

2026-2027 Y-Care Enrollment Form

Parents and Guardians,

Thank you for choosing the YMCA for your afterschool program! We're excited to start another wonderful year with your child.

To be sure you secure your child's spot, please fully complete the attached enrollment form and include a copy of your child's recent immunization records.

Parent's Health Statement for School-Age Child (pg 3)

If your child has any health or medical conditions including a food allergy, noted on the Parent's Health Statement, licensing requires that the attached Individualized Care Plan (ICP) be completed by a physician or specialist along with the enrollment form. In order to make a food substitution for snack, we require the attached food substitution form to be completed by a medical professional.

Completed forms must be turned in to the Knowles YMCA front desk

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

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**AM Yclub enrollment forms for TJMS and LCMS can be found
online or at the Knowles front desk**

2026-2027 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 MANDATORY FOR ANY BIOLOGICAL PARENT
BARRED FROM ACCESSING THEIR CHILD.**

**Immunization Records are
Required Every Year**

2026-2027 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: _____
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SNACK provided in PM only

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

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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 convenience.

PARENT SIGNATURE:

DATE:

**Immunization Records are
Required Every Year**

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An 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 below by providing the last 4 digits of the card and CVC/CVV

or

the last 4 digits of their bank account.

Otherwise, please complete the form below in full.

Name on Account for Draft: _____

Name of Bank: _____

Bank Routing Number: _____

Bank Account Number: _____ Checking Savings

Credit/Debit Card: _____ CVC/CVV: _____

Expiration Date: ____/____



**Immunization Records are
Required Every Year**



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 COMMUNITY FOOD AND NUTRITION ASSISTANCE (CFNA)
 SUMMER FOOD SERVICE PROGRAM (SFSP)
MEDICAL FOOD SUBSTITUTION RECORD

Authorization by a recognized medical authority is required for food substitutions to the Summer Food Service Program meal pattern. A recognized medical authority includes a 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.

PARTICIPANT'S NAME:	DATE OF BIRTH
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MEDICAL CONDITION / REASON:

SPECIAL ASSISTANCE/EQUIPMENT REQUIRED:

FOOD SUBSTITUTION LIST:

Fluid Milk	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Meat & Meat Alternates (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)
Fruits & 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 OF MEDICAL AUTHORITY	TITLE	DATE
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MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
 OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE
INDIVIDUAL PLAN FOR SPECIALIZED CARE

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	

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