



South Sound YMCA

Parent Agreement Letter and Child Care Enrollment Form

Child's Last Name: _____

School: _____ Grade: _____ Date Care Begins: _____

| DAYS PER WEEK | BEFORE SCHOOL | AFTER SCHOOL |
|---------------|---------------|--------------|
| 4-5 DAYS | _____ | _____ |
| 2-3 DAYS | _____ | _____ |
| DROP-IN | _____ | _____ |

Child's Name: _____ Male/Female: _____ Date of Birth: _____ Grade: _____

Address: _____ City: _____ Zip Code: _____

 Parent / Guardian: _____ Home Phone: _____ Cell Phone: _____ **Auth. to Pick Up? Y N***

Employer: _____ Work Phone: _____ Work Address: _____

 Parent / Guardian: _____ Home Phone: _____ Cell Phone: _____ **Auth. to Pick Up? Y N***

Employer: _____ Work Phone: _____ Work Address: _____

 Other Parent/Guardian: _____ Home Phone: _____ Cell Phone: _____ **Auth. To Pick Up? Y N***

Employer: _____ Work Phone: _____ Work Address: _____

Relationship to Child: _____

Parent / Guardian E-mail Address: _____

Child lives with: Both Parents _____ Mother _____ Father _____ Other: _____ Phone: _____

Emergency contact other than parents / guardians: _____ Relationship to Child: _____

 Address: _____ Home Phone: _____ Cell Phone: _____ **Auth. to Pick Up? Y N**
***APPROPRIATE COURT DOCUMENTS MUST BE IN PLACE IN ORDER TO DENY PARENT ACCESS**
LIST ALL NAMES OTHER THAN ABOVE WHO ARE AUTHORIZED TO PICK UP YOUR CHILD (You must list at least one.)

| Name | Address | Phone Number | Relationship to Child |
|----------|---------|--------------|-----------------------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |

I AGREE TO PAY VIA BANK DRAFT THE: MONTHLY RATE OR CO-PAYMENT OF \$ _____
- BANK DRAFT AUTHORIZATION FORM MUST BE ATTACHED -
A bank draft waiver is available to those with extenuating circumstances. Please call the Child Care Office for more information.
I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING: (Please initial each line.)

- A. _____ I have received or been advised of where to find the Parent Handbook and will adhere to all YMCA policies stated within.
- B. _____ **Two weeks notice** to the YMCA Child Care Office is required when canceling or changing my child's schedule of care.
- C. _____ In the event that I may qualify for a refund of tuition paid, processing time may be a minimum of two weeks.
- D. _____ I must submit new enrollment paperwork each school-year my child is in care, and maintain a current basic membership, if applicable, for the duration of the program. In the event that the basic membership expires prior to the end of the school-year, my account will be charged for a renewal.
- E. _____ **Accounts paid by hand after the 5th of the month will be assessed a \$20.00 late fee** unless alternate arrangement has already been made with the Child Care Office.
- F. _____ When initiating bank draft, I must pay the first month by hand either at the time of registration, or by the appropriate payment due date for the month my child is to begin care.
- G. _____ **DSHS ONLY:** If my DSHS coverage expires I will be responsible for the full cost of my child's care with the YMCA.

First Name: _____

| | |
|---|-------------|
| Reviewed by: _____ Staff Signature | Date: _____ |
| Is there an accompanying signed Certificate of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No | |



DOH 348-013
Rev: 10/15/08

Certificate of Immunization Status (CIS)

| | | | |
|-----------------------|-------------|----------------------------|------------------|
| Child's Last Name: | First Name: | Middle Initial: | Child's Address: |
| Child's Birthdate: | | Child's Sex: | |
| Parent/Guardian Name: | | Parent/Guardian Day Phone: | |

If completing by hand, write the vaccine in the row to the left of "Dose" and the date the vaccine was received in the "Date" column. Age column is optional.

◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only

| Vaccine | Dose | Date | Age | Vaccine | Dose | Date | Age | Vaccine | Dose | Date | Age |
|---|------|------|-----|--|--|---|-----|---|------|------|-----|
| ◆ Hepatitis B (Hep B) | | | | ● Pneumococcal (PCV, PPV) | | | | Hepatitis A (Hep A) | | | |
| | 1 | | | | 1 | | | | 1 | | |
| | 2 | | | | 2 | | | | 2 | | |
| | 3 | | | | 3 | | | | | | |
| | | | | | 4 | | | | | | |
| Hepatitis B (Hep B) Alternate schedule for teens | | | | ◆ Polio (IPV, OPV) | | | | Meningococcal (MCV4, MPSV4) | | | |
| | 1 | | | | 1 | | | | 1 | | |
| | 2 | | | | 2 | | | | | | |
| Rotavirus | | | | Influenza (most recent) | | | | Human Papillomavirus (HPV) | | | |
| | 1 | | | | 1 | | | | 1 | | |
| | 2 | | | | 2 | | | | 2 | | |
| | 3 | | | | 3 | | | | 3 | | |
| | | | | | 4 | | | | | | |
| ◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT) | | | | ◆ Measles, Mumps, Rubella (MMR) | | | | Other | | | |
| | 1 | | | | 1 | | | | | | |
| | 2 | | | | 2 | | | | | | |
| | 3 | | | | | | | | | | |
| | 4 | | | | | | | | | | |
| | 5 | | | | | | | | | | |
| ◆ Diphtheria, Tetanus, Pertussis (Tdap, Td) | | | | ◆ Varicella (chickenpox) | | | | <p>I certify that the information provided here is correct and verifiable.</p> <p>_____ Signature of Parent or Guardian</p> <p>_____ Date</p> | | | |
| | 1 | | | | 1 | | | | | | |
| | 2 | | | | 2 | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| ● Haemophilus influenzae type b (Hib) | | | | ▼ Verification of varicella disease history ▼ | | | | <p>Licensed HCP Signature (MD, DO, ND, PA, ARNP) Date</p> <p>_____</p> <p>Either initial with parent approval or get parent signature below:</p> <p>Staff initials indicating parent approval: _____</p> <p>Parent Signature indicating approval: _____</p> | | | |
| | 1 | | | <input type="checkbox"/> Health Care Provider (HCP) Verified ▶ | <input type="checkbox"/> Signed note from HCP attached or <input type="checkbox"/> HCP provider signature here: ▶ | | | | | | |
| | 2 | | | <input type="checkbox"/> HCP Verified by Registry ▶ | No HCP Sig required if box at left checked. | If school staff find verification in the Registry, then school staff must: ▶ | | | | | |
| | 3 | | | <input type="checkbox"/> Parental Report ▶ | ONLY acceptable for some grades. Write date or age child had disease: | | | | | | |
| | 4 | | | | | | | | | | |

See the back of this page for documentation of immunity, a vaccine trade name reference guide, and a vaccine abbreviation list.

Documentation of Immunity by Blood Test (titer)

I certify that the child named on this form has laboratory evidence of immunity to (check all that apply):

- Diphtheria
 Hepatitis A
 Hepatitis B
 Hib
 Measles
 Mumps
 Polio
 Rubella
 Tetanus
 Varicella
 Other (list): _____ lab report(s) attached (required)

X
 Typed or Printed Name of **Licensed Health Care Provider** (MD, DO, ND, PA, ARNP)

X
 Signature of **Licensed Health Care Provider** (required) Date (required)

Vaccine Trade Names*

Read down and across - Trade Names are in Alphabetical Order.

| Trade Name | Vaccine | Trade Name | Vaccine |
|------------|-------------|--------------|--------------------|
| Acel-Imune | DTaP | Menomune | MPSV4 |
| ActHIB | Hib | OmniHIB | Hib |
| Adacel | Tdap | Pediarix | DTaP + IPV + Hep B |
| Boostrix | Tdap | PedvaxHIB | Hib |
| Certiva | HPV | Pentacel | DTaP + IPV + Hib |
| Comvax | Hib + Hep B | Pentavalente | DTaP + Hep B + Hib |
| Daptacel | DTaP | Pneumovax | PPV23 |
| Decavac | Td | Prevnar | PCV or PCV7 |
| Engerix-B | Hep B | ProHIBit | Hib |
| Fluarix | Flu | ProQuad | MMRV |
| FluMist | Flu | Quadracel | DTaP + IPV |
| Fluvirin | Flu | Recombivax | Hep B |
| Fluzone | Flu | Rotarix | Rotavirus |
| Gardasil | HPV | RotaTeq | Rotavirus |
| Havrix | Hep A | Tetramune | DTP + Hib |
| HibTITER | Hib | TriHIBit | DTaP + Hib |
| HyperTET | TIG | Tri-Immunol | DTP |
| HyperHEP B | HBIG | Tripedia | DTaP |
| Ipol | IPV | Twinrix | Hep B + Hep A |
| Infanrix | DTaP | Vaqa | Hep A |
| Kinrix | DTaP + IPV | Varivax | Varicella |
| Menactra | MCV4 | | |

Vaccine Abbreviations*

Read down – Abbreviations are in Alphabetical Order.

| Abbreviations | Full Vaccine Name |
|-------------------|--|
| DT | Diphtheria, Tetanus |
| DTaP | Diphtheria, Tetanus, acellular Pertussis |
| DTP | Diphtheria, Tetanus, Pertussis |
| Flu (TIV or LAIV) | Influenza |
| HBIG | Hepatitis B Immune Globulin |
| Hep A (HAV) | Hepatitis A |
| Hep B (HBV) | Hepatitis B |
| Hib | <i>Haemophilus influenzae</i> type b |
| HPV | Human Papillomavirus |
| IPV | Inactivated Poliovirus Vaccine |
| MCV4 | Meningococcal Conjugate Vaccine |
| MPSV4 | Meningococcal Polysaccharide Vaccine |
| MMR | Measles, Mumps, Rubella |
| MMRV | Measles, Mumps, Rubella, Varicella |
| OPV | Oral Poliovirus vaccine |
| PCV or PCV7 | Pneumococcal Conjugate Vaccine |
| PPV23 | Pneumococcal Polysaccharide Vaccine |
| Rota (RV1 or RV5) | Rotavirus |
| Td | Tetanus, Diphtheria |
| Tdap | Tetanus, Diphtheria, acellular Pertussis |
| TIG | Tetanus immune globulin |
| VAR or VZV | Varicella |

*These lists may not be comprehensive; visit <http://www.doh.wa.gov/cfh/immunize/forms/default.htm> for updated lists.

Certificate of Exemption (COE)

From School, Child Care and Preschool Immunization Requirements¹



DOH 348-106 Revised: 10/15/08

| | | | |
|-----------------------|--------------|-----------------|----------------------------|
| Child's Last Name: | First Name: | Middle Initial: | Child's Address: |
| Child's Birthdate: | Child's Sex: | | |
| Parent/Guardian Name: | | | Parent/Guardian Day Phone: |

Please choose the exemption(s) that apply to your child as listed below.

Temporary Medical Exemption

Permanent Medical Exemption

I certify that the child named on this form is medically exempted from the requirement for the following vaccine(s):

Vaccine(s) Until Date (or Perm.)

X
Type or Print Name of Licensed Health Care Provider (MD, DO, ND, PA, ARNP)

X
Signature of Licensed Health Care Provider Date

Personal/Philosophical Exemption

Religious Exemption

I do not want my child to get the following vaccine(s).

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hib |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pertussis (whooping cough) |
| <input type="checkbox"/> Pneumococcal | <input type="checkbox"/> Polio | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Varicella (chickenpox) | |

Other (indicate):

Parent/Guardian Notice: "I certify that the information provided here is correct and verifiable. I understand that if there is an outbreak of a vaccine-preventable disease my child has not been fully immunized against (as indicated above, for medical, personal/philosophical or religious reasons), my child may be at risk for disease and can be **excluded** from school, child care or preschool until the outbreak is over."

Signature of Parent/Guardian

Date

¹ RCW 28A.210.080-090 state that before or on the first day of every child's attendance at any public and private school or licensed day care center in Washington State must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the state board of health, or (3) a certificate of exemption, signed by a parent or guardian. Medical exemptions must be signed by a licensed health care provider.



South Sound YMCA Child Care Drop-In Program Policy Agreement

Thank you for your interest in our Drop-In program. The following is a list that explains our policies and the procedures that we require all participants to follow. **Please review and sign this agreement as an acknowledgement of the program policy, even if you are not currently registering for the Drop-In Program.**

- Drop-in is a program designed for children that only need to be in care a maximum of 1-2 days per week. A child that requires more care than this must be upgraded to a part-time or full-time schedule.
- Registration needs to be completed each school year, requires a \$25 registration fee to be paid, and that the child is at least a basic member of the South Sound YMCA.
- Drop-in care may only be used if there is space available. You must call the site 24 hours in advance to request care for your child on a particular day.
- A coupon must be turned in to the site at the time of care. Drop-in coupons can be purchased at the Downtown YMCA, the Briggs Community YMCA, the Child Care Office, or you can mail in an order form to the Child Care Office with payment and have coupons mailed back to you. Order forms are available online at www.southsoundymca.org.
- If you fail to provide a drop-in coupon on the day of care, we will issue a replacement coupon at the site and charge your account the price of a coupon plus an additional \$2 fee. You will then be responsible to make that payment before your child uses another day of care.
- There are separate coupons that must be purchased for early release, late start, and in-service days.
- Unused coupons can be turned in to one of the branches at the end of the school year for a refund.

Please call the Child Care office at (360) 705-2642 if you have questions or if you need a phone number for one of our sites. Thank you.

By signing this I agree to the policies and procedures listed above and acknowledge that I am financially responsible for any charges that may accrue from my child's attendance.

Signature of Parent or Guardian

Date