



# Griffin YMCA Early Learning Center 2025-2026 REGISTRATION FORM

## General Information

**Operation's Name:** Griffin YMCA Early Learning Center    **Director's Name:** Bhakti Patel    bpatel@ymcagoldencrescent.org    361-551-2562

**ADMISSION DATE:** \_\_\_\_\_ **DATE OF WITHDRAWAL:** \_\_\_\_\_

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
*Last First MI*

Child's Home Address \_\_\_\_\_  
*Street Address Apartment/Unit*  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Child lives with:     Both Parents     Mom     Dad     Guardian

Name of Parent or Guardian  
Completing Form \_\_\_\_\_  
*Last First MI*

Address (if different  
From child's) \_\_\_\_\_  
*Street Address Apartment/Unit #*  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

List contact information where parents/guardian may be reached while child is in care:

Parent 1 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Phone No. \_\_\_\_\_ Email Address \_\_\_\_\_

Parent 2 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Phone No. \_\_\_\_\_ Email Address \_\_\_\_\_

Custody Documents on File?     Yes     No

Give the name, address, and phone number of the responsible individual to call in case of an emergency if parents/guardian cannot be reached:

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address \_\_\_\_\_ Apartment/Unit# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize the child care operation to release my child to leave the child care operation **ONLY** with the following person(s). List name and telephone number for each. Children will only be released to a parent or guardian or to a person designated by the parent/guardian after the verification of I.D.

Name \_\_\_\_\_ Name \_\_\_\_\_ Name \_\_\_\_\_  
Phone No. \_\_\_\_\_ Phone No. \_\_\_\_\_ Phone No. \_\_\_\_\_

## Consent Information

CHECK ALL THAT APPLY

### 1. TRANSPORTATION

I give consent for my child to be transported and supervised by the operation's employees:

- for 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:

- water table play     sprinkler play     splashing/wading pools     swimming pools     aquatic playgrounds

Is your child able to swim without assistance:     Yes     No

*If no, your child is required to wear a life jacket while in or near a swimming pool*

Is your child a competent swimmer\*:     Yes     No

Does your child have any physical, health, or other conditions that would put them at risk while swimming?

- Yes     No    *If yes, your child is required to wear a life jacket while in or near a swimming pool.*

\*A competent swimmer can enter and exit a pool safely on their own, tread water or float on their back for one minute, and swim 25 yards with no assistance.

### 4. RECEIPT OF WRITTEN OPERATIONAL POLICIES

I acknowledge receipt of the facility's operation policies, including those for:

- |  |  |
|--|--|
| <input type="checkbox"/> Discipline and Guidance   | <input type="checkbox"/> Illness and exclusion criteria  |
| <input type="checkbox"/> Suspension and expulsion  | <input type="checkbox"/> Procedures for dispensing medications   |
| <input type="checkbox"/> Safe sleep  | <input type="checkbox"/> Immunization requirements for children  |
| <input type="checkbox"/> Procedures for release of children  | <input type="checkbox"/> Meals and food services practices   |
| <input type="checkbox"/> Emergency plans   | <input type="checkbox"/> Procedures to visit the center without securing prior approval                                      |
| <input type="checkbox"/> Procedures for conducting health checks   | <input type="checkbox"/> Procedures for parents to discuss concerns with Director  |
| <input type="checkbox"/> Promotion of indoor and outdoor physical activity including criteria for extreme weather conditions | <input type="checkbox"/> Procedures for parents to contact Child Care Licensing, DFPS, Child Abuse Hotline, and DFPS website |
|  | <input type="checkbox"/> Procedures for parents to participate in operations activities                                      |

### 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:

- Monday     Tuesday     Wednesday     Thursday     Friday

During the hours of: \_\_\_\_\_ am pm thru \_\_\_\_\_ am pm

### 7. RECEIPT OF PARENT'S RIGHTS

I acknowledge I have received a written copy of my rights as a parent or guardian of a child enrolled at this facility.

**Parent or Legal Guardian:**

Date Signed:

X \_\_\_\_\_

## Child's Special Care Needs

CHECK ALL THAT APPLY:

- |   |  |
|---|--|
| <input type="checkbox"/> Environmental allergies                        | <input type="checkbox"/> Limitations or restrictions on child's activities |
| <input type="checkbox"/> Food intolerances                              | <input type="checkbox"/> Reasonable accommodations or modifications        |
| <input type="checkbox"/> Existing illness                               | <input type="checkbox"/> Adaptive equipment (include instructions below)   |
| <input type="checkbox"/> Previous serious illness                       | <input type="checkbox"/> Symptoms or indications of complications          |
| <input type="checkbox"/> Injuries and hospitalizations (past 12 months) | <input type="checkbox"/> Medications prescribed for long-term use          |

Other: \_\_\_\_\_

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. 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:**

## School Age Children

My child attends the following school:

Name of School \_\_\_\_\_ Grade \_\_\_\_\_ School Phone No \_\_\_\_\_

Child's required immunizations, vision, hearing, and TB records are current and on file at school:  Yes  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/her sibling under 18 years old

Other: \_\_\_\_\_

Authorized pick up/drop off locations other than the child's address: \_\_\_\_\_

## Authorization for Emergency Medical Attention

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

Name of Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Name of Emergency Care Facility \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

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

**Signature – Parent or Legal Guardian:**

## Requirements for Exclusion from Compliance

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

I have attached a signed 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				<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Left				<input type="checkbox"/> Pass	<input type="checkbox"/> 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 following statement:

My child had varicella disease (chickenpox) on or about \_\_\_\_\_ (date) and does not need the varicella vaccine.

**Signature – Parent or Legal Guardian:**

### TB Test (if required)

Positive     Negative

Date: \_\_\_\_\_

### Additional Information Regarding Immunizations

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at [www.dshs.state.tx.us/immuniz/public.shtm](http://www.dshs.state.tx.us/immuniz/public.shtm).

### 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

DFPS values your privacy. For more information, read the Privacy and Security Policy online at [Http://www.dfps.state.tx.us/policies/privacy.asp](http://www.dfps.state.tx.us/policies/privacy.asp).

### Signatures

**Child's Parent or Legal Guardian:**

Date Signed:

X \_\_\_\_\_

\_\_\_\_\_

Center Designee:

Date Signed:

X \_\_\_\_\_

\_\_\_\_\_

### 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 2025-2026

Child's Name \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_

Child's date of birth \_\_\_\_\_ Phone Number \_\_\_\_\_

PAYMENT OPTION 1 - AUTOPAY

- Tuition fees are due weekly and will be deducted from my Bank Account or Credit/Debit Card EVERY FRIDAY BY 2:00pm, 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 Membership Director, Julia Maseda, a TWO WEEK NOTICE via email at jmaseda@ymcagoldencrescent.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\*\*\*

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: \_\_\_\_\_ Date Signed: \_\_\_\_\_
X \_\_\_\_\_

## Childcare Payment Agreement 2025-2026

Child's Name \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_

Child's date of birth \_\_\_\_\_ Phone Number \_\_\_\_\_

### PAYMENT OPTION 2 – IN-HOUSE PAYMENTS

- 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 Membership Director, Julia Maseda, a **TWO WEEK NOTICE** via email at [jmaseda@ymcavictoria.org](mailto:jmaseda@ymcavictoria.org) or phone 361-551-2562  
**Initials** \_\_\_\_\_

### AUTOMATIC PAYMENT INFORMATION 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:**

**Date Signed:**

X \_\_\_\_\_

\_\_\_\_\_