



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

**Rye YMCA – Offsite at Bellows  
After School Adventures - ASA  
Registration 2022- 2023**

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**Registration Packet**

**RYE YMCA**

21 Locust Ave Rye, NY 10580

[www.ryeymca.org/childcare](http://www.ryeymca.org/childcare)

PH (914) 967-6363 x 116 Fax (914) 967-0644

Liliana Gudino

Child Care Director

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# RYE Y OFFSITE @ BELLOWS AFTERSCHOOL PROGRAM 2022-2023 REGISTRATION FORM

<b>Child's Name:</b>		<b>Date of Birth:</b>	<b>Gender:</b>
<b>Home Address:</b>			
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Home Phone:</b>		<b>Grade as of September 2022:</b>	
<b>School:</b>		<b>Teacher:</b>	
<b>Parent 1:</b>		<b>Home address if different than above</b>	
<b>Parent 2:</b>		<b>Home address if different than above</b>	
<b>Marital Status: Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Unmarried ( )</b>			
<b>Custody Schedule (if applicable):</b>			
<b>If there is a court order restricting visitation/pickup, a copy must be provided to the YMCA by state law.</b>			

<b>Mother's Work Phone:</b>	<b>Father's Work Phone:</b>
<b>Hours:</b>	<b>Hours:</b>
<b>Cell Phone/Other:</b>	<b>Cell Phone/Other:</b>
<b>Email Address: (please print)</b>	<b>Email Address: (please print)</b>

**\*\*\* Your child's Immunization Records and most recent Health Appraisal are required prior to their first day of attendance. \*\*\***

**CHECK PROGRAM(S) REQUESTED:**

**AFTER SCHOOL PROGRAM (ASA) 3:00-6:00** ( ) 5 DAYS ( ) 4 DAYS ( ) 3 DAYS

CIRCLE DAYS IF LESS THAN 5: M T W TH F (Minimum 2 days)

FIRST DAY ATTENDING \_\_\_\_\_

**2022/2023 MONTHLY RATES (billing will be automatically on the 15<sup>th</sup> of each month)**

<b>PROGRAM OPTIONS</b>	<b>YMCA Member</b>	<b>Non-Member</b>
<b>ASA 5-DAYS</b>	<b>\$556</b>	<b>\$607</b>
<b>ASA 4-DAYS</b>	<b>\$505</b>	<b>\$556</b>
<b>ASA 3-DAYS</b>	<b>\$443</b>	<b>\$474</b>
<b>ASA 2-DAYS</b>	<b>\$350</b>	<b>\$386</b>

### PERSONAL HISTORY

Child's Name:	Nickname:
Names/ages of other children in family:	How does your child get along with siblings, other children, and friends?
What are your child's favorite activities?	Are there specific methods you use when dealing with difficult behavior from your child?
Does your child have any specific fears? Please describe/explain:	What do you hope your child will gain from this experience?
Do you want your child to begin homework at the after-school program? ( ) Yes ( ) No (PLEASE be sure your child knows your wishes.)	In order for our staff to assure your child a happy, meaningful experience at our After-School program, please share any information that you feel would be helpful. (Learning disabilities, emotional, behavioral, limitations, etc.)

**PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW. YOUR CHILD IS NOT CONSIDERED REGISTERED WITHOUT A SIGNATURE.**

I give permission for my child to participate in all program activities. He/she is in good health and may participate in normal program activities unless I specify otherwise on the health history form. I give the YMCA permission to transport my child to or from their designated school on a school bus monitored by a staff member. This may include Vacation Camp Days as well. I consent that photographs taken of my child are the property of the Rye YMCA and may be reproduced and publicized as the YMCA desires, at any time, free of claims on my part. In case of an emergency, I authorize the staff of the Rye YMCA to seek emergency care for my child and/or provide First Aid by a trained staff member. I understand that medical information and personal data will be used in the programs, when necessary, to protect my child's well being. I do hereby agree to hold free from any and all liability the Rye YMCA and its respective officers, employees and members, including but not limited to, its or their own negligence and do hereby for myself/ourselves, heirs, executors and administrators, waive, release and forever discharge any and all rights and claims for damages which I/we may have or which may hereafter accrue to me arising out of or connected with my participation in any of the activities of the Rye YMCA, use of facilities or use of equipment within its facilities. I HAVE RECEIVED, READ, AND UNDERSTAND THE POLICIES LISTED IN THE PARENT HANDBOOK. I UNDERSTAND THAT IF I DO NOT COMPLY WITH THESE POLICIES, MY CHILD IS SUBJECT TO SUSPENSION/TERMINATION FROM THE PROGRAM.

Parent/Guardian Signature:	Date:
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<b>Child's Name:</b>
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IN THE EVENT OF AN EMERGENCY, PARENTS WILL BE CONTACTED FIRST. IF NOT AVAILABLE, THE OTHER INDIVIDUALS ON EMERGENCY CONTACT LIST WILL BE CONTACTED.

### EMERGENCY CONTACTS AND PICK UP AUTHORIZATIONS

1. Name:	Home Phone:	Relationship:
Address:	Cell Phone:	Work Phone:
2. Name:	Home Phone:	Relationship:
Address:	Cell Phone:	Work Phone:
3. Name:	Home Phone:	Relationship:
Address:	Cell Phone:	Work Phone:
4. Name:	Home Phone:	Relationship:
Address:	Cell Phone:	Work Phone:

### THE FOLLOWING INDIVIDUALS ARE NOT ALLOWED TO PICK UP MY CHILD

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

## HEALTH HISTORY

**Child's Name:**

**\*\*\*A copy of your child's Immunization Records and most recent Physical are required prior to their first day of attendance. \*\*\***

<p>Does your child have any allergies? Please list. Explain reaction</p>	<p>Any dietary restrictions? Please list.</p>
<p>Any chronic/recurring illness or medical conditions? Please list and explain.</p>	<p>Any activities your child cannot participate in?</p>
<p>Is your child covered by medical/hospital insurance? ( ) YES ( ) NO</p> <p>Indicate: Carrier</p>	<p>Name of Family Physician:</p> <p>Phone Number:</p>
<p>Name of Family Dentist:</p> <p>Phone Number:</p>	<p>Is your child currently on any medication?</p>



**RYE Y OFFSITE @ BELLOWS  
AFTER SCHOOL PROGRAM  
2022-2023 CREDIT CARD FORM**

CHILD'S NAME:

NAME AS IT APPEARS ON CARD:

TYPE OF CARD:

CREDIT CARD NUMBER:

EXPIRATION DATE:

- 1) You will be charged prior to the start of each month on the 15<sup>th</sup>.
- 2) You must notify us if your card information changes or expires.
- 3) If you do not use a credit/debit card you will need to make arrangements with the director.

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**DAY CARE ENROLLMENT**

PHOTO OF CHILD (Optional)	PROGRAM NAME: <b>Rye YMCA</b>		ADDRESS: <b>200 Carroll Ave, Mamaroneck, NY 10543</b>		PHONE NUMBER: <b>( 914 ) 450 - 1535</b>
	CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:			DATE OF BIRTH: / /	GENDER:
	CHILD'S HOME ADDRESS:				
	NAME OF PERSON ENROLLING CHILD:		RELATIONSHIP TO CHILD: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____		
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: (   ) - <input type="checkbox"/> ok to text			ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):		
EMAIL ADDRESS:					
<b>EMERGENCY INFO</b>	<b>EMERGENCY CONTACT NAMES / ADDRESSES</b>		<b>Authorized to Pick Up Child</b>	<b>PRIMARY PHONE NUMBER</b>	<b>OTHER PHONE NUMBER / EMAIL</b>
	PRIMARY CONTACT:		<input type="checkbox"/> Yes <input type="checkbox"/> No	(   ) - <input type="checkbox"/> ok to text	(   ) - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	(   ) - <input type="checkbox"/> ok to text	(   ) - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	(   ) - <input type="checkbox"/> ok to text	(   ) - <input type="checkbox"/> ok to text
<b>FOR PROGRAM USE ONLY</b> DATE OF ENROLLMENT:   /   /			<b>FOR PROGRAM USE ONLY</b> DATE OF DISENROLLMENT:   /   /		

CHILD'S FULL NAME:		DATE OF BIRTH: / /
<b>Check boxes below to indicate if your child has any special needs/services:</b> <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (Please list) _____ <input type="checkbox"/> Other _____		
Please provide information here <b>AND</b> discuss with your child care provider:		
CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:		PHONE NUMBER: (   ) -
PREFERRED HOSPITAL:		PHONE NUMBER: (   ) -
CHILD'S DENTAL CARE:		PHONE NUMBER: (   ) -
<b>Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: <a href="https://nystateofhealth.ny.gov/">https://nystateofhealth.ny.gov/</a></b>		
<b>AGREEMENTS</b>		
• I consent to emergency medical treatment for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I provided information on my child's special needs to the program to assist in caring for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I agree to review and update this information whenever a change occurs and at least once every year.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:		DATE: / /