



Date ____ / ____ / ____

Program Rates & Times

Y Member: **\$45/day**
Non-Member: **\$55/day**
(7AM - 6PM)

Payment for a snow day is due at the time of registration.

Weather conditions may change location hours. Please call the branch in advance or check our mobile app for closure updates.

Please send your child with a ready-to-eat peanut-free lunch, snacks, a water bottle, bathing suit, and towel.

Please note snow clubs are capped at 30 participants and space is granted on a first come, first serve basis.

Child's Information

First Name _____ Last Name _____

DOB ____ / ____ / ____ Male Female Emergency Contact (____) ____ - _____

Address _____

City _____ State ____ Zip _____

Billing Party Information (all correspondence will be delivered to this party)

Capital District YMCA Member Non-Member Capital District YMCA Staff

First Name _____ Last Name _____

DOB ____ / ____ / ____ Male Female

Address _____

City _____ State ____ Zip _____

Home (____) ____ - _____ Work (____) ____ - _____ Cell (____) ____ - _____

Email _____

Billing Payment Information

Cash: Due at your local YMCA

Online Payment: Accessible at www.cdymca.org *Manage My Account*

Check: Due at your local YMCA or by mail. Made payable to CDYMCA.

(Childcare Billing, Capital District YMCA, 465 New Karner Rd., Albany NY, 12205)

Automatic Withdrawal: Credit Card charge or Direct Bank withdrawal (ACH)

Credit Card (Write only the last four digits of your card number if it is on file)

Name on Card _____ Card Type _____

Card Number _____ Exp ____ / ____

Address _____

City _____ State ____ Zip _____

Bank Withdrawal (ACH) (Write only the last four digits of your account number if it is on-file)

Name _____

Bank Name _____

Routing Number (9 Digits) _____ Checking Savings

Account Number _____

Terms: I authorize my financial institution to honor pre-authorized debit/charges initiated by the YMCA on my account for childcare payments. Should any payments not be honored by the above financial institution, I understand that in addition to the regular payment, I will be charged a \$20 NSF (Non-Sufficient Funds) fee.

Signature (I have read and understand the terms of this draft authorization) _____

Date _____

Financial Assistance

Department of Social Services (attach DSS approval letter)

YMCA Scholarship (attach approval letter)

Third Party

Please print your child's name in the memo section of your check. When you provide a check as payment, you authorize a one-time EFT (Electronic Fund Transfer) from your account to process the payment.

[OFFICE USE ONLY] Staff Signature _____ Date _____ Receipt # _____

Payment Attached Y N Scholarship Percentage _____ Special Information _____

Authorized Pick-Up Information

Please list secondary individuals who may pick up your child

1. First Name _____ Last Name _____ Relationship _____

Address: _____

Contact Information: Main (___) ___ - _____ Work (___) ___ - _____ Cell (___) ___ - _____

2. First Name _____ Last Name _____ Relationship _____

Address: _____

Contact Information: Main (___) ___ - _____ Work (___) ___ - _____ Cell (___) ___ - _____

I give permission for my child to be released from YMCA care with the above individuals. I understand that the people listed are required to show identification for a child to be released. I also agree to notify YMCA staff in advance when I will not be picking up my child.

Parent/Guardian Signature (I have read and understand the above statement)

Date

Custody Information

Parent's Marital Status: Married Divorced Separated Single Widowed

If divorced or separated, who has legal custody? _____

Note: Court orders are needed if a parent is denied access to the child

Medical Information

Medications Child Is Currently Taking _____

If your child will need to take medications during the Snow Day, you will need to provide the medication in the prescription bottle, a doctor's prescription with dosage instructions, and a note from you authorizing the YMCA to administer the medication. If documentation is not provided, your child's medication will not be permitted to be left onsite.

Physician's Name _____ Phone (___) ___ - _____

Dosage Instructions _____

Allergies _____ Last Tetanus Shot ___ / ___ / _____

In case of allergic reaction, what action should be taken? _____

Does your child have disabilities? Hearing Speech Vision Seizures Other _____

Please Describe _____

In the event that I/we cannot be reached to make arrangements for emergency medical attention, I/we, being the parent(s) legal guardian(s) of the named minor, do hereby appoint the YMCA staff to act on my/our behalf in authorizing emergency medical, dental, surgical care and hospitalization in my/our absence for the named minor.

Parent/Guardian Signature (I have read and understand each of the above statements)

Date

Additional Information

Does your child have any special needs? Please Explain _____
