



SCOTTSBLUFF FAMILY YMCA After School Program

School Attending:	Days of Care: <input type="radio"/> Every Day <input type="radio"/> Wednesdays Only	
Payment Options (select all that apply):		
<input type="radio"/> Monthly Automatic Withdrawal	<input type="radio"/> State Subsidy	<input type="radio"/> Gering C4K Scholarship
Corresponding Paperwork MUST BE INCLUDED (must match the options selected above):		
<input type="radio"/> Signed ACH Card	<input type="radio"/> Authorization Form	<input type="radio"/> Scholarship Application

1) Child's Name:		Grade in Fall:
Age:	Date of Birth:	<input type="radio"/> Male <input type="radio"/> Female
Severe/Life-Threatening Allergies:		
Required Medications:		
Special Considerations/Needs:		

2) Child's Name:		Grade in Fall:
Age:	Date of Birth:	<input type="radio"/> Male <input type="radio"/> Female
Severe/Life-Threatening Allergies:		
Required Medications:		
Special Considerations/Needs:		

3) Child's Name:		Grade in Fall:
Age:	Date of Birth:	<input type="radio"/> Male <input type="radio"/> Female
Severe/Life-Threatening Allergies:		
Required Medications:		
Special Considerations/Needs:		

Primary Parent/Guardian Name:		Date of Birth:
Relation to Child: <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Other:		<input type="radio"/> Male <input type="radio"/> Female
Address:		
Phone Number:	Email:	
Custodial Parent? <input type="radio"/> Yes <input type="radio"/> No	May we release to non-custodial parent? <input type="radio"/> Yes <input type="radio"/> No	

Secondary Parent/Guardian Name:		Date of Birth:
Relation to Child: <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Other:		<input type="radio"/> Male <input type="radio"/> Female
Address:		
Phone Number:	Email:	

Emergency Contact/Authorized Pick Up (other than parents):	
Relation to Child:	Phone Number:

1) Additional Authorized Pick Up Person:	
Relation to Child:	Phone Number:

2) Additional Authorized Pick Up Person:	
Relation to Child:	Phone Number:

3) Additional Authorized Pick Up Person:	
Relation to Child:	Phone Number:

<p>Medications Policy:</p> <ul style="list-style-type: none"> • Non-prescription medications require written note and instructions by a physician. • We require a medication form signed by parent(s) for any medication. • Medication must be current; we will not accept or administer expired medications. • We require medication to be in its original container. • We allow the self-carry of emergency medications only for children diagnosed with asthma or anaphylaxis. Self carry is only permitted with the prescribing physician's written permission. <p>Authorization for Medical Treatment: In the event that I cannot be reached to make arrangements for medical treatment, I authorize the YMCA Staff to administer first aid and/or transport to the nearest hospital or emergency care facility.</p>
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Name of Licensed Physician or Emergency Care Facility:	
Address:	
Phone Number:	Parent Signature:

I understand that a copy of the YMCA After School Program Handbook is available online and am responsible for the terms, policies, and procedures outlined within the Handbook. I understand and am aware that my child will/may be participating in physical activities and that the potential for accidents does exist. In consideration for being allowed to participate in the YMCA's program, I agree to assume the risk of such exercise and further agree to defend and hold harmless the Scottsbluff Family YMCA and its staff conducting this YMCA program from any and all claims, suits, losses, or related causes of action for damages, including (but not limited to) such claims that may result from injury or death (accidental or otherwise) during, or arising in any way from the program. I also understand that the Scottsbluff Family YMCA may use, for publicity and/or promotional purposes, my (or my child's) name or pictures participating in this program, without obligation or liability to me or my family.

Primary Parent/Guardian Signature:	Date:
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Parent Information Brochure For Licensed Child Care

Nebraska Child Care Licensing Website:
<http://dhhs.ne.gov/licensure/pages/Child-Care-Licensing.aspx>

Expectations of Child Care Consumers

Read thoroughly all the information your provider gives you.

Complete your Child's Record Forms and return to your provider before your child begins care. Review and update these records as needed.

Supply your provider with your child's immunization records and keep them updated as needed.

Sign and date the receipt of this Parent Information Brochure for Licensed Child Care and return it to your provider before your child begins care.

Talk to your Child Care provider regularly to address needs and concerns for your children in care and as a parent.

Contact Child Care Licensing with any questions or concerns you may have.

Email: DHHS.ChildCareLicensing@nebraska.gov

Phone: 800-600-1289 OR 402-471-6564

Mail: Nebraska Child Care Licensing
Department of Health and Human Services
PO Box 94986
Lincoln, NE 68509-4986

**Sign, date and return to your Child Care provider before your child(ren) begin care.
Your Child Care Provider must retain this receipt for onsite review.**



Child Care Program Name: _____

Enrolled Child(ren)' Names: _____

Parent/Guardian Names: _____

Parent/Guardian Signature: _____

Licensed Child Care

You have chosen to use a licensed Child Care provider for the care of your child or children. Nebraska Law requires anyone providing care to four or more children from different families, for compensation, to be licensed. The Types of Licensed Child Care in Nebraska are:



- Family Child Care Home I
- Family Child Care Home II
- Preschool
- Child Care Center
- School-Age Only Center



Responsibilities of Child Care Licensing

The roles and responsibilities of DHHS Child Care Licensing staff are to ensure that programs are providing proper care for and treatment of the children they serve, and that the care and treatment are consistent with the child's physical well-being, safety, and protection.

Licensed Child Care programs are encouraged to involve you. We urge you to let your Child Care providers and/or staff know of any concerns. There may be situations where you believe that the program is not responding to your concerns or may not be meeting state licensing standards. This brochure, which Child Care providers are required to share with you, provides information that might be helpful in those situations.

Please complete the receipt section and return it to your Child Care provider. This will be kept with your child's records.

Responsibilities of Licensed Child Care Provider

Comply with child care regulations for their license type at all times.

Obtain and maintain accurate records for children they have in care, such as Enrollment Forms, Parent Information Brochure Receipts, Immunization Records and Medication Administration records.

Keep accurate and up-to-date records for their license on themselves and staff members. Report changes to Child Care Licensing and complete required paperwork to reflect changes.

Allow access to their licensed facility when children are in care at all times to parents, Child Care Licensing representatives and the Fire Marshal.

Develop policies and procedures for their programs.

Communicate with families their needs and concerns for the children in care.

Contact Child Care Licensing with any questions or concerns they may have.

**COMPLETE THE OTHER SIDE
AND RETURN TO
YOUR CHILD CARE PROVIDER**

AUTHORITY TO WITHDRAW ACH DEBITS OR CREDIT CARD DRAFTS FOR MEMBERSHIP/PROGRAM PAYMENTS

NAME (PLEASE PRINT)		MEMBERSHIP/PROGRAM	MO. PAYMENT
			\$
YMCA OF SCOTTSBLUFF	DAY OF WITHDRAWAL - MONTHLY		
		TOTAL	\$

I understand that this authorization will remain in effect until I cancel in writing and I agree to notify the YMCA of Scottsbluff in writing of any changes to my account information or termination of this authorization. I understand that all changes to membership must be made by the 10th of the month to be effective for the current month. In case of a bank draft being rejected for Non-Sufficient Funds (NSF) I understand the YMCA of Scottsbluff may at its discretion attempt to process the charge again within 60 days through a third party collector and agree to an additional \$25.00 charge. I certify that I am an authorized user to this bank account/credit card to pay for this membership/program. The YMCA Board of Directors may, at their discretion, adjust the monthly rate applicable to my category of membership/program.

FULL NAME OF BANK (IF PAYING THROUGH BANK ACCOUNT) BANK ACCOUNT NUMBER BANK ROUTING NUMBER	CREDIT CARD INFO (IF PAYING THROUGH CREDIT CARD)		
	CARD TYPE	CARD NUMBER	EXPERATION DATE
	SIGNATURE OF BANK DEPOSITOR (AS SHOWN ON BANK RECORDS)		
	DATE		