Griffin YMCA Early Learning Center
2024-2025 Registration

General Information			
Operation's Name: **Griffin YMCA Early Learning Center 2024**	Director's Name: **Jade Maseda jademaseda@ymcavictoria.org 361-551-2562**		
Child's Full Name:	Child's Date of Birth:	Child Lives With? ◯ Both parents ◯ Mom ◯ Dad ◯ Guardian	
Child's Home Address:	Date of Admission:	Date of Withdrawal:	
Name of Parent or Guardian Completing Form:	Address of Parent or Guardian *(if different from the child's)*:		
List phone numbers below where parents or guardian may be reached while child is in care.			
Parent 1 Name:	Parent 1 Phone No.:	Parent 1 Date of Birth:	Parent 1 Email Address:
Parent 2 Name:	Parent 2 Phone No.:	Parent 2 Date of Birth:	Parent 2 Email Address:
Guardian's Name:	Guardian's Phone No.:	Guardian's Date of Birth:	Guardian's Email Address:
Custody Documents on File? ◯ Yes ◯ No			
In case of an emergency:			
Name of Emergency Contact:	Relationship:	Area Code and Phone No.:	
Address:			
I authorize the child care operation **to release** my child to leave the child care operation **ONLY** with the following persons. Please list name and phone number for each. Children will only be released to a parent or guardian or to a person designated by the parent or guardian after verification of ID.			
Name:	Area Code and Phone No.:		
Name:	Area Code and Phone No.:		
Name:	Area Code and Phone No.:		

Consent Information

1. Transportation:

I give consent for my child to be transported and supervised by the operation's employees for (Check all that apply)

◯ emergency care ◯ on field trips ◯ to and from home ◯ to and from school

2. Field Trips:

◯ I give consent for my child to participate in field trips. ◯ I do not give consent for my child to participate in field trips.

Comments:

3. Water Activities:

I give consent for my child to participate in the following water activities (Check all that apply).

☐ water table play ☐ sprinkler play ☐ splashing or wading pools ☐ swimming pools ☐ aquatic playgrounds

Is your child able to swim without assistance: ◯ Yes ◯ No

If no, what type of assistance is needed: _____

4. Receipt of Written Operational Policies:

I acknowledge receipt of the facility's operational policies, including those for (Check all that apply).

☐ Discipline and guidance
☐ Suspension and expulsion
☐ Emergency plans
☐ Procedures for conducting health checks
☐ Safe sleep
☐ Procedures for parents to discuss concerns with the director
☐ Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions
☐ Procedures for parents to participate in operation activities
☐ Procedures for release of children
☐ Illness and exclusion criteria
☐ Procedures for dispensing medications
☐ Immunization requirements for children
☐ Meals and food service practices
☐ Procedures to visit the center without securing prior approval
☐ Procedures for supporting inclusive services
☐ Procedures for parents to contact Child Care Licensing (CCL), DFPS, Child Abuse Hotline, and CCL website

5. Meals:

I understand that the following meals will be served to my child while in care (Check all that apply):

☐ None ☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack

6. Days and Times in Care:

My child is normally in care on the following days and times:

Day of the Week	A.M.	P.M.
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Child's Special Care Needs (check all that apply)

- ☐ Environmental allergies
- ☐ Food intolerances
- ☐ Existing illness
- ☐ Previous serious illness
- ☐ Injuries and hospitalizations *(past 12 months)*
- ☐ Other: _____
- ☐ Limitations or restrictions on child's activities
- ☐ Reasonable accommodations or modifications
- ☐ Adaptive equipment *(include instructions below)*
- ☐ Symptoms or indications of complications
- ☐ Medications prescribed for continuous long-term use

Explain any needs selected above:

Does your child have diagnosed food allergies? ◯Yes ◯ No Food Allergy Emergency Plan Submitted Date: _____

Child day care operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. To learn more, visit https://www.ada.gov/resources/child-care-centers/. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

_____ _____

Signature — Parent or Legal Guardian **Date Signed**

School Age Children

My child attends the following school:	School Area Code and Phone No.:

My child has permission to *(check all that apply)*:

☐ walk to or from school or home ☐ ride a bus ☐ be released to the care of his or her sibling under 18 years old

Authorized pick up or drop off locations other than the child's address:

☐ Child's required immunizations, vision and hearing screening, and TB screening are current and on file at their school.

Authorization For Emergency Medical Attention

In the event I cannot be reached to arrange for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician	Address	Phone No.
Name of Emergency Care Facility	Address	Phone No.

I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____ _____

Signature — Parent or Legal Guardian **Date Signed**

Requirements for Exclusion from Compliance

◯ I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized.

◯ I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of.

Vision Exam Results

Right Eye 20/ Left Eye 20/ ◯Pass ◯Fail

Signature **Date Signed**

Hearing Exam Results

Ear	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
Right				◯ Pass ◯ Fail
Left				◯ Pass ◯ Fail

Signature **Date Signed**

Admission Requirement

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission. *(Select **only one** option.)*

◯ Health Care Professional's Statement: I have examined the above named child within the past year and find that he or she is able to take part in the day care program.

◯ A signed and dated copy of a health care professional's statement is attached.

◯ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

◯ My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and submit it to the child care operation.

Name of Health Care Professional, if selected

Address of Health Care Professional, if selected

Signature — Health Care Professional

Date Signed

Signature — Parent or Legal Guardian

Date Signed

Vaccine Information

The following vaccines require multiple doses over time. Please provide the date your child received each dose.

Vaccine	Vaccine Schedule	Dates Child Received Vaccine
Hepatitis B	Birth (first dose)	
	1–2 months (second dose)	
	6–18 months (third dose)	
Rotavirus	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
Diphtheria, Tetanus, Pertussis	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	15–18 months (fourth dose)	
	4–6 years (fifth dose)	
Haemophilus Influenza Type B	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Pneumococcal	2 months (first dose)	
	4 months (second dose)	
	6 months (third dose)	
	12–15 months (fourth dose)	
Inactivated Poliovirus	2 months (first dose)	
	4 months (second dose)	
	6–18 months (third dose)	
	4–6 years (fourth dose)	
Influenza	Yearly, starting at 6 months. Two doses given at least four weeks apart are recommended for children who are getting the vaccine for the first time and for some other children in this age group.	
Measles, Mumps, Rubella	12–15 months (first dose)	
	4–6 years (second dose)	
Varicella	12–15 months (first dose)	
	4–6 years (second dose)	
Hepatitis A	12–23 months (first dose)	
	The second dose should be given 6 to 18 months after the first dose.	

Varicella (Chickenpox)

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about [date] and does not need varicella vaccine.

Signature **Date Signed**

Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/public.shtm.

TB Test (If required)

◯Positive ◯Negative Date: _____

Gang Free Zone

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security

Signatures

Child's Parent or Legal Guardian **Date Signed**

Center Designee **Date Signed**

Physician or Public Health Personnel Verification

Signature or stamp of a physician or public health personnel verifying immunization information above:

Signature **Date Signed**

Childcare Payment Agreement 2024-2025

Child's Name _____ **Parent/Guardian Name** _____

Child's Date of Birth _____ **Phone Number** _____

PAYMENT OPTION 1 - AUTOPAY

USE THIS FORM IF YOU WANT YOUR CHILDCARE ACCOUNT ON AUTO-PAY

- Tuition fees are due weekly and will be deducted from my Bank Account or Credit/Debit Card **EVERY FRIDAY BY 2:00am**, for the following week of child care.
  Initials _____
- If my child does **NOT** attend a week, I will still be responsible for a **full week of tuition**.
  Initials _____
- A $25 late fee applies to all payments made after the due date. These fees **WILL NOT** be waived.
  Initials _____
- A $30 return fee applies to any payments declined by my Financial Institution. These fees **WILL NOT** be waived.
  Initials _____
- If I pick up my child later than the designated pick up time, I will be charged a late pick-up fee of $1 per minute.
  Initials _____
- Payments, late fees and past due balances must be paid in full before the child or family members can return to any YMCA Program, Child Care or Membership.
  Initials _____
- Enrollment fees are **NON-REFUNDABLE**.
  Initials _____
- It is my responsibility to know when my Financial Assistance expires. Should my FA expire, I will pay full rate until my FA has been renewed. (Allow 2 weeks for application processing)
  Initials _____
- The auto-draft is a continuous payment plan that will remain in effect until I request to terminate my child care account.
  Initials _____
- If I wish to terminate or change my child care account in any way, I must give the Billing Coordinator, Julia Maseda, a **TWO WEEK NOTICE** via email at jmaseda@ymcavictoria.org or phone 361-551-2562
  Initials _____

AUTOMATIC PAYMENT INFORMATION: Credit/Debit Card Payments

PAYMENTS DRAFTED BETWEEN 12:00AM - 11:59PM

Card Type: MASTERCARD_____ VISA_____ AMEX_____ DISCOVER_____
Name on Card:_____ Card Number:_____
Expiration Date:_____ Security Code:_____
Billing Address:_____
City/ST/Zip:_____
******Effective 01/01/2025, a flex fee of 3% will be imposed on all credit card transactions******

AUTOMATIC PAYMENT INFORMATION: Bank Account Payments

ALLOW UP TO 10 DAYS TO REFLECT ON YOUR BANK ACCOUNT

Account Type: Checking_____ Savings_____
Name of Bank:_____ Name on Bank Account:_____
Routing Number:_____ Account Number:_____

Signature of Person Responsible for Payments

Signature _____ **Date Signed** _____

Childcare Payment Agreement 2024-2025

Child's Name _____ **Parent/Guardian Name** _____

Child's Date of Birth _____ **Phone Number** _____

PAYMENT OPTION 2 – IN-HOUSE PAYMENTS

USE THIS FORM IF YOU DO NOT WANT YOUR CHILDCARE ACCOUNT ON AUTO PAY

- Tuition fees are due by 8pm **EVERY FRIDAY**, for the following week of child care.
  Initials _____
- If my child does **NOT** attend a week, I will still be responsible for a **full week of tuition**.
  Initials _____
- A $25 late fee applies to all payments made after the due date. These fees **WILL NOT** be waived.
  Initials _____
- A $30 return fee applies to any payments declined by my Financial Institution. These fees **WILL NOT** be waived.
  Initials _____
- If I pick up my child later than the designated pick up time, I will be charged a late pick-up fee of $1 per minute.
  Initials _____
- Payments, late fees and past due balances must be paid in full before the child or family members can return to any YMCA Program, Child Care or Membership.
  Initials _____
- Enrollment fees are **NON-REFUNDABLE**.
  Initials _____
- It is my responsibility to know when my Financial Assistance expires. Should my FA expire, I will pay full rate until my FA has been renewed. (Allow 2 weeks for application processing)
  Initials _____
- If I wish to terminate or change my child care account in any way, I must give the Billing Coordinator, Julia Maseda, a **TWO WEEK NOTICE** via email at jmaseda@ymcavictoria.org or phone 361-551-2562
  Initials _____

Credit/Debit Card Payments

INSTANT DEBIT

Card Type: MASTERCARD_____ VISA_____ AMEX_____ DISCOVER_____
Name on Card:_____ Card Number:_____
Expiration Date:_____ Security Code:_____
Billing Address:_____
City/ST/Zip:_____
******Effective 01/01/2025, a flex fee of 3% will be imposed on all credit card transactions******

Bank Account Payments

ALLOW UP TO 10 DAYS TO REFLECT ON YOUR BANK ACCOUNT

Account Type: Checking_____ Savings_____
Name of Bank:_____ Name on Bank Account:_____
Routing Number:_____ Account Number:_____

Signature of Person Responsible for Payments

Signature _____ **Date Signed** _____