



# Conejo Valley YMCA

## \*\*Child Care Rate Sheet\*\*

### 2008-2009

		Plan A Includes school days, minimum days & pupil free days. 10 equal payments	Plan B Includes all of Plan A & Winter & Spring Camps. 10 equal payments
<b>GRADES K – 8th, OFFERED AT PEACH HILL ONLY</b>			
<b>Morning Care: 6:30 – Start of School</b>	1-5 Days	\$152/ month	N/A

<b>GRADES K – 8th</b>			
<b>6:30am – Start of School AND After School – 6:00pm</b>	4-5 Days	\$456/month	\$504/month
	1 – 3 Days	\$380/month	\$428/month
<b>After school Till 6:00pm</b>	4-5 Days	\$318/month	\$366/month
	1 – 3 Days	\$266/month	\$314/month

**Payment Information:**

- Entire School Year – Total payment is payable upon enrollment (Plans A & B = 10 x monthly rate). If this method is chosen, you will be given one free week of one of our holiday camps.
- Plans A & B – Two monthly payments are due at time of enrollment and will be applied to Sept. and June. The remaining 8 are due on the 1<sup>st</sup> of each month from Oct. to May.
- A late fee of \$25 will be assessed for payments received after the 5<sup>th</sup> of the month. **No exceptions!**
- Our preferable methods of payment are automatic credit card draft and automatic bank draft. Please note that bank and credit card drafts will take place on the 1st of each month. Checks will only be accepted at the YMCA main office, not at the childcare sites.
- YMCA Membership Fee (\$80 for family; \$40 for an individual), an Earthquake supply kit at \$10, and \$50 registration fee are payable at the time of enrollment.

**Transportation Information:**

- Morning transportation is available from Peach Hill to Arroyo West and Mountain Meadows. Space is limited.
- Unless the minimum quota is met, there will be no transportation offered by the YMCA from Chaparral, Santa Rosa or Mesa Verde Schools. Please contact MUSD to purchase a bus pass.

YMCA Holidays (closed): Labor Day, Thanksgiving Day and the day after Thanksgiving, Christmas Eve and Christmas Day, New Year's Eve and New Year's Day, President's Day and Memorial Day.

Form updated on August 14, 2008

**Conejo Valley YMCA**  
 4031 N. Moorpark Rd. Thousand Oaks, CA 91360  
 Phone: (805) 523-7613 Fax: (805) 523-8831



# Conejo Valley YMCA Child Care \*\*Registration Form\*\* 2008-2009

For Office Use Only

MST User \_\_\_\_\_  
 PID # \_\_\_\_\_  
 Total Received \$ \_\_\_\_\_  
 Collected Completed Forms:  
 LIC 700     LIC 702  
 LIC 627     LIC 613A  
 LIC 995    Date: \_\_\_\_\_

Child's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Child's School \_\_\_\_\_ Grade \_\_\_\_\_  
 Parent/Guardian \_\_\_\_\_ Cell Phone \_\_\_\_\_ Employer \_\_\_\_\_  
 Parent/Guardian \_\_\_\_\_ Cell Phone \_\_\_\_\_ Employer \_\_\_\_\_  
 Family Email \_\_\_\_\_ Child lives with:  Mom  Dad  Both  Other

Grades K-8:  6:30-Start of School (Full time only) (only at Peach Hill then transported to appropriate site)  
 6:30am – Start of School **AND** After School - 6:00pm;     Full Time (4-5 Days/week)     Part Time (1-3 Days)  
 After School - 6:00pm;     Full Time (4-5 Days/week)     Part Time (1-3 Days)  
 If Part Time, Days of Child Care Needed (up to 3):  Monday     Tuesday     Wednesday     Thursday     Friday  
 YMCA Site Location:  Arroyo West     Campus Canyon     Mountain Meadow     Peach Hill  
 \*Santa Rosa     \*Chaparral     \*Mesa Verde    \*Transported to Peach Hill if min. quotas are met  
 Select Desired Plan:  Plan A     Plan B (Includes Winter and Spring Break [\$48 extra per month])  
 Transportation Needed:  Not needed     Yes, mornings only     Yes, afternoons only     Yes, both AM and PM  
 Time your child is dismissed from school: \_\_\_\_\_  
 Payment Method:  Credit Card Draft     Bank Draft

Enrollment:    Start Date: \_\_\_\_\_    Classroom # \_\_\_\_\_    Teacher: \_\_\_\_\_

**Insurance:** It is the responsibility of every individual, their parent or legal guardian to provide for their own accident and medical insurance coverage while participating in YMCA activities. The YMCA does not provide any accident or health coverage for its participants.

**Participation:** I give my permission for my child to participate in activities, field trips, overnights, swimming and to be transported according to the program content as authorized by the YMCA; and I give my permission for the YMCA to use any photographs of my child for future promotional purposes and waive all royalty considerations.

**Medical Treatment:** I hereby give permission for my child to receive emergency medical treatment by a qualified YMCA staff member or medical personnel. I also give my permission for my child to be transported by ambulance, YMCA van or car to an emergency center in the event that I cannot be contacted. I further consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital selected by the YMCA Director when deemed immediately necessary or advisable by the physician to safeguard my child's health.

**Parent Handbook for Day Camp and Child Care only:** I have received, read and understand the Parent Handbook for Day Camp and/or Child Care.

**Late Fee Policy:** Payments are due on the 1<sup>st</sup> of each month. A \$25.00 late fee will be added to the account if payment is not received by the 5<sup>th</sup> of the month. If payment is not received, the participant will be dropped from the program on the 15<sup>th</sup> of the month.

*I have read and understand the above information and have completed this form to the best of my ability.*

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Form updated on Aug. 8, 2008

**IDENTIFICATION AND EMERGENCY INFORMATION**  
**CHILD CARE CENTERS/FAMILY CHILD CARE HOMES**  
To Be Completed by Parent, Domestic Partner or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )
ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					BIRTHDATE
FATHER'S/GUARDIAN'S/DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ( )
MOTHER'S/GUARDIAN'S/DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )	
HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP
					HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

**ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY**

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

**PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY**

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

CALL EMERGENCY HOSPITAL       OTHER      EXPLAIN: \_\_\_\_\_

**NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY**

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT, DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GUARDIAN/DOMESTIC PARTNER OR AUTHORIZED REPRESENTATIVE	DATE
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**TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE**

DATE OF ADMISSION	DATE LEFT
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**CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT**

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/DOMESTIC PARTNER'S NAME	DOES FATHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
MOTHER'S/DOMESTIC PARTNER'S NAME	DOES MOTHER/DOMESTIC PARTNER LIVE IN HOME WITH CHILD?	
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION	

**DEVELOPMENTAL HISTORY** (\*For infants and preschool-age children only)

WALKED AT*	MONTHS	BEGAN TALKING AT*	MONTHS	TOILET TRAINING STARTED AT*	MONTHS
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**PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:**

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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**DAILY ROUTINES** (\*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST	WHAT ARE USUAL EATING HOURS?
	LUNCH	BREAKFAST _____
	DINNER	LUNCH _____
		DINNER _____

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?
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IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE?*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*		

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENTS/DOMESTIC PARTNER'S SIGNATURE

DATE

# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT, DOMESTIC PARTNER, OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE  
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

\_\_\_\_\_. THIS CARE MAY BE GIVEN UNDER  
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD  
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_ DATE

\_\_\_\_\_ PARENT, DOMESTIC PARTNER, OR AUTHORIZED REPRESENTATIVE SIGNATURE

\_\_\_\_\_ HOME ADDRESS

HOME PHONE  
( )

WORK PHONE  
( )

**PERSONAL RIGHTS****Child Care Centers**

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
  - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
  - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
  - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
  - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), domestic partner(s), or guardian(s) of the child.
  - (6) Not to be locked in any room, building, or facility premises by day or night.
  - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES, COMMUNITY CARE LICENSING

ADDRESS

360 SOUTH HOPE AVENUE SUITE C-105

CITY

SANTA BARBARA

ZIP CODE

93105

AREA CODE/TELEPHONE NUMBER

805-682-7647

DETACH HERE

TO: PARENT/DOMESTIC PARTNER/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: **PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

**ACKNOWLEDGMENT:** I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/DOMESTIC PARTNER/GUARDIAN)

(DATE)

**CHILD CARE CENTER  
NOTIFICATION OF PARENTS' RIGHTS**

**PARENTS' RIGHTS**

As a Parent/Domestic Partner/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: CA DEPT. OF SOCIAL SVCS., COMMUNITY CARE LICENSING

Licensing Office Address: 360 SOUTH HOPE AVENUE SUITE C-105

Licensing Office Telephone #: 805-682-7647

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

**NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/DOMESTIC PARTNER/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/DOMESTIC PARTNER/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.**

*For the Department of Justice "Registered Sex Offender" database, go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)*

LIC 995 (1/08)

(Detach Here - Give Upper Portion to Parents)

**ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS  
(Parent/Domestic Partner/Authorized Representative Signature Required)**

I, the parent/domestic partner/authorized representative of \_\_\_\_\_, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

\_\_\_\_\_  
Name of Child Care Center

\_\_\_\_\_  
Signature (Parent/Domestic Partner/Authorized Representative)

\_\_\_\_\_  
Date

**NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/domestic partner/authorized representative.**

*For the Department of Justice "Registered Sex Offender" database go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)*