Five Days Per Week: $963 per month
Three Days Per Week: $681 per month
Two Days Per Week: $286 per month
One Day Per Week: $154 per month

The Part-Day Preschool Plan provides care at the Longmont Y from 7:00am-noon. Participants, ages 2-6 years, may enroll at any time providing space is available. We follow the St. Vrain Valley School District school year start and end dates. Registered children may participate in any Y program and receive the member rate. Families enrolled in preschool are eligible to receive a free family membership to the YMCA of Northern Colorado. The registration fee is $50 for one child, $75 for two or more children annually. First month tuition fee is due upon registration. Changes or cancellations require a 30 day written notice. No refunds or credits for missed days will be issued. Schedules are set and days may not be changed/substituted without the director’s approval.

FULL-DAY PRESCHOOL PLANS: The Full-Day Preschool Plan provides care at the Longmont Y from 7am-6pm. Participants, ages 2 1/2 to 6 years, may enroll at any time providing space is available. We follow the St. Vrain Valley School District school year start and end dates. Registered children may participate in any Y program and receive the member rate. Families enrolled in preschool are eligible to receive a free family membership to the YMCA of Northern Colorado. The registration fee is $50 for one child, $75 for two or more children annually. First month tuition fee is due upon registration. Changes or cancellations require a 30 day written notice. No refunds or credits for missed days will be issued. Schedules are set and days may not be changed/substituted without the director’s approval.

PART-DAY PRESCHOOL PLANS: The Part-Day Preschool Plan provides care at the Longmont Y from 7:00am-noon. Participants, ages 2 1/2 to 6 years, may enroll at any time providing space is available. We follow the St. Vrain Valley School District school year start and end dates. Registered children may participate in any Y program and receive the member rate. Families enrolled in preschool are eligible to receive a free family membership to the YMCA of Northern Colorado. The registration fee is $50 for one child, $75 for two or more children annually. First month tuition fee is due upon registration. Changes or cancellations require a 30 day written notice. No refunds or credits for missed days will be issued. Schedules are set and days may not be changed/substituted without the director’s approval.
Registration fee is due at time of registration.

Child’s Name ___________________________ DOB ___________________________

Responsible Party (Full Name) ___________________________ Relationship to child ___________________________

Address ___________________________ City ___________________________ State _____ Zip ___________________________

Home Phone ___________________________ Cell Phone ___________________________

Work Phone ___________________________ Email ___________________________

YMCA Financial Assistance and CCAP participants must be authorized before registering. All YMCA Financial Assistance and CCAP participants must complete and sign this form. I am a CCAP Client □ I am applying for YMCA Financial Assistance □ I have been approved for YMCA Financial Assistance □

PRESCHOOL PLANS: Fees are determined by plan selection. You must notify the Y Business Office at reg@ymcabv.org or 303-443-4474 x1295 of any errors immediately upon reviewing your confirmation statement. Enrollment for preschool is from the first day of school- July 31, 2019. The billing cycle is August 2018-July 1, 2019. First month tuition fee is due upon registration. Manual payments are due by the 1st of every month. Program fees must be paid in full to receive services for the month. Payment receipts are available and can be accessed through your online Y account. No refunds or credits for missed days will be issued.

Late Fees: A $25 late fee will be assessed when payment is not received by the 7th of each month. If payment is not received by the 15th of the month, care will be suspended until fees are paid in full. Please ensure that you submit a new Payment Authorization Form before the month your for all ECP or credit card changes. This can be done with your preschool director.

Change/Cancellation Policy: The responsible party must submit a change/cancellation form to the site director by the 15th of the month to cancel/change plan for the upcoming month. A $25 fee will be assessed when plan changes are submitted on a change/cancellation form. No refunds are issued for fees already paid. A credit may be placed on the account for future Y programs at the discretion of the Business Office Manager. No credits or refunds are issued for cancellation of any plan. Please make sure you are signed up for the correct plan.

Y Community Support Campaign: More than 35% of Youth Program participants receive some form of financial assistance. If your family would like to help another child in need, please add a donation amount.

Yes, I would like to make a monthly donation in the amount of: $ ___________ or a one time donation of: $ ___________

Payment Options: You must select a payment plan option upon registration. The balance owed may include any program related fees due in accordance with the Parent Handbook, Parent Policy Agreement, Fee Schedule or additional Preschool Programs. The amount charged may include any incurred fees related to the program in accordance to published policies. This authorization shall remain in effect until service is canceled with a written notice received by the 15th of the month for the upcoming month. Any fees incurred by the YMCA of Northern Colorado due to collection efforts are owed by the responsible party and will be billed according to laws of the state.

Autodraft Pay Option: By providing my signature below, I authorize the YMCA of Northern Colorado to charge my debit/credit card. The amount charged may include any incurred fees related to the program in accordance to published policies. I understand it is my responsibility to update any changes or expiration dates for my account before the draft date. If I wish for my payment plan to change, I must submit a new Payment Authorization Form 30 days in advance of draft date.

CREDIT/DEBIT CARD DRAFT

Credit/Debit Card Holder Name ___________________________ Visa/MC/Amex/Disc Card # ___________________________

VIN Code ___________________________ Exp. Date ___________________________

Responsible Party Name (print) ___________________________ Signature ___________________________ Date ___________________________

Manual Pay Option (Requires prior approval only): Cash or check payment. Weekly payment is due the Monday prior to care being provided.

Responsible Party Name (print) ___________________________ Signature ___________________________ Date ___________________________

Payment made today: Registration amount $ ___________ + 1st payment $ ___________ = today’s payment $ ___________
GENERAL INFORMATION (please print clearly) □ Returning Participant □ New Participant

Child’s Name ____________________________ Gender __________ Date of Birth __________ Grade __________

Address __________________________________ City __________ State __________ Zip __________

Parental Custody ________________________ Child Lives With: Mom ________ Dad ________ Both ________ Other ________

Parent/Guardian 1 ________________________ Relationship to Child __________ Gender __________ Date of Birth __________

Address __________________________________ City __________ State __________ Zip __________

Home Phone ____________________________ Cell Phone __________________________ Cell Phone Carrier (required for text alerts) __________

Email (must have valid email address for ePACT) ____________________________________________

Please provide your cell phone carrier if you wish to receive texts from us (Verizon, AT&T, etc.) ____________________________

Place of Employment ______________________ Phone __________________________

Address __________________________________ City __________ State __________ Zip __________

Parent/Guardian 2 ________________________ Relationship to Child __________ Gender __________ Date of Birth __________

Address __________________________________ City __________ State __________ Zip __________

Home Phone ____________________________ Cell Phone __________________________ Cell Phone Carrier (required for text alerts) __________

Email (must have valid email address for ePACT) ____________________________________________

Place of Employment ______________________ Phone __________________________

Address __________________________________ City __________ State __________ Zip __________

EMERGENCY CONTACTS AND PICKUP AUTHORIZATIONS

In addition to parents, ONLY those on the below list will be allowed to pickup a child from a Y program. I understand that the following contacts must be at least 18 years old and have photo ID. Myself or one of the below listed contacts will be available to pick up my child and/or assume emergency responsibility within a half an hour should an emergency or illness occur. I accept responsibility for informing the YMCA, in writing, when the information changes. If you want to limit the contacts below to emergency contact only, please check the box below: EC=Emergency Contact Only

Name ____________________________ Address ____________________________ Age ________

Relationship ____________ Home Phone ____________ Cell Phone ____________ Work Phone ____________ EC □

Name ____________________________ Address ____________________________ Age ________

Relationship ____________ Home Phone ____________ Cell Phone ____________ Work Phone ____________ EC □

Name ____________________________ Address ____________________________ Age ________

Relationship ____________ Home Phone ____________ Cell Phone ____________ Work Phone ____________ EC □

PARTICIPATION AGREEMENT AND RELEASE: Please read very carefully and sign. Please contact the Y with any questions.

I am aware of all Y program activities and allow my child to participate fully unless otherwise noted on this form. I allow and hereby certify that my child named herein is capable of safely participating in Y program activities including field trips and swimming. I indemnify and hold harmless the YMCA, any officer, volunteer or employee of the YMCA and all involved with YMCA programs from liability for any harm that befalls my child as a result of participation in YMCA programs. I consent, unless noted, that photographs and video taken of him or her are the property of the YMCA of Northern Colorado and may be reproduced and publicized for program and marketing purposes, free of claims on my part. I agree to allow my child to be transported by BVSD or other district bus, YMCA vehicles, RTD bus or walking. I understand that children must be signed in and out every day by an authorized adult 18 years and older. Parents and any of my emergency pick up/contacts must have a photo ID available to show staff every day. I agree to adhere to all program policies published by the Y.

Signature ____________________________________________________________________________ Printed Name ____________________________ Date ____________
HEALTH HISTORY INFORMATION

☐ May participate in all activities ☐ Please restrict from these activities:

Current medical, mental or psychological condition pertinent to routine care of child including any current treatment/care (i.e. interests, guidance techniques, current chronic illnesses, current fears, life impacting events):

________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Addition information you feel helpful:

________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Routine Medications: Include prescription, holistic/over the counter, vitamins, lotions, lip balms, etc. ☐ None ☐ Yes

1. _______________ Times: _______________ For: _______________.
2. _______________ Times: _______________ For: _______________.

Must fill out a state medication release form signed by physician and parent if medications are needed during program times. Please refer to Parent Handbook for specific regulations.

IMMUNIZATION RECORDS: You must provide an immunization record on a form approved by the Colorado Department of Health and Human Services (a print out from your child’s school, physician’s office or immunization card completed and signed).

☐ None ☐ Yes: ALLERGIES/ASTHMA Type: _______________ Reactions if exposed: _______________.

Treatment: _______________.

You must also complete a state licensed allergy/asthma health care plan form for any condition requiring medication or emergency treatment.

☐ None ☐ Yes: DIETARY RESTRICTIONS: _______________. Reason: _______________. Reaction: _______________.

You may be required to provide healthy snacks which accommodate your child’s dietary restrictions.

Does your child have an I.E.P./504 Plan with his/her school? ☐ NO ☐ YES (If yes, please submit a copy). Any special need/accommodation/restriction must be determined with the parents/guardian, program director and VP of program and approved prior to start date. Attendance for children who require additional staffing is dependent on availability of staff and may be at family’s expense. Please refer to Special Needs Policy in Parent Handbook.

Is your child capable of toileting independently? ☐ NO ☐ YES

MEDICAL CONTACTS/INFORMATION

Physician _______________ Address _______________ Phone _______________.

Dentist _______________ Address _______________ Phone _______________.

Hospital Preference _______________ Address _______________ Phone _______________.

Insurance Co. _______________ Policy # _______________ ID# _______________.

MEDICAL AUTHORIZATION AND LIABILITY RELEASE: Please read very carefully and sign. Please contact the Y with any questions.

In case of illness or emergency, as parent/legal guardian, I authorize the Y program director or trained and certified personnel to provide care or secure the services of a doctor if necessary. I hereby hold harmless the YMCA staff, volunteers and all involved with YMCA programs from liability for any accidents resulting from participation and consent to the YMCA to secure emergency care as needed or prescribed for my child, at my expense. This care may be given under whatever conditions are necessary to preserve life, limb or well being of my child. I also give permission to the YMCA to provide transportation as needed for my child in case of an emergency, at my expense. I understand that it is my responsibility to inform the YMCA of any changes to my child’s health. I understand that medical information and personal data will be used only in YM programs, when necessary, to protect a child’s well being.

Parent/Guardian Signature: _______________.

Preschool Swim: All students enrolled at the YMCA Preschool are invited to participate in swim days utilizing the children’s pool at the YMCA. Parents may choose to not have their child participate in swim days.

☐ I do want my child to participate in swim time ☐ I do NOT want my child to participate in swim time

Person(s) restricted from contact with restraining order/photo attached: Please provide any of the information below which is available. In the event that this person should try to pick up child, the staff will contact the police, contact you and do everything possible to prevent them from taking your child, without risking the safety of the participants and staff.

Name: _______________. Age: _______________. Relationship to child: _______________.

Last Known Address _______________. City _______________. State _______________. Zip _______________.

Home Phone: _______________. Cell Phone: _______________. Work Phone: _______________. Court Order _______________. Date _______________.

I understand that if the 2nd parent/legal guardian is not available to sign this form, I take full responsibility in informing him/her of all policies.

1ST PARENT/LEGAL GUARDIAN Print Name: _______________. Signature: _______________. Date: _______________.

2ND PARENT/LEGAL GUARDIAN Print Name: _______________. Signature: _______________. Date: _______________.

Handbook for specific regulations.
Child’s Name ____________________________ Nickname ____________________________
DOB ____________________________ Birth Place ____________________________

FAMILY MEMBERS RESIDING IN THE SAME HOUSEHOLD

1. Name ____________________________ Gender ☐ M ☐ F Birthdate _______________ Relationship ____________________________
2. Name ____________________________ Gender ☐ M ☐ F Birthdate _______________ Relationship ____________________________
3. Name ____________________________ Gender ☐ M ☐ F Birthdate _______________ Relationship ____________________________
4. Name ____________________________ Gender ☐ M ☐ F Birthdate _______________ Relationship ____________________________
5. Name ____________________________ Gender ☐ M ☐ F Birthdate _______________ Relationship ____________________________
6. Name ____________________________ Gender ☐ M ☐ F Birthdate _______________ Relationship ____________________________

IMMEDIATE FAMILY MEMBERS RESIDING OUTSIDE THE HOUSEHOLD

1. Name ____________________________ Gender ☐ M ☐ F Birthdate _______________ Relationship ____________________________
2. Name ____________________________ Gender ☐ M ☐ F Birthdate _______________ Relationship ____________________________
3. Name ____________________________ Gender ☐ M ☐ F Birthdate _______________ Relationship ____________________________

PERSONAL HISTORY

Pets’ names and types _________________________________________________________________

What are your child’s interests, activities, toys? ____________________________

Has he/she had any other group experience? ☐ NO / ☐ YES If yes, explain: _________________________________________________________________

Does he/she speak in words? ☐ NO / ☐ YES Complete Sentences? ☐ NO / ☐ YES

Any difficulty speaking? ☐ NO / ☐ YES If yes, explain: _________________________________________________________________

Primary language used? ____________________________ Other languages spoken? ____________________________

Special Needs? _________________________________________________________________

SOCIAL RELATIONSHIPS

Has your child had any experience playing with other children? ____________________________

Briefly describe your child’s personality (i.e. friendly, aggressive, shy) _________________________________________________________________

Does your child like to be alone? ____________________________ How does he/she relate to strangers? _________________________________________________________________

Does your child demand a lot of adult attention? _________________________________________________________________

What makes him/her upset? _________________________________________________________________

How does your child show feelings? _________________________________________________________________

What is the best way of handling your child? _________________________________________________________________

Additional Information that would be helpful: _________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________
GENERAL HEALTH HISTORY (If yes, please explain.)

Ever been hospitalized? □ NO / □ YES

Ever had surgery? □ NO / □ YES

Have recurrent/chronic illness? □ NO / □ YES

Ever had Measles? □ NO / □ YES

Ever Have Mumps? □ NO / □ YES

Ever have Rheumatic Fever? □ NO / □ YES

Ever have Chicken Pox? □ NO / □ YES

Ever have Scarlet Fever? □ NO / □ YES

Any medications given on a regular basis? □ NO / □ YES

Have allergies? □ NO / □ YES

Have asthma/wheezing/shortness of breath? □ NO / □ YES

Any physical disabilities? □ NO / □ YES

Have problems with falling asleep/sleepwalking? □ NO / □ YES

How many colds has your child had this past year? __________

How does your child react to elevated temperatures? _____________________________

Additional information you feel helpful (special instructions if your child becomes ill, reactions to allergens, reactions to medications, etc.):

EATING HABITS (If yes, please explain.)

1. Is your child usually hungry at meal times? □ NO / □ YES

2. Between meals? □ NO / □ YES

3. Does your child use utensils? □ NO / □ YES

3. What are his/her favorite foods? ___________________________________________

4. What foods are refused? _______________________________________________

5. Any food allergies? □ NO / □ YES

Additional information you feel helpful: _______________________________________

TOILET HABITS

Can your child be relied upon to indicate his/her bathroom needs? □ NO / □ YES If no, explain:

What is the word used for urination? ________________________ Bowel movements? ________________________

Does your child need to go to the bathroom more frequently than normal for his/her age? □ NO / □ YES

Is he/she afraid of the bathroom? □ NO / □ YES If yes, explain: __________________________

Does your child need help in the bathroom? □ NO / □ YES If yes, explain: __________________________

When was toilet training started? ______________ When accomplished? ______________ Was your child □ easy or □ difficult to train? __________________________

Does your child wet the bed at night? □ NO / □ YES If yes, how often? __________________________

SLEEPING HABITS

What time does your child go to bed? ______________ Awaken? ______________ Does he/she have his/her own room? □ NO / □ YES Own bed? □ NO / □ YES

Does he/she walk or talk or cry during sleep? □ NO / □ YES If yes, explain: __________________________

What does he/she usually take to bed with him/her? __________________________

Does he/she take naps? □ NO / □ YES If yes, from when? __________________________ to __________________________

What is his/her mood upon awakening? __________________________

I understand that if the 2nd parent/legal guardian is not available to sign this form, I take full responsibility in informing him/her of all policies.

PARENT/LEGAL GUARDIAN Print Name: __________________________ Signature: __________________________ Date: __________
PARENT/GUARDIAN: Complete top section and give this form to your child’s health-care provider for review.

Childs Name: ___________________________ Gender ___________________ DOB: ___________________________

I, ________________________________ give consent for my child’s health provider, school or camp personnel to discuss my child’s health concerns. My child’s health provider may fax this form (and applicable attachments) to my child’s childcare provider, school or camp.

Parent/Guardian Signature: ___________________________ Date (authorization expires 365 days after this date): ___________________________

HEALTH CARE PROVIDER

Please complete all remaining sections of this form. Attach additional information if needed. If physical exam is not completed during office visit please provide a signed copy of the most recent physical completed with in the last 12 months or per AAP Guidelines.

PHYSICAL EXAM

Physical exam completed today: □ YES / □ NO  If no, date of last physical (mm/dd/yr.): ___________________________

□ NORMAL / □ ABNORMAL

Weight (lbs): ___________________________ Height (ft, in): ___________________________ Blood Pressure: ___________________________ Lead Level: ___________________________

ALLERGIES/ASTHMA: □ None Known / □ Yes If yes, list foods, medications, environment, other:

______________________________________________________________________________________________________________________________________________

Symptoms which occur:

Recommended treatment:

Asthma Health Care Plan (list triggers, medications, inhaler use):

______________________________________________________________________________________________________________________________________________

MEDICATIONS: □ No daily medications / □ Yes, will take the following medication(s) while at preschool (name, dose, frequency-describe below)

______________________________________________________________________________________________________________________________________________

SIGNIFICANT HEALTH CONCERNS: □ None / □ Yes (Check and explain. If necessary, include instructions to childcare providers):

□ Reactive Airways Disease □ Seizures □ Diabetes □ Developmental Delays □ Vision □ Hearing □ Hospitalizations □ Severe Allergies

□ Other (describe)

______________________________________________________________________________________________________________________________________________

MEDICAL TREATMENTS: □ None / □ Yes, the child is undergoing treatment at this time for the following condition (describe below)

______________________________________________________________________________________________________________________________________________

IMMUNIZATIONS: □ Up-to-date / □ See attached immunization record / □ Administered today:

______________________________________________________________________________________________________________________________________________

SPECIAL DIET: □ None / □ Yes, describe

______________________________________________________________________________________________________________________________________________

RESTRICTIONS: □ No restrictions / □ Yes, the child will require limitations or restrictions to the following activities while at preschool (describe below)

______________________________________________________________________________________________________________________________________________

Next Well Visit: □ Per AAP Guidelines or □ Age _________ This child is healthy and may participate in all routine activities, sports, camps and childcare. Any concerns or exceptions are identified on this form.

NAME OF LICENSED PROVIDER Print Name: ___________________________ Signature: ___________________________ Date: ___________________________

Office Address: ___________________________ Office Stamp: ___________________________

Phone: ___________________________
The YMCA of Northern Colorado accepts payment from CCAP (Colorado Childcare Assistance Program) at a much lower fee than our regular rates. It is important that you read and understand the fee schedule so you are aware of the rates you will be charged for any YMCA services used which are not covered by your third party funding. This agreement is REQUIRED for all families who are subsidized by CCAP, third party agencies or other individuals.

As parent or legal guardian of (child’s name) ____________________________________________________________, I understand and agree to the following:

Initial ______ I am responsible for payment of tuition fees when waiting for authorization or if my authorization expires with CCAP. I understand that I must provide payment in full upon starting the program if not authorized by CCAP prior to the start date.

Initial ______ I understand that excessive absentism will result in the possible loss of my child’s space in the preschool program.

Initial ______ I am responsible for payment of my parent fee by the 1st of every month. I have read the Parent Agreement and Fee Schedule including payment policies and understand that I am responsible for any fees not covered by CCAP or a third party.

Initial ______ I am responsible for payment at the full fee for any care I use that is not authorized by CCAP. This includes, but is not limited to:
1. Any care that occurs before or after the dates authorized by CCAP
2. Care used on days/times not authorized by CCAP
3. Late pick-up fees
4. Late payment fees
5. No notification fees
6. Any other fees as indicated in YMCA documents including the Parent Handbook

Initial ______ I am responsible for contacting CCAP and the YMCA immediately in writing if my situation changes (employment status, hours of work, enrollment in school, custody, living arrangements or change of address).

Initial ______ I am responsible for providing my caseworker with documentation at least two weeks before my current expiration date. This gives your caseworker time to process your information and provide a new authorization to the Y before your current authorization expires.

Initial ______ I understand that cancellation/expiration of CCAP does not automatically cancel enrollment in childcare with the YMCA. I am responsible for completing registration and change/cancellation forms according to YMCA policies. If your CCAP expires, we assume you want to continue childcare as a full paying family unless we are notified otherwise.

Initial ______ I understand that YMCA financial assistance may be available if I do not qualify for CCAP. Financial assistance is not retroactive so it is important to apply immediately if denied by CCAP.

Initial ______ I understand that failure to make payments as scheduled can/will result in termination of my care and will result in lack of CCAP benefits for future providers. Failure to pay fees in a timely manner may result in dis-enrollment from the program and my account may/will be sent to collections.

Initial ______ I understand that I must use my CCAP card and swipe it each attendance day in order for my childcare to be subsidized by CCAP. I must correct all denied swipes as soon as notified. Otherwise, I may be responsible for charges on my account.

PARENT/LEGAL GUARDIAN Print Name: __________________________________________ Signature: __________________________ Date: ____________