



YMCA SCHOOL AGE CHILD CARE (SACC) REGISTRATION 2010/2011

All fields on this form MUST be completed. Incomplete forms will not be processed and will be returned.

FOR OFFICE USE ONLY:

Date Received: _____ Time: _____
 Date Processed: _____ Date Confirmation Sent: _____
 Admission Date: _____ Withdrawal Date: _____

Child's First Name: _____ Child's Last Name: _____

Birthdate: (year/month/day) _____/_____/_____ Gender: (M/F) _____

Years in SACC program: New 1 yr 2 yrs 3 yrs 4 yrs 5 yrs 6 yrs or more

School Age Centre Requesting: _____ Name of School (if different): _____ Will your child be in JK/SK in the upcoming year? yes no

Please register my child for (choose only one option):

Full-time: Before school After school Before & After school

OR

Part-time (minimum of 2 regular scheduled days each week):

Before school After school Before & After school

Days Requesting: M T W Th F

CHILD AND FAMILY INFORMATION

Child's Address: _____

City: _____ Postal Code: _____

Home Phone Number: _____

Resides with: Mother Father Both parents Guardian

Primary Contact: _____ Relationship: _____

Business Name: _____

Business Address: _____ City: _____

Daytime phone #: _____ Cell #: _____

E-mail: _____

Primary contact home address (if different from child): _____

City: _____

Secondary Contact: _____ Relationship: _____

Business Name: _____

Business Address: _____ City: _____

Daytime phone #: _____ Cell #: _____

Secondary contact home address (if different from child): _____

City: _____

Emergency Contact: (in the event that primary or secondary contacts cannot be reached)

1) Name: _____ Relationship: _____

Address: _____

City: _____ Phone #: _____

2) Name: _____ Relationship: _____

Address: _____

City: _____ Phone #: _____

Family Physician Name: _____

Address: _____

City: _____ Phone #: _____

Authorized Pick-ups (in addition to the primary contact, secondary contact, and emergency contacts;

must be 16 years of age or older; must sign child out at arrival or departure):

1) _____ Relationship: _____

2) _____ Relationship: _____

Please indicate if child experiences or has experienced any of the following:

** If child requires an epi-pen, an "epi-pen information form" found in the registration package will need to be completed. If child requires medication at SACC, please fill out the "administration of medication" form (located online) and review the medication policy in the parent handbook.

Allergies	Details
<input type="checkbox"/> Nuts	Epi-pen <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bee Stings	Epi-pen <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hay Fever	
<input type="checkbox"/> Medication	
<input type="checkbox"/> Food	Epi-pen <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Latex	Epi-pen <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other:	
Medical	
<input type="checkbox"/> Seizures	
<input type="checkbox"/> Vision/ Hearing	
<input type="checkbox"/> Mobility	
<input type="checkbox"/> Asthma	Inhaler <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> ADHD	
<input type="checkbox"/> Autism	
<input type="checkbox"/> Previous illness/operations?	
<input type="checkbox"/> Currently taking medication?	
<input type="checkbox"/> Medication will need to be given at program	
<input type="checkbox"/> Other:	

Is your child immunized? (if No, please attach a copy of exemption) Yes No

Any dietary or exercise restrictions? Yes No Details: _____

Does your child require additional assistance (YMCA SACC maintains a 1:15 staff to child ratio)? Yes No

If Yes, please specify if there is anything we should be aware of concerning school, relationships, learning abilities, etc: _____

- I have read the Parent Handbook and agree to comply with the rules and regulations as specified;
- My child is able to participate in the full range of activities.
- I give consent that medical treatment be given in the event of an emergency.

- I consent that any photographs or video taken at the YMCA may be used for promotional purposes.
- I permit my child go on supervised excursions outside the SACC Centre.
- I will not hold the YMCA responsible for lost or stolen items.

- I will not hold the YMCA, its staff or volunteers responsible for accidents which may occur
- I understand the legal obligation of the staff to report any suspected abuse.
- I understand that the YMCA may decline a child due to physical and/or verbal aggression towards staff or other children or if the safety of the child and/or others is at risk.

Signature of Primary Contact: _____ Signature of Secondary Contact: _____

The collection, use and disclosure of personal information is governed by the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c.M.56

EMERGENCY INFORMATION CARD (please duplicate information given on the registration form)

Child's First Name: _____ Child's Last Name: _____ Birthdate: (year/month/day) _____/_____/_____ Gender: (M/F) _____

Child's Address: _____ City: _____ Postal Code: _____ Home Phone Number: _____

Medical Information (please describe any allergies or medical information): _____

Primary Contact: _____ Relationship: _____

Business Name: _____

Business Address: _____ City: _____

Daytime phone #: _____ Cell #: _____

Primary contact home address (if different from child): _____

City: _____

Emergency Contact: (in the event that primary or secondary contacts cannot be reached)

1) Name: _____ Relationship: _____

Address: _____ City: _____ Ph #: _____

2) Name: _____ Relationship: _____

Address: _____ City: _____ Ph #: _____

Secondary Contact: _____ Relationship: _____

Business Name: _____

Business Address: _____ City: _____

Daytime phone #: _____ Cell #: _____

Secondary contact home address (if different from child): _____

City: _____

Authorized Pick-ups (other than primary, secondary, emergency contacts; must be 16 years of age or older):

1) _____ Relationship: _____

2) _____ Relationship: _____

Family Physician Name: _____

Address: _____ City: _____ Ph #: _____

If at any time emergency medical treatment is necessary for my child, I give consent for it to be given. I understand that every effort will be made to contact the primary or secondary contacts. I agree to let my child go on supervised excursions outside of the School Age Child Care centre.

Signature of Primary Contact: _____ Signature of Secondary Contact: _____