants.			
Medical Insurance Company	Policy Number		

PARENT OR GUARDIAN						
Legal First Name	M	Legal Last Name	Preferred Name	Date of Birth	Gender	Ethnicity
Home Address (if different than child)	Apt		City	State	Zip	
Phone Number	Cell Phone	Work Phone	Does Child Live With You?			
Primary Email						
Employer Name						

PARENT OR GUARDIAN						
Legal First Name	M	Legal Last Name	Preferred Name	Date of Birth	Gender	Ethnicity
Home Address (if different than child)	Apt		City	State	Zip	
Phone Number	Cell Phone	Work Phone	Does Child Live With You?			
Primary Email						
Employer Name						

**PICK UP AUTHORIZATIONS**

<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Phone Number</i>		
<i>Address</i>		<i>Apt</i>	<i>City</i>	<i>St</i>	<i>Zip</i>
<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Phone Number</i>		
<i>Address</i>		<i>Apt</i>	<i>City</i>	<i>St</i>	<i>Zip</i>
<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Phone Number</i>		
<i>Address</i>		<i>Apt</i>	<i>City</i>	<i>St</i>	<i>Zip</i>
<i>Legal First Name</i>	<i>M</i>	<i>Legal Last Name</i>	<i>Phone Number</i>		
<i>Address</i>		<i>Apt</i>	<i>City</i>	<i>St</i>	<i>Zip</i>

**YMCA POLICIES**

**Everyone is Welcome:** The YMCA is a membership organization open to all people.

**Financial Assistance:** If you cannot afford the full cost of a program or membership, please ask for a confidential scholarship application. Financial assistance, to the extent possible, is available to those in need.

**Personal Safety Discussions:** Our staff will engage children in discussions to help them understand how they can set their own personal safety and touching limits. These discussions will emphasize respect, set the ground rules for appropriate behavior, and encourage children to tell if someone touches them in a way that makes them feel uncomfortable. The YMCA of Greater Seattle respects the diversity and rights of the individuals it serves.

**AUTHORIZATIONS****Participation**

I give permission for my child to participate in all activities, including field trips, climbing wall, overnights, and swimming and to be transported as authorized by the YMCA. I give permission for the YMCA to use any pictures of my child for future promotional purposes.

**Medical Treatment**

I hereby give permission for my child to be given cardiopulmonary resuscitation (CPR) and first aid treatment by a qualified staff member of the YMCA. In the event I cannot be contacted, I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. I further consent to the disclosure of health information and to the medical, surgical and hospital care treatment and procedures (including, but not limited to, administration of necessary anesthetics, tests, x-ray examinations, transfusions, injections, drugs) to be performed for my child by a licensed physician or hospital selected by the YMCA director when deemed immediately necessary or advisable by the physician to safeguard my child's health.

**Release from Liability**

Recognizing that the YMCA will do its best to ensure a safe experience, I understand that accidents may occur both from my child's participation in program activities and from transportation to and from the program. I agree to assume these risks. By signing below, I release the YMCA of Greater Seattle, its employees, volunteers, independent contractors, directors and agents from all liability based on any damage, loss or injury whether it is the result of ordinary negligence or otherwise, caused to my child or to me from participation in YMCA programs.

**Photo Release:**

The applicant hereby gives permission for the YMCA (local, national and international) to use, without limitation or obligation, photographs or other media that may include the members' image or voice to promote or interpret YMCA programs.

**I have read and understand the above and have completed this form to the best of my ability.**

Signature of parent or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_



# Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

Office Use Only:

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Signed Cert. of Exemption on file?  Yes  No

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Information System.

<b>Child's Last Name:</b>	<b>First Name:</b>	<b>Middle Initial:</b>	<b>Birthdate (mm/dd/yyyy):</b>	<b>Sex:</b>	I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.	
Symbols below: <input checked="" type="checkbox"/> Required for School and Child Care/Preschool <input type="checkbox"/> Required for Child Care/Preschool Only <input type="checkbox"/> Recommended, but not required						
I certify that the information provided on this form is correct and verifiable.					Parent/Guardian Signature Required _____	Date _____

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Hepatitis B (Hep B)</b>				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
<b>■ Rotavirus (RV1, RV5)</b>				
	1			
	2			
	3			
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
	1			
	2			
	3			
	4			
	5			
<b>◆ Tetanus, Diphtheria, Pertussis (Tdap)</b>				
	1			
<b>■ Tetanus, Diphtheria (Td)</b>				
	1			
	2			
<b>● Haemophilus influenzae type b (Hib)</b>				
	1			
	2			
	3			
	4			
<b>■ Influenza (flu, most recent)</b>				

Vaccine	Dose	Date		
		Month	Day	Year
<b>● Pneumococcal (PCV, PPSV)</b>				
	1			
	2			
	3			
	4			
	5			
<b>◆ Polio (IPV, OPV)</b>				
	1			
	2			
	3			
	4			
<b>◆ Measles, Mumps, Rubella (MMR)</b>				
	1			
	2			
<b>◆ Varicella (chickenpox)</b>				
	1			
	2			
<b>■ Hepatitis A (Hep A)</b>				
	1			
	2			
<b>■ Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand</b>				
	1			
	2			
	3			
<b>■ Meningococcal (MCV, MPSV)</b>				
	1			
	2			

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.  
**Mark option 1, 2, OR 3 below (see # 5 on back)**

1)  Chickenpox disease verified by printout from the Immunization Information System (IIS)  
Must be marked by printout (not by hand) to be valid.

2)  Chickenpox disease verified by healthcare provider (HCP)  
If you choose this box, mark 2A OR 2B below.  
2A)  Signed note from HCP attached OR  
2B)  HCP sign here and print name below:

\_\_\_\_\_  
Licensed healthcare provider signature      Date  
(MD, DO, ND, PA, ARNP)

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

3)  Chickenpox disease verified by school staff from the Immunization Information System

**If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.**

**Documentation of Disease Immunity**

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.  
**Signed lab report(s) MUST also be attached.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	

\_\_\_\_\_  
Licensed healthcare provider signature      Date  
(MD, DO, ND, PA, ARNP)

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

**Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.**

**#1 To print with information filled in:** First, ask if your healthcare provider's office puts vaccination history into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS**, and return it to school or child care. If your provider's office does not use the IIS, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

**EXAMPLE**

**#2 To fill in by hand:** Print your child's name, birthdate, sex, and your own name in the top box.

**#3** Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ►

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
DTaP	<b>1</b>	01	12	2011
DTaP	<b>2</b>	03	20	2011
DTaP	<b>3</b>	06	01	2011

**#4** If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

**#5** If your child had chickenpox (varicella) disease and not the vaccine, **use only one** of these three options to record this on the CIS:

- 1)  If your child's CIS is printed directly from the IIS (by your healthcare provider or school), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the IIS printout (not by hand).
- 2)  If your healthcare provider can verify that your child had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your provider, or 2B if your provider signs and dates in the space provided. Be sure your provider's full name is also printed.
- 3)  If school staff access the IIS and see verification that your child had chickenpox, they will mark box 3.

**#6** Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your healthcare provider fill in this box. Ask your provider to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

**#7** Be sure to **sign and date the CIS**, and return to the school or child care.

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Vaccine Trade Names in alphabetical order									
(For updated lists, visit <a href="https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf">https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf</a> )									
Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	FluLaval	Flu	Ipol	IPV	PedvaxHIB	Hib	Twinrix (Twnrx)	Hep A + Hep B
Adacel	Tdap	FluMist	Flu	Infanrix	DTaP	Pentacel (Pntcl)	DTaP + Hib + IPV	Vaqta	Hep A
Afluria	Flu	Fluvirin	Flu	Kinrix (Knrx)	DTaP + IPV	Pneumovax	PPSV or PPV23	Varivax	Varicella
Boostrix	Tdap	Fluzone	Flu	Menactra	MCV or MCV4	Prevnar	PCV or PCV7 or PCV13		
Cervarix	HPV2	Gardasil	HPV4	MenHibrix (Mnhbrx)	Meningococcal C/Y-HIB-PRP	ProQuad (PrQd)	MMR + Varicella		
Daptacel	DTaP	Havrix	Hep A	Menomune	MPSV or MPSV4	Recombivax HB	Hep B		
Engerix-B	Hep B	Hiberix	Hib	Menveo	Meningococcal	Rotarix	Rotavirus (RV1)		
Fluarix	Flu	HibTITER	Hib	Pediarix (Pdrx)	DTaP + Hep B + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order							
(For updated lists, visit <a href="https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf">https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf</a> )							
Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	<i>Haemophilus influenzae</i> type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vecine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (IIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella



**PARENT/GUARDIAN STATEMENT OF UNDERSTANDING**

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

**I understand that the adult who signs the child up for the program is responsible for payments to the YMCA.**

**I understand all financial, attendance, enrollment and other business documents will be provided only to the adult who signs the child up for the program and is responsible for payment.**

**I understand that YMCA staff are not allowed to baby-sit or transport children outside of the YMCA program.**

**I understand children should not receive gifts (video games, jewelry, movie tickets...) that are not part of the YMCA program from YMCA staff or volunteers, and I should report this to a supervisor if they do.**

**I understand that I have free access, at all times, to areas of the program used by my child. I also understand that I will have opportunities to participate in program activities, and that this participation may require me to go through a screening process. I also understand that if my participation obstructs the program in any way, this privilege will be revoked.**

**I understand that I am not to leave my child at the YMCA or program site unless a YMCA staff 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.**

**I understand that should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police.**

**I understand that YMCA staff will engage children in discussions to help them understand how they can set their own personal safety and touching limits.**

**I understand that I will be provided information about my child's progress and/or any issues related to his/her care, however, both parents/guardians may receive this information upon request.**

**I understand that staff in licensed child care programs, family and mental health services and specific staff in other programs are mandated by state law to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation. I also understand that employees in all YMCA programs follow the same reporting protocol. Furthermore, our staff are protected from liability for good faith reporting.**

**I understand that the Health Care Plan is posted and available for my review.**

**I have read and understand the statements above and I have received a copy of:**

\_\_\_\_\_ Family Handbook (Containing all policies, procedures, philosophy, Medical Procedures, Disaster Preparedness Plan, Pesticide Policy, and Statement for Prevention of Abuse)

\_\_\_\_\_ *Protect Your Child From Abuse When Your Child Is Not With You* brochure is available from your YMCA branch and on ykids.org.

\_\_\_\_\_  
**Child's Full Name**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

COPY OF STATEMENT WILL BE FILED WITH CHILD'S RECORDS.



\_\_\_\_\_ (Please initial) **I have read and understand the Payment, Credit and Refund Policy, page 10 of the Child Care Programs Handbook, outlined below.**

- Payment must be received no later than 1<sup>st</sup> day of the month of care. If payments are not received by the due date, your child care may be cancelled and deposit will be forfeited.
- Cancellations or transfers require written notice 30 days prior to the effective date of the change.
- Registration fees are non-refundable and non-transferrable.
- A Payment Schedule is located in your Child Care Programs Handbook.
- A fee of \$30 will be assessed for any returned/declined payment transactions.
- Refund and credit policy will use guidelines below:

Notice Given Prior To:	Refund	Credit
Thirty days with written notice	100%	100%
Two weeks with written notice	0%	50%

\_\_\_\_\_ (Please initial) **I have read and understand the No Tolerance Policy, page 16 of the Child Care Programs Handbook.**

\_\_\_\_\_ (Please initial) **I have read and understand the Snack, Meals Plans & Lunch, page 7 of the Child Care Programs Handbook, outlined below.**

I understand that if I would like to provide alternate food for your child during snack time (eg. food from home, extra food from their packed lunch) for dietary, health or other reasons please ask for a YMCA Parent Meal Plan Agreement (WAC 170-297-7525-Parent or Guardian Provided Food).

\_\_\_\_\_ (Please initial) **I have read and understand the Peanut and Nut Policy, page 7 of the Child Care Programs Handbook, outlined below.**

To help the YMCA create a safe environment for children with life-threatening nut allergies, you may be asked to refrain from sending your child with food containing peanut butter or other nuts and/or other foods manufactured in a plant that processes nuts.

\_\_\_\_\_ (Please initial) **I have read and understand the Holiday & Site Closures as listed on page 18 of the Child Care Programs Handbook and agree to the following statement:**

I have read and understand the days outlined for holiday or training closures.

<p><b><u>Agreement</u></b></p> <p>I have read and initialed the above information and I fully understand all policies of the YMCA's Child Care Programs.</p> <p>Child's Full Name: _____</p> <p>Parent/Guardian Signature: _____ Date: _____</p>
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YMCA OF GREATER SEATTLE
Payment Authorization Form – Youth Enrichment Programs

PRIMARY MEMBER

Legal First Name, MI, Legal Last Name, Address, Phone Number

PAYMENT AUTHORIZATION (Please select preference for payment method.)

Please charge my Electronic Funds Transfer on file ending in \_\_\_ \_\_\_ \_\_\_. [ ] Checking [ ] Savings

Please charge my Credit Card or Debit Card on file ending in \_\_\_ \_\_\_ \_\_\_

I will log in to my Active account to enter Credit Card or Debit Card information before the 1st of the month. I understand I will not be fully registered until this is provided.

Please contact me for payment information. I understand that I will not be fully registered until this is provided.

Please read and initial/sign below.

I understand that I will be charged on the 1st of the month my child attends. \_\_\_ initial
I understand that changes and cancelations need to be made in writing 30 days prior to each month to avoid being charged for the month. \_\_\_ initial
(DSHS Families Only) I Understand that my co-payment for care is due on the 25th of the month preceding care. \_\_\_ initial

I hereby authorize my financial institution to honor pre-authorized debit entries by the YMCA on my account for YEP payments and when my financial institution honors such debits by charging my account this shall constitute my receipt for payment. \_\_\_ initial

I hereby authorize the YMCA to charge my credit card on a monthly basis for payments as indicated above. When my financial institution honors such debits by charging my account this shall constitute my receipt for payment. \_\_\_ initial

YMCA OF GREATER SEATTLE FINANCIAL POLICIES

I further stipulate the following conditions (please read and sign at the bottom):

- I understand that the YMCA membership and programs are continuous and that monthly charges or debits, as indicated above, will continue until I give written notice to change or terminate the membership or program.
I understand any custody agreements involving division of program costs are solely between the legal parties involved and are outside the Payment Agreement made with the YMCA of Greater Seattle.
I understand that I must give the YMCA written notice (in person or by email ONLY) 30 days prior to the next scheduled draft to change or cancel my membership or program fees. Failure to do so will make the subsequent draft non-refundable. Any outstanding balances will be due at the time of cancellation. I am liable for any fees that the YMCA may incur in its effort to collect any remaining balance due
I understand that I must inform the YMCA 14 days in advance of any changes to my name, address, telephone number or payment information. Failure to provide the YMCA with current information may result in non-refundable fees and that I am personally responsible for any payments not processed by my financial institution and/or the YMCA
I understand that the YMCA will notify me at least 30 days in advance of any increase to my monthly membership dues or program fees.
I understand that it is my responsibility to bring any billing discrepancies to the YMCA's attention within 60 days after they first appear on my financial statements. After 60 days, I waive my right to dispute such discrepancies.
I understand and authorize that NSF or collection of fees will be charged to me for any declined or returned monthly dues. Such non-sufficient fees will be the maximum amount allowed by law and will include applicable taxes.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_