

YWCA KIDSLINK REGISTRATION

Date of Application:		School Child Attends:		Start Date:	
Child's Legal Name:			Nickname: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Child's Grade:			Child's Teacher:		
Date of Birth:			Child's Home Phone:		
Child's Home Address:				Zip Code:	
Parent/Guardian's Name:			Parent/Guardian's Name:		
Relationship to child:			Relationship to child:		
Email Address:			Email Address:		
Home Address:			Home Address:		
Home Phone:			Home Phone:		
Cell Phone:			Cell Phone:		
Employer:			Employer:		
Occupation:			Occupation:		
Work Address:			Work Address:		
Work Phone:			Work Phone:		
Work schedule:			Work Schedule:		
Child's race/ethnicity: <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Multi Racial <input type="checkbox"/> Native American <input type="checkbox"/> Other/Unknown <input type="checkbox"/> Prefer not to answer					
Please enclose a \$50.00 deposit that will be applied to the first tuition payment. (An additional one-time \$50 registration fee will be required for any new family to our program.) A CURRENT YWCA MEMBERSHIP IS REQUIRED TO PARTICIPATE IN THE PROGRAM. All tuition deposits, registration, and membership fees are non-refundable unless the program is cancelled. All programs are subject to minimum enrollment.					
Monthly payments are due on the 20 th of the preceding month 2008-2009 Tuition rates of 9 Monthly Installments:					
Please contact the center directly for information about rates: <ul style="list-style-type: none"> • Bolton: Bolton Municipal Building: (860) 645- 2240 • Manchester: Bowers, Buckley, Keeney, Martin, Waddell: (860) 645- 2240 • Rocky Hill: Stevens, West Hill: (860) 525-1163 • West Hartford: Bugbee, Duffy, Webster Hill, Wolcott: (860) 525-1163 • Wethersfield: Charles Wright: (860) 525-1163 					

Parent/Guardian Signature: _____ Date: _____

Does your child have allergies to:

Food (types): _____

Medication (types): _____

Other (types): _____

Severity and type of reaction? _____

Does your child take any medicine regularly?

If so, what: _____

When: _____

How is this medication best given? _____

EMERGENCY CONTACTS: (Names of people authorized to pick up your child if you cannot be reached.)

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

PLEASE NOTE: It is the parent's responsibility to inform the staff of changes in any of the above information.

I hereby authorize the above persons to pick up my child from the YWCA program site. If there are any changes in these arrangements I will let the Director know with advanced written notice.

Parent/Guardian Signature: _____ Date: _____

*The YWCA of the Hartford Region welcomes applications from all families.
We provide an inclusive educational environment.*

AUTHORIZATION / AGREEMENT

CHILD'S NAME: _____

SCHOOL: _____

I grant permission for my child to use all the play equipment and participate in all the activities of the program, except as otherwise noted here: _____

Signature: _____

Date: _____

I hereby allow my child to be videotaped or photographed in projects related to the program. I understand that I will be notified prior to the event if the photos or taping are to be shown and/or used outside of the YWCA of the Hartford Region, Inc.

Signature: _____

Date: _____

I am aware that it is my responsibility to inform the YWCA, in writing, of any concerns which may affect the care of my child.

Signature: _____

Date: _____

I understand that any inaccurate or incomplete information provided may result in immediate dismissal.

Signature: _____

Date: _____

In the event my child develops a medical problem which the YWCA personnel feel needs the prompt evaluation of a physician, and the staff is unable to contact either myself or those persons whom I have designated as emergency contacts, I authorize the YWCA of the Hartford Region personnel to contact my child's physician and/or arrange for my child to be taken to the nearest medical facility and receive necessary treatment. I further understand that I will be responsible for any medical and transportation costs incurred.

In the event of a ***medical emergency*** occurring while my child is attending the YWCA of the Hartford Region program, I understand that the following procedure will be followed:

1. The staff, after determining that a medical emergency exists, will call 911. If necessary, appropriately trained YWCA staff will perform CPR and/or other first aid measures until Emergency Medical Technicians (EMT) arrive and the child is taken to the nearest hospital appropriate to the emergency situation, as determined by the EMT's.
2. The staff will telephone a parent to inform him or her of the situation and request that the parent immediately meets the child in the Emergency Room of the hospital designated by the EMT's. If a parent cannot be reached, staff will attempt to telephone "emergency contacts" that the family has provided.
3. Staff will arrange for transportation by ambulance to the Emergency Room designated. A staff member will accompany the child and stay at the hospital until the parent arrives.

If the EMT's determine that there is a choice of hospital to which the child may be transported, my preference is:

Connecticut Children's Medical Center

St. Francis Hospital

Hartford Hospital

Other: _____

Manchester Memorial Hospital

Name of Hospital

Signature: _____

Date: _____

YWKIDSLINK STUDENT HISTORY

The YWCA of the Hartford Region strives to support your child's well being in all aspects of our program. If there is anything about your child's physical, emotional, or psychological history that will assist us in working with your child, we ask that you provide us with complete information in advance of enrollment.

Please answer all questions completely

Parents/Guardians: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Living Together <input type="checkbox"/> Prefer not to answer		
Does your child have any siblings?		
Name: _____	Date of Birth: _____	
Name: _____	Date of Birth: _____	
Name: _____	Date of Birth: _____	
Please list other people living in your home:		
Name: _____	Relationship: _____	Age: _____
Name: _____	Relationship: _____	Age: _____
Name: _____	Relationship: _____	Age: _____
Primary language spoken in your home:		
Does your child speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No Understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has your child had any serious illness, operations, or accidents since birth? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What health problems has your child had in the past?		
Describe your child's current health:		
Does your child have any physical medical condition or limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		
Does your child have any recurring chronic illness or health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your child have P.E. Tubes? <input type="checkbox"/> Yes <input type="checkbox"/> No When were they inserted?		
Does your child have a medical condition which has been diagnosed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		
Has your child had a vision screening? <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any vision concerns?		
Has your child had a hearing screening? <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any hearing concerns?		
Has your child had any eating problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what are they?		
Have you noticed any sensitivity to particular foods? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		
Are there any foods your child should not have? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what are they?		

CHILD'S NAME: _____

SCHOOL: _____

How does your child get along with other children?
Does your child have a favorite toy, special interest or hobby? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, list:
How does your child get along with other adults?
How does your child react to redirection/positive behavior guidance techniques?
How does your child express his/her feelings?
How does he/she react to frustration?
Does your child have any fears or concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
Has your child ever attended a before and afterschool program or camp? <input type="checkbox"/> Yes <input type="checkbox"/> No
What suggestions do you have for us to help your child adjust to this program?
How do you comfort your child?
Additional information that will help us care for your child or that you would like the staff to know about your child?

PLEASE NOTE: It is the parent's responsibility to inform the staff of changes in any of the above information.

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____