2025-2026 Y-Care Child Enrollment

Parents and Guardians,

Thank you so much for choosing our after-school program! We're thrilled to launch another exciting year.

To get started, please fill out the attached enrollment form and include your child's current immunization records. We want to make sure we have everything we need to secure your child's spot, so please complete every section of the form.

If your child has food allergies, behavioral concerns, or special medical needs, we're here to support you! Please complete a food substitution, Individualized Care Plan (ICP), or submit an IEP/504 plan, based on the health information from page 3 under the parent health statement. You can find these forms in your packet, or you can pick them up at the Knowles YMCA front desk.

Completed forms must be turned in to the Knowles YMCA.

If you have any questions or need assistance, feel free to reach out to our childcare staff. We're always here to help!

Brittany Watkins
573.761.0716 | bwatkins@jcymca.org
Dalton Green
573.761.3196 | dgreen@jcymca.org

Yclub for TJMS and LCMS enrollment forms are online or at the Knowles front desk

2025-2026 Y-CARE ENROLLMENT FORM

CHILD'S NAME:

DOB:

Gender

School:

Grade:

Child's Street Address:

City & Zip:

Circle all that apply:

Y-MEMBER NON Y-MEMBER OUTREACH SCHOLARSHIP

JCSD EMPLOYEE BLAIR OAKS EMPLOYEE Y EMPLOYEE

PARENT/GUARDIAN

NAME: DOB (required):

STREET ADDRESS:

CITY/ZIP:

HOME & CELL PHONE:

EMAIL ADDRESS:

EMPLOYER:

EMPLOYER STREET ADDRESS:

EMPLOYER CITY & ZIP CODE:

WORK HOURS: WORK DAYS: S M T W T F S

WORK PHONE:

NAME: DOB (required):

STREET ADDRESS:

CITY/ZIP:

HOME & CELL PHONE:

EMAIL ADDRESS:

EMPLOYER:

EMPLOYER STREET ADDRESS:

EMPLOYER CITY & ZIP CODE:

WORK HOURS: WORK DAYS: S M T W T F S

WORK PHONE:

COURT DOCUMENTATION IS REQUIRED FOR ANY BIOLOGICAL PARENT BARRED FROM ACCESSING THEIR CHILD.

Immunization Records are Required Every Year

2025-2026 Y-CARE ENROLLMENT FORM

EMERGENCY CONTACT OTHER THAN PARENTS

NAME:

STREET ADDRESS:

CITY/ZIP:

PHONE:

RELATIONSHIP:

AUTHORIZED PICK UP: PLEASE LIST OTHER PEOPLE WHOM YOU AUTHORIZE TO PICK UP YOUR CHILD:

AUTHORIZATION FOR MEDICAL CARE

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I authorize YMCA to contact the following:

DOCTOR: PHONE NUMBER:

HOSPITAL (circle one): SSM ST MARY'S 681-3000 CAPITAL REGION 632-5000

CACFP (Child and Adult Care Food Program) Requirement

CHECK HERE DAYS your child will attend		What time does your child arrive?	What time does your child leave?	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
MON		*2:45 PM*	*PM*	
TUES		*2:45 PM*	*PM*	
WED		*2:45 PM*	*PM*	
THUR		*2:45 PM*	*PM*	
FRI		*2:45 PM*	*PM*	

Ethnic and Racial Makeup. ***Circle one***

American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or other pacific Islander	White	Not listed: _____

SNACK provided in PM only

Snack provided on the following holidays: Columbus Day, Veterans Day, Election Day

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2025-2026 Y-CARE ENROLLMENT FORM

ACKNOWLEDGEMENTS

I have read and understand the Y-Care Parent Handbook, which contains policies regarding admission, care and discharge of children (Available online at www.jcymca.org. Printed copies by request).
I have been informed that a copy of the licensing rules for child care centers is available at this facility for review.
The YMCA and I have agreed on a plan for continuing communication regarding my child's development, behavior and individual needs.
When my child is ill, I understand and agree that s/he may not be accepted for or remain in care.
I give the YMCA permission to transport my child if necessary. I understand that Y-Care does not participate in field trips.
I understand that before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations, or exemptions from immunizations.
I have been notified that I may request notice at initial enrollment or any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.

PARENT SIGNATURE: **DATE:**

LIABILITY RELEASE

I, the undersigned, request permission for _____to enter the Jefferson City Area YMCA (hereinafter the YMCA) school age programs and to participate in the YMCA activities associated with the program. I know and assume all risks related to the participation in such activities, where such risks arise on or off the YMCA premises. In consideration of demands, damage actions and cause of action (present or future, whether known or unknown, anticipated or unanticipated) for any and all personal damages to my property relating to my presence on the YMCA premises and participation in any YMCA activity. I certify that I am 18 years of age and that my participation in the YMCA activities are voluntary. I give consent for my child to be photographed, videotaped or to appear in local newspaper articles or other local media.

PARENT SIGNATURE: **DATE:**

PARENT'S HEALTH STATEMENT FOR SCHOOL-AGE CHILD

My child is in good health, is able to participate in group care, and has no special health or medical requirements.
If my child is able to participate in group care but has special health or medical requirements, I have listed them here. PLEASE LIST ANY SPECIAL HEALTH OR MEDICAL CONDITIONS, including chronic health problems (Asthma, seizures), behavioral disorders, special needs, etc.:

_____

_____

_____

_____

An Individualized Care Plan form is REQUIRED for any child with a condition as listed above. Falsification of records is grounds for expulsion from the program.
A food substitution form is REQUIRED to make food accommodations
Both forms are attached for your convience.

PARENT SIGNATURE: **DATE:**

Immunization Records are Required Every Year

2025-2026 Y-CARE ENROLLMENT FORM

AUTHORITY TO DRAW ACH DEBITS OR DRAFTS FOR YMCA & AFFILIATE PAYMENTS

DAY OF WITHDRAWAL - MONTHLY 1st

NAME OF CUSTOMER

MAILING ADDRESS OF CUSTOMER (STREET CITY STATE & ZIP CODE)

MEMBERSHIP/PROGRAM MONTHLY PAYMENT

I HAVE GIVEN AUTHORITY TO:

FULL NAME OF BANK/CREDIT CARD

ADDRESS, CITY, STATE AND ZIP

to honor preauthorized checks drawn by you on my account for membership/program payments as indicated above. It is understood that your sending of a preauthorized check to the bank as a payment becomes due shall constitute valid notice of such payment due on this membership/program. When the bank honors the check by charging my account, such check shall constitute my receipt for the payment. Should any preauthorized check not be honored by said bank when received by them, then it is understood that the payment is to be made by me in the amount of said payment.

ACCOUNT NO.

BANK TRANSIT NO.

Please attach a voided check or a letter from your bank stating the routing and account numbers.

☐ Checking ☐ Savings ☐ Credit Card / Exp. Date _____

Begin Draft _____ @ $ _____

Change Draft _____ @ $ _____

YMCA MEMBER & AFFILIATE AGREEMENT

1. I understand:

   _____ initial this is a continuous membership and I am committing to maintain it for at least one year. Should I cancel my membership before making 12 monthly payments, I will pay either the joining fee or the balance of the year's membership dues. <u>This final payment will be drafted from my account.</u>

   _____ initial at this time I am paying the joining fee designated for my membership type.

2. Membership dues are neither refundable or transferable.
3. It is to my complete understanding that if I wish to terminate or change my membership/program in any way, I must give written notice in person. <u>Bank drafts for membership dues and/or program fees must be cancelled in writing by the 25th day of the calendar month to be effective for the forth-coming month.</u> Drafted amounts are not refundable except in the case of double drafts or incorrect amounts.
4. The YMCA Board of Directors may, at their discretion, adjust the monthly rate applicable to my category of membership/ program. I understand that I will receive at least 30 days written notice prior to any such change.
5. Should any membership/program draft not be honored by my bank for any reason, I realize that I am still responsible for payment plus a service charge applied by the YMCA. This is in addition to any service fee my bank may make.

_____ Date

_____ Member Signature

_____ Staff Signature

Auto draft is required for registration. Parents who are current Y patrons with an electronic payment method on file with the YMCA may indicate that account above by providing the last 4 digits of the card or bank account. Otherwise, complete the form above in full.

Immunization Records are Required Every Year

2025-2026 Y-CARE ENROLLMENT FORM

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

MEDICAL FOOD SUBSTITUTION RECORD

The Child & Adult Care Food Program Requirements for Meal Pattern Substitutions Section 7.5 require food substitutions to be authorized by a recognized medical authority. Recognized medical authority includes physician, physician assistant, or nurse practitioner. The recognized medical authority must specify, in writing, the food to be omitted from the patient's diet and the food or choice of foods that may be substituted.

PATIENT'S NAME:

MEDICAL DIAGNOSIS / REASON:

SPECIAL ASSISTANCE/EQUIPMENT REQUIRED:

FOOD SUBSTITUTION LIST:

Fluid Milk	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Meat & Meat Alternative (e.g., eggs, cheese peanut butter, dry bean, yogurt, etc.)	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Bread, Cereal or Whole Grain Products	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Fruit & Vegetables or Juice	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)

Additional Dietary Concerns and/or Required Equipment or Assistance Needed:

I (medical authority) certify that the above patient must be provided a special diet or requires special accommodations as indicated above.

SIGNATURE	TITLE	DATE

MO 580-2641 (8-06) CACFP-227

Immunization Records are Required Every Year

2025-2026 Y-CARE ENROLLMENT FORM

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE

INDIVIDUAL PLAN FOR SPECIALIZED CARE

SAVE
PRINT
RESET

IDENTIFYING INFORMATION

CHILD'S NAME	BIRTHDATE

AREA OF CONCERN

ADAPTIVE EQUIPMENT OR SUPPLIES NEEDED AT DAY CARE

MEDICATION/TREATMENT CHILD IS TO RECEIVE AT FACILITY DURING CHILD CARE HOURS

If the child is to receive treatments during his/her scheduled hours of care, how and by whom is this treatment to be administered?

SYMPTOMS/INDICATORS/POSSIBLE PROBLEMS RELATING TO CHILD'S CONDITION/TREATMENT HEALTH PROBLEMS THAN CAN RESULT IN AN EMERGENCY

PHYSICIAN/SPECIALIST SIGNATURE	DATE
X	

Immunization Records are Required Every Year