



WELCOME TO YMCA YOUTH DEVELOPMENT!

At the YMCA, we are committed to **youth development, healthy living, and social responsibility**. Our programs nurture children by incorporating the core values of **caring, honesty, respect, and responsibility** into everything we do. Our youth development programs are built on these principles and provide wellness initiatives, academic support, and a learning environment that promotes excellence. To help us deliver these services effectively, our YMCA Child Care Program is staffed with **qualified, trained, and experienced professionals**. Thank you for choosing the YMCA to support your child's development. We value this partnership and are committed to helping your child thrive.

2025–2026 School Year Registration Instructions

Please follow the steps below to complete your child's registration. Completion of all required forms is necessary to comply with local licensing regulations. Care cannot be provided until all forms are submitted and reviewed.

Step 1: Application Packet

Complete all pages of the application packet, including:

- YMCA Application Form
- Travel & Activity Authorization
- Authorization for Child's Emergency Medical Treatment
- Registration Record for Child Receiving Care Away from Home

Note: Every blank on the forms must be filled. Write **"N/A"** for fields that do not apply. **Incomplete forms will not be accepted.**

Step 2: Vouchers

If you are using a **childcare voucher**:

- Contact your **OSSE worker** and notify them that you want to use your voucher at your child's YMCA campus.
- If you do **not** currently have a voucher and would like to apply for one, please contact OSSE or your campus director for guidance.

Step 3: Submit Your Forms

Choose one of the following methods to submit your completed application:

- **In-Person:** Hand in completed forms to a YMCA representative at your child's campus.
- **Email:** Send your packet to your campus director at the corresponding address below:

Campus	Programs	Director	Email
Shaw	Grow, Lead, Will	Kendra Milliard	kmillard@ymcawashdc.org
Webb	Connect, Spring, Northeast	Kayla King	kaylaking.ymca1@gmail.com
Wheeler	Pride, TLC, Inspire, Honor	Antonio Huff	antonio.huff@ymcadc.org
Smilow	ATA, Quest, Valor	Keyonna Bennett	keyonna.bennett@ymcadc.org
Douglass	Discover, Heights, AIM	Brittney Hardy	brittney.hardy@ymcadc.org
Benning	Leap, Promise, Key	Ms. Theresa Williams	theresa.williams@ymcadc.org

Step 4: Confirmation

Once your packet has been received and reviewed, your **campus director will contact you** to confirm your child's **start date**.

If you need help at any point in this process, please contact your campus director. We look forward to working with you and supporting your child's growth and success!

Please Check the Box Next to the Campus Your Child(ren) will attend

Selection	Campus	Selection	Campus
	Benning Campus (Leap, Promise, KEY)		Webb Campus (Connect, Spring, NE)
	Douglass Campus (Discover, Heights AIM)		Smilow Campus (ATA, Quest, Valor)
	Shaw Campus (Grow, Lead, WILL)		Wheeler Campus (Pride, TLC, Inspire, Honor)

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Part I Participant Information

Child's Full Name (Last, First, Middle)		Nickname	Birth Date (Month/Day/Year)		Gender
Home Address		City	State	Zip	
Previous Child Care	School Currently Enrolled in (2025-2026)			Grade Level	

Part II Parent / Guardian Information

Parent/Guardian #1 Name (Last, First, Middle)		DOB:	Home Phone:	Cell Phone:	
Home Address		City	State	Zip	
Email	Employer Name and Address:			Work Phone:	
Parent/Guardian #2 Name (Last, First, Middle)		DOB:	Home Phone:	Cell Phone:	
Home Address		City	State	Zip	
Email	Employer Name and Address:			Work Phone	

Part III Emergency Contact Information (local, other than parents)

Emergency Contact #1 (Last, First)		Relationship to Child			
Home Address		City	State	Zip	
Home Phone	Cell Phone	Work Phone			

☐ Check this box if emergency contact #1 is ALSO authorized to pick up child (Normal/Standard)

Emergency Contact #2 (Last, First)		Relationship to Child			
Home Address		City	State	Zip	
Home Phone	Cell Phone	Work Phone			

☐ Check this box if emergency contact #2 is ALSO authorized to pick up child (Normal/Standard)

Other Persons Authorized to Pick Up your child (if any):

- 1.
- 2.

Person(s) NOT Authorized to Pick Up your child (if any). Appropriate paperwork (custody order) must be attached if a parent is NOT allowed to pick up the child.

- 1.
- 2.

- In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to the hospital.
- Your signature below also authorizes the Childcare Staff to post your child's birth date, photo and allergy information in the childcare rooms.

Signature: _____

Date: _____

Part IV Child's Physician / Insurance Information			
Child's Physician		Physician Phone Number	
Street Address	City	State	Zip
ACTION TO BE TAKEN IN AN EMERGENCY			
Insurance Company Name			
Street Address	City	State	Zip
Policy Holder's Name		Policy Number	
Part V Child's Medical Information			
PLEASE NOTE ANY ALLERGIES, INTOLERANCES TO MEDICATION, FOOD OR OTHER SUBSTANCES			
Medicine:		Food:	Other:
PLEASE LIST ANY SPECIAL NEEDS AND MEDICATION CHILD IS PRESCRIBED			
Special Needs:		Developmental Delays:	Medication:
Chronic Physical Problems / Special Accommodations: (For special accommodations, or to share important information about your child, please complete an INCLUSION FORM.)			
Does your child take medications or vitamins on doctor's orders? (If the program is to administer medications during the day, emergency or routine, please complete a MEDICATION AUTHORIZATION FORM.)			
Part VI Swimming Assessment			
<input type="checkbox"/> Non-Swimmer (unable to swim/no swim instruction)	<input type="checkbox"/> Beginner (some limited swim instruction)	<input type="checkbox"/> Intermediate (average swimming ability)	<input type="checkbox"/> Advanced (skilled swimmer)

WAIVER:

I HEREBY GRANT PERMISSION FOR MY CHILD TO BE TRANSPORTED BY THE YMCA FOR ACTIVITIES TO, BUT NOT LIMITED TO SWIMMING, AND FIELD TRIPS. I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT ME OR MY EMERGENCY CONTACT. IF I, OR SOMEONE ON THE EMERGENCY FORM CANNOT BE REACHED, I GIVE THE YMCA PERMISSION TO SECURE THE MEDICAL TREATMENT NECESSARY FOR MY CHILD, INCLUDING HOSPITALIZATION, INJECTION, ANESTHESIA, OR SURGERY. I UNDERSTAND IN EMERGENCIES REQUIRING IMMEDIATE MEDICAL ATTENTION, YOUR CHILD WILL BE TAKEN TO THE NEAREST HOSPITAL EMERGENCY ROOM. MY SIGNATURE AUTHORIZES THE RESPONSIBLE PERSON AT THE CHILD CARE FACILITY TO HAVE YOUR CHILD TRANSPORTED TO THE HOSPITAL.

I UNDERSTAND THAT THE YMCA OF METROPOLITAN WASHINGTON ASSUMES NO RESPONSIBILITY FOR INJURIES OR ILLNESSES WHICH I MAY SUSTAIN AS A RESULT OF MY PHYSICAL CONDITION OR RESULTING FROM MY PARTICIPATION IN ANY ATHLETIC ACTIVITIES, SPORTS PROGRAMS, AND THE USE OF ANY EQUIPMENT, EXERCISE, OR OTHER ACTIVITIES. I EXPRESSLY ACKNOWLEDGE ON THE BEHALF OF MYSELF AND MY HEIRS THAT I ASSUME THE RISK FOR ANY AND ALL INJURIES AND ILLNESSES WHICH MAY RESULT FROM PARTICIPATION IN THESE ACTIVITIES. I HEREBY RELEASE AND DISCHARGE THE YMCA OF METROPOLITAN WASHINGTON, ITS AGENTS, SERVANTS AND EMPLOYEES FROM ANY AND ALL CLAIMS FOR INJURY, ILLNESS, DEATH, LOSS OR DAMAGE WHICH I MAY SUFFER AS A RESULT OF MY PARTICIPATION IN THESE ACTIVITIES. I UNDERSTAND THAT THE YMCA OF METROPLITAN WASHINGTON IS NOT RESPONSIBLE FOR PERSONAL PROPERTY LOST OR STOLEN WHILE MEMBERS AND/OR PROGRAM PARTICIPANTS ARE USING YMCA FACILITIES ON YMCA PREMISES. I GIVE MY PERMISSION TO THE YMCA OF METROPOLITAN WASHINGTON TO USE INDEFINITELY, WITHOUT LIMITATION OR OBLIGATION, PHOTOGRAPHS, FILM FOOTAGE OR TAPE RECORDINGS WHICH MAY INCLUDE MY OR MY HEIRS IMAGE OR VOICE FOR PURPOSE OR INTERPRETING YMCA PROGRAMS. I ACKNOWLEDGE THE WAIVER SET FORTH ABOVE.

Parent/Guardian Signature:**Date:**



ACKNOWLEDGEMENTS

1. **Tuition** – Tuition is an annual fee divided into 10 equal installments for SACC. There is no tuition adjustment for absences, unscheduled closings or delays, vacations and/or school holidays. Tuition is due in advance. **Please note there are a few months with 5 weeks of service**
2. **Payment Options** – There are 2 payment options: Semi-Monthly EFT Drafts (Drafts occur on the 10th and 26th of each month). Payments are electronically retrieved from a Bank Account or a Credit Card Account twice a month. If a draft is returned for any reason you have 2 business days from the time we contact you in writing, to replace the missed draft. If the draft is not replaced by the end of the 3rd business day your child will not be able to attend programs. OR Monthly EFT Draft (Draft occur on the 26th of each month). Payments are electronically retrieved from a Bank Account or a Credit Card Account once a month. If a draft is returned for any reason you have 2 business days from the time we contact you in writing, to replace the missed draft. If the draft is not replaced by the end of the 3rd business day your child will not be able to attend programs.
3. **Other Fees** – All returned checks will incur a \$20.00 processing fee. Any Bank Draft or Credit Card Draft payment returned with non-sufficient funds will incur a \$20.00 processing fee. The prorated or first full month of tuition is required by all new participants. This fee is non-refundable and cannot be applied towards other YMCA programs if child is cancelled out of the program before the scheduled start date. **There is an annual non-refundable activity fee per child.**
4. **Enrollment, Deposits & Withdrawal** – If at any time there is to be a change, deletion, or cancellation of my child's enrollment; it is to be submitted in writing to **the YMCA two weeks prior to the draft date**. If the mandatory two weeks notice is not given prior to your draft date then your next scheduled draft will still occur. There will be no refunds given.
5. **Special Concerns** – Prior to the time of registration, any behavioral problems, or special physical, emotional, Psychological, or medication needs of your child should be identified and discussed with the Director.
6. **Swimming Release** – A parent's signature on this form permits the child to go swimming while in YMCA programs.
7. **Medical Treatment** – The YMCA does not normally administer any medication and will do so only when directed in writing by the child's parent or guardian and local Licensure guidelines.
8. **Late pick up Policy** - The YMCA program closes at 6:30pm each day. Children must be picked up no later than 6:30pm. In the event that a child is not picked up, you will be assessed a later fee of \$2.00 per minute. YMCA staff members will remain with the child, but the parent is responsible for paying late fees to cover the cost of the staff's time. See Parent Handbook for fee schedule and full late pick up policy.
9. **Illness** – In case your child becomes ill during the course of the program, parents will be notified, and arrangements must be made to pick up the child as soon as possible, as the YMCA does not have facilities to care for ill children. If your child or anyone in the child's household develops a communicable disease (as defined by the department of health) it is necessary to inform the center within 24 hours or the next business day, except in the case of a life threatening illness, which must be reported immediately. Refunds will not be administered for any Covid-19 related closures or absences.
10. **Parent Handbook** - I understand that it is my responsibility to read and understand/be aware of ALL policies, and agree to all blanket permission forms and opt out requests, as outlined in the parent handbook upon receipt.
11. **Emergency and Inclement Weather Policy** – I have received a copy of the Emergency and Inclement Weather Policy
12. **Important Program Dates** – I have received a copy of the Important Program Dates and understand that it is my responsibility to read and be aware of Program dates and times.
13. **Part-Time Care** – If applicable, part-time days are non-transferrable.
14. **Please Note:** Policies and procedures are subject to change with no less than a two week notice.

I understand and agree to the fifteen (14) acknowledgments outlined above.

Parent/Guardian Signature: _____

Date _____

CHECK THE BOX NEXT TO PROGRAM YOU WISH TO ENROLL YOUR CHILD IN:

Selection	SACC Program	Weekly Program Cost	Annual Fee
	Beforecare Only	\$82.00	\$60.00
	Aftercare Only	\$82.00	\$60.00
	Both Beforecare and Aftercare	\$94.00	\$60.00

SACC AUTHORIZATION: SY 2025-2026 Child's Name _____

Person Financially Responsible _____ Relation to Child _____

Please check the correct payment option:

- Option 1: Semi-monthly EFT (Draft will occur on the 10th and 26th of each month)
- Option 2: Monthly EFT (Draft will occur on the 26th of each month)

Note: The Annual Registration will be charged at the time of enrollment.

**PLEASE COMPLETE PAYMENT AUTHORIZATION
BELOW CREDIT CARD AUTHORIZATION**
Your account will be drafted on the 10th & 26th of each month.

I authorize the YMCA to charge my credit card for child care payments. I understand that I must provide written notice of cancellation. If at any time there is to be a change, deletion, or cancellation of my child's child care enrollment, it is to be submitted in writing to the YMCA branch where child care was purchased two weeks prior to the date of my credit card draft in order to discontinue the debit.

Name As It Appears on Card_____
Credit Card Number_____
EXP DATE_____
Signature of Card Holder**BANK DRAFT AUTHORIZATION: Your account will be drafted on the 10th & 26th**

I authorize the YMCA to charge my credit card for child care payments. I understand that I must provide written notice of cancellation. If at any time there is to be a change, deletion, or cancellation of my child's child care enrollment, it is to be submitted in writing to the YMCA branch where child care was purchased two weeks prior to the date of my account draft in order to discontinue the debit.

Name of Bank _____

Account Number _____

Transit/Routing No. _____

Please Print Name _____

Signature of ACCT. Holder _____



DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION

REGISTRATION RECORD FOR CHILD RECEIVING CARE AWAY FROM HOME

Child: _____ Sex: ☐ Male ☐ Female
Last First M.I.
Date of Birth: _____ Home #: _____ Language Spoken At Home _____

Home Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Parent: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Relative or Guardian: _____ Home # _____
Last First M.I. Business # _____

Home Address: _____
Number Street Apt. # State ZIP

Business Address: _____
Number Street Apt. # State ZIP

Person to be contacted in case of an emergency (other than parent/guardian):

_____ Relationship to child: _____
Last First M.I.

Address: _____
Number Street Apt. # State ZIP Phone #

Designated individual authorized to receive child at end of session:

_____ Last First M.I.

_____ Last First M.I.

_____ Last First M.I.

Signature: _____ **Relationship to child:** _____ **Date:** _____

TO BE COMPLETED BY THE FACILITY

Site of Admission: _____
Site of Withdrawal: _____ **Reason:** _____



DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION

DIVISION OF EARLY LEARNING
Licensing and Compliance Unit

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT
(Update Annually)

If my child _____, born on ____/____/____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____
or:

Physician: _____ M.D. Telephone No: _____
(Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caregiver
_____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: ☐ DC ☐ MD ☐ VA

Child's known Allergies or Physical Conditions: _____

Parent/Guardian Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____
Home Business Cell Phone

Date: _____ Date Updated: _____
Month/Day/Year Month/Day/Year

Place in child's folder/record.



DISTRICT OF COLUMBIA

OFFICE OF THE STATE SUPERINTENDENT OF

EDUCATION**TRAVEL AND ACTIVITY AUTHORIZATION**

☐ Special one time permission for this activity only ☐ Blanket permission for all given activities

I, _____ parent/guardian of
Name of Parent/Guardian

_____ give my permission
Name of Child

_____ for my child to
participate in the following activities:

Trips in the van/automobile (facility or parent - owned)

Explain planned activity - where and when

Field trips away from the facility

Explain planned activity - where and when

I understand that the facility will use the appropriate child restraint devices and abide by all District of Columbia safety rules when my child is transported in a vehicle. The facility will also notify me each time that my child participate in an activity that would involve transportation.

In addition, if the facility has planned activities outside the fenced area of the facility,

☐ I will allow my child to play outside the fenced area; or

☐ I will not allow my child to play outside the fenced area.

This authorization is valid from ____/____/____ to ____/____/____

Parent/Guardian Signature

Date Signed

PLEASE KEEP A COPY IN THE CHILD'S FILE.



Medication Authorization Form

Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.1; "A Licensee shall not administer medication or treatment to a child in care, with the exception of emergency first aid, whether prescription or non-prescription, unless: parental permission to administer the medication or treatment is documented on a completed, signed, and dated medication authorization form that is received by the Licensee before the medication or treatment is administered or a licensed health care practitioner has approved the administration of the medication and the medication dosage."

Pursuant to Title 5A, Chapter 1 of the District of Columbia Municipal Regulations (DCMR), Section 153.5, "A Licensee shall maintain a medication log, on a form approved by OSSE. Each time medication is administered to a child, a staff person shall enter the date, time of day, medication, medication dosage, method of administration, and the name of the person administering the medication in the medication log."

Part I: To be completed by the parent/guardian and child's physician:

I do hereby give permission to _____ to administer the following
Name of Facility

prescribed medication to my child _____ born on _____.

Name of Medication	Time/Frequency	Dosage	Effective Dates	
			From:	To:

Signature of Physician

Date

Signature of Parent/Guardian

Date

Part II: To be completed by the center director or staff administering medication who has current medication administration certificate:

Name of Medication	Date	Time Given	Reactions	Staff Initials

PLEASE PLACE A COPY IN THE CHILD'S FILE.