



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

AFTER SCHOOL PROGRAM BONITA SPRINGS YMCA 2018-19

School Attending _____

Site attending: YMCA Rec Center

Child Name: _____ Grade Entering: _____

Birth Date: _____ Gender: M or F Phone Number: _____

Ethnicity: Asian African American Hispanic Native American Caucasian Other

Address: _____ Zip code: _____

Family Email Address: _____

Custodial Parent/Guardian Name: _____

Birth Date: _____ Place of Employment: _____

Work#: _____ Cell#: _____

Email: _____

2nd Custodial Parent/Guardian Name: _____

Birth Date: _____ Place of Employment: _____

Work#: _____ Cell#: _____

Email: _____

Emergency Contact: _____ Phone #: _____

Physician's Name: _____ Phone #: _____

Please list any allergies, medications, dietary restrictions, or any other special concerns:

Persons Authorized to pick-up my child (name other than parent): (Must be 18 years of age or older) Child will not be released to others without written permission.

<u>Name</u>	<u>Relationship to Child</u>	<u>Phone#</u>

Discipline Policy

Our discipline policy is based on recognizing and providing positive reinforcement for appropriate behaviors and natural or logical consequences as a response to less desirable ones. We believe that children truly want to learn how to behave in an appropriate manner. Our job is to help them learn this by serving as role models and guides. Our discipline policy is designed to be effective in a variety of situations and is based on the following components: Consistency, Emphasis on the positive, Logical consequences, Response. *We will never use any type of physical punishment. Nor will we shame, scold, or humiliate children.*The YMCA reserves the right to dismiss a child from the YMCA After School program if repeated efforts at modifying misbehavior have failed and/or if parents are not cooperating with our policies.

Authorization for Emergency Treatment

Medical Information: I give Permission for the staff of the Bonita Springs YMCA to contact the following medical personnel to obtain emergency medical care if necessary:

Doctor: _____ Phone # _____

I give permission for the staff of the Bonita Springs YMCA to take whatever steps may be necessary for my child’s medical care in the case of an emergency.

Parent Signature X _____ **Date:** _____

Tuition Payments

It is my complete understanding that I am responsibility for making sure all payments are complete. Failure to due so will result in dismissal from the program. It is also my complete understanding that if I wish to terminate or change my child care in anyway I must submit it in writing to the Program Director prior to the next payment date. If proper notice is not given, I will be responsible for tuition regardless of whether or not my child attends.

Payments are due the 1st and 15th of the month. **Payment must be paid in advance and will be drafted from a credit card or bank account.**

Parent or Guardian X _____ **Date:** _____



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YMCA School Age Care Statement of Understanding

- I have received the Parent Handbook from the YMCA, and agree that the YMCA has informed me of its' policies and procedures by providing me with the handbook. I understand that if I have a question regarding specific content in the handbook, a YMCA staff will clarify for me.
- I agree to follow all program policies as stated in the Parent Handbook, with special attention to the following areas: Guidance Policy, Fees and Collection Policy and Supervision/Safety Policy
- I understand that my child will not be release to anyone without proper documentation and presentation of valid photo identification.
- I understand that the YMCA staff cannot withhold a child from a custodial or biological parent without legal documentation (i.e. court orders, custody papers, etc.)
- I understand and will follow the YMCA's fee policy as outlined in the Parent Handbook.
- I understand that if my child is ill or will not be attending for any reason; the YMCA program must be notified prior to my child's scheduled attendance.
- I understand that credits will not be issued for any absences. Credits will only be issued for program closings due to severe weather or facility closings where other arrangements have not or could not be made by the YMCA.
- I understand that the YMCA is not responsible for and discourages employees from providing paid care and custody for a YMCA participate under the age of 18 outside of a YMCA program. (i.e. babysitting).
- I have reviewed the YMCA Code of Conduct for Parents.
- The information given in the registration paperwork and medical information paperwork is correct and complete to the best of my knowledge, and the person herein described has permission to engage in all activities in the program except those noted. All necessary and important medical information regarding my child has been documented on the medical forms provided in the registration paperwork.
- I agree to hold harmless the YMCA, its' agents and employees for all incidents alleging bodily injuries, or property damage or loss incurring while the person herein described is a participant at a YMCA sponsored activity on or off the YMCA premises. I will not hold harmless the YMCA from any liability arising out of negligence of the YMCA.

Parent Signature X _____ Date: _____

YMCA Liability Release

I give permission for my child to participate in the YMCA afterschool program. I understand that even when reasonable precaution is taken, accidents can sometimes happen. I hereby acknowledge that I am releasing the Bonita Springs YMCA as well as its staff members and volunteers from all liability due to injury, loss, or damage, which may occur on the YMCA or granted property while my child participates in the activities of this program. By signing below I acknowledge that I have read and understand, and voluntarily agree to this authorization and release and that I have received information regarding compliance with State Regulations.

Parent Signature X _____ **Date:** _____

Information/Photography Release

Please check the appropriate line in regards to YMCA staff photographing or video taping my child for YMCA promotional purposes (ads, brochures, newspapers, recruitment videos,) or for onsite activity purposes.

_____ I do give the YMCA permission to take my child’s picture/video tape for promotional purposes or onsite activities.

_____ I do not give the YMCA permission to take my child’s picture/video tape for promotional purposes or onsite activities.

Parent Signature X _____ **Date:** _____

**SKY Family YMCA
Draft Authorization Form
Childcare Programs**

I hereby authorize the SKY FAMILY YMCA, INC. to initiate a debit to my CREDIT/CHECKING account at the financial institution indicated below, and initiate adjustments (if necessary) for any transactions debited in error. This authority will remain in effect until the SKY Family YMCA is notified by me in writing to cancel in such time as to afford the SKY Family YMCA and Financial Institution a reasonable opportunity to act on it.

Customer Signature

Date

Customer Name (print)

Child’s Name (print)

Please note: All payments returned as non-fundable, whether by electronic charge or check will be assessed a \$25.00 administrative fee per occurrence. It is the individual's responsibility to notify the YMCA of any changes to their billing information at least 15 days prior to the scheduled draft date, regardless of reason. Exceptions will not be made.

Draft Information

Program Involved: Bonita Springs YMCA

Accounts will be drafted the first and fifteenth of the month. If your credit card is replaced it is your responsibility to notify the Bonita Springs YMCA.

Please staple voided check to this form.

Credit Card/ACH Verification (Circle One)

Account Holder Name: _____

Last 4 Digits of Account Number: _____

Account Holder Signature: _____

Transportation

Attached Good Wheels form must be filled out for each child. We receive free transportation from this company and they require the form filled out. The only part needed are the top information sections and your signature on the back.

**TRANSPORTATION DISADVANTAGED AND/OR
MEDICAID TRANSPORTATION DETERMINATION FORM**

All items must be completed and TYPED or PRINTED legibly or form will be returned

SECTION I - IDENTIFYING INFORMATION

Medicaid Gold Card No.: _____ S.S.# / / _____ Phone #: _____
Last Name: _____ First Name: _____
Home Street Address: _____ Apt. #: _____
Is this a: House Apartment Nursing Facility ACLF Boarding Home
City: _____ County: _____ Zip Code: _____
Date of Birth: / / _____ Your Current Age: _____ Male Female
Total Monthly Income: _____
Optional: White Black Hispanic Native American Asian Other _____

SECTION II - NEED DETERMINATION

Have you applied for ADA Transportation with Lee County: Yes No
If yes, were you: Approved Disapproved
Are you eligible for Medicaid Non-Emergency Transportation? Yes No
Are you able to operate an automobile, even for short distances? Yes No
Do you or anyone in your household own a car? Yes No

What are your vehicle license plate(s) number(s)? _____

Total # of persons who reside in your household: _____ Please list below:

Name	Is this person Related to you	Social Security No.	Does this person Own a car
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you lived in a Assisted Care Living Facility, Nursing Home, ICFMR or Boarding Home,
Does this facility have a vehicle? Yes No
Have you ever been transported by the facility? Yes No
Do you have any family or friends who live in the County you reside in? Yes No
Has this person(s) ever transported you to the doctor? Yes No
Would this person(s) take you to the doctor if you asked them? Yes No
Do you know someone who would transport you if you paid for the gas? Yes No
Have you ever taken the LeeTran bus to the doctor or to other places? Yes No
Can you travel on a LeeTran bus? Yes No
If NO, please explain why: _____
Would you use the LeeTran bus if you could ride free? Yes No
Can you walk without help to the distances below? (Check those that apply)
 Across a room One block Two blocks Three blocks One mile

SECTION III - DISABILITY

Are you currently receiving Supplemental Security Income (SSI)? Yes No
Are you currently receiving Social Security Disability? Yes No
Do you consider yourself to be disabled? Yes No

If YES, what is the nature of your disability? (Check all the apply)
 Blind/Legally Blind Wheelchair User Difficulty Walking
 Arthritis Cerebral Palsy Multiple Sclerosis
 Neuromuscular Disease Alzheimer's Disease Stoke
 Epilepsy Respirator or Oxygen Dependent Other (describe)
 Muscular Dystrophy Mentally Challenged _____

Do you require mobility aids? Yes No

If YES, which aids do you require? (Check all that apply)
 Walker Guide Dog Personal Care Attendant
 Scooter Cane Wheelchair
 Other _____

SECTION IV - FREQUENCY OF USE/DESTINATIONS

What doctors or medical clinics do you visit on a regular basis?

<u>NAME AND ADDRESS OF HOSPITAL, DOCTOR OR CLINIC</u>	<u>NUMBER OF VISITS EACH MONTH OR WEEK</u>
_____	_____
_____	_____
_____	_____

SECTION V - SIGNATURE, PREPARER AND WITNESS

I affirm that the information provided in this application for services is true and correct and understand that making false statements, having others make false statements, or making false statements on behalf of others constitutes welfare fraud and is considered a felony under the laws of the State of Florida.

Medicaid and/or Transportation Disadvantaged Recipient's

Signature: _____ Date: ____/____/____

Preparer's Signature: _____ Date: ____/____/____

RETURN COMPLETED FORM TO:

<p>Good Wheels, Inc. Community Transportation Coordinator 10075 Bavaria Rd., SE Fort Myers, FL 33913 1-239-768-2900 1-800-741-1570 (Toll Free)</p>	<p>Florida Relay System: 1-800-955-8770 - Voice 1-800-955-8771 - TTY</p>
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ACCESSIBLE FORMATS ARE AVAILABLE UPON REQUEST