YMCA DAY CAMP REGISTRATION FORM

CAMPER NAME: _____ Grade Entering August 2025: _____

Gender: _____ Birthdate: _____ Age: _____ Ethnicity: _____

Home Address: _____

Parent/Guardian Name: _____ Birthdate: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ Work Phone: _____

E-Mail: _____

DCN #: _____ (if applicable)

PARENT PICK-UP AUTHORIZATION & EMERGENCY CONTACTS – Not including parents/guardians. Please list up to TWO people who are authorized to pick up your child from camp. Children will only be released to someone listed below. They must have a photo ID on file.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Please mark the weeks and days your child will be attending.

WEEK OF CAMP	THEME	Bank Draft Date	DAYS OF WEEK
Week 1 May 27-May 30	We are family	Paid at time of registration	[ ]T [ ]W [ ]Th [ ]F
Week 2 June 2-6	Empowerment	Wednesday, June 4	[ ]M [ ]T [ ]W [ ]Th [ ]F
Week 3 June 9-13	Astronomy	Wednesday, June 11	[ ]M [ ]T [ ]W [ ]Th [ ]F
Week 4 June 16-20	History is cool	Wednesday, June 18	[ ]M [ ]T [ ]W [ ]F
Week 5 June 23-27	Let's get outside	Wednesday, June 25	[ ]M [ ]T [ ]W [ ]Th [ ]F
Week 6 June 30– July 4	Splash Around	Wednesday, July 2	[ ]M [ ]T [ ]W [ ]Th
Week 7 July 7-11	4 core values	Wednesday, July 9	[ ]M [ ]T [ ]W [ ]Th [ ]F
Week 8 July 14-18	Mythbusters	Wednesday, July 16	[ ]M [ ]T [ ]W [ ]Th [ ]F
Week 9 July 21-25	Express yourself	Wednesday, July 23	[ ]M [ ]T [ ]W [ ]Th [ ]F
Week 10 July 28-Aug 1	No "I" in team	Wednesday, July 30	[ ]M [ ]T [ ]W [ ]Th [ ]F
Week 11 Aug 4-8	Camp Rock	Wednesday, August 6	[ ]M [ ]T [ ]W [ ]Th [ ]F

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

INCOME ELIGIBILITY FORM

To apply for free or reduced-price meal eligibility benefits for your child(ren), please fill out this form and return it to the program.

PART 1 CHILDREN ENROLLED IN THE PROGRAM

Complete information below for children enrolled at the camp/site. If child(ren) are receiving Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp) or Temporary Assistance (formerly AFDC, now funded by TANF), complete Parts 1, 3, and 4 only. Complete Parts 1, 2, 3, and 4 if you did not provide a SNAP case number or Temporary Assistance case number. ***In certain cases, foster children are eligible for free meals regardless of household income. If foster children live in your household, please contact the camp or site sponsor for more information.***

NAME (first and last)	BIRTH DATE	FOSTER CHILD	SNAP CASE NUMBER	TEMPORARY ASSISTANCE CASE NUMBER

PART 2 HOUSEHOLD AND INCOME INFORMATION

List all members of the household including the children listed in Part 1. Indicate source and amount of current income for all members of the household before deductions, such as taxes and social security. Where there are wage earners and self-employed adults, the income of the wage earner cannot be offset by the business losses of the self-employed adult. If last month's income does not accurately reflect your circumstances, you may provide a projection of your current annual income. Irregular self-employed income may be averaged over the prior 12 months.

INCOME BASED ON (CHECK ONE): YEARLY ☐ MONTHLY ☐ 2 X A MONTH ☐ EVERY 2 WEEKS ☐ WEEKLY ☐

HOUSEHOLD MEMBERS	GROSS WAGES	WELFARE, CHILD SUPPORT, ALIMONY	PENSIONS, RETIREMENT, SOCIAL SECURITY	OTHER

PART 3 PARTICIPANT's ETHNIC AND RACIAL INFORMATION (Optional)

Hispanic or Latino: ☐ **YES** ☐ **NO**

Race: AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐

PART 4 SIGNATURE

I hereby certify that all information provided is correct and true and that all income is reported. I understand that this information is being given in connection with the receipt of federal funds, that institution officials may verify information, and that deliberate misrepresentation may subject me to prosecution under applicable state and federal

SIGNATURE OF ADULT FAMILY MEMBER	SOCIAL SECURITY NUMBER	DATE
PRINTED NAME OF ADULT	**ADDRESS**	**PHONE NUMBER**

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance (TA) Program case number for your household or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. These verification efforts may be carried out through program reviews and investigations, and may include contacting employers to determine income, contacting a SNAP or welfare office to determine current certification for receipt of SNAP or Temporary Assistance benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to provide the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

FOR SPONSOR USE ONLY

TOTAL HOUSEHOLD SIZE:	INCOME:	INCOME BASED ON (CHECK ONE): YEAR ☐ MONTH ☐ 2 X A MONTH ☐	EVERY 2 WEEKS ☐	WEEKLY ☐	SNAP (Food Stamp) ☐	TEMPORARY ASSISTANCE ☐

Eligibility Determination: ☐ Eligible ☐ Ineligible

SIGNATURE OF CENTER REPRESENTATIVE	DATE
▶	

DAY CAMP BANK DRAFT FORM

First Name	MI	Last Name	M/F	Birth Date

Telephone	Cell	Email

Billing Address

Street	City	State	Zip

Payment Terms & Conditions

■ You must provide a **ONE WEEK WRITTEN** notice for any changes to your account. Please Initial _____

■ In order to provide for convenient Day Camp payments to the YMCA of St. Joseph, we authorize electronic funds transfer (EFT) from this specified checking/savings account, charge card or debit card. We will provide a one week written notice for any changes to our account. Please Initial _____

■ Should any EFT or charge not be honored, we understand that the Y will attempt to redraft the payment. If the EFT or charge is not honored on the redraft, we will be required provide another form of payment plus a $10 service charge.
Please Initial _____

Payment Options

Electronic Funds Transfer (EFT): $. beginning (MMYY)

A. ☐ Checking ☐ Savings Bank Name:_____

Account Number

Routing Number

Please attach a voided check

B. Debit/Credit Card: ☐ Visa ☐ MC ☐ Discover ☐ AMEX

Expire Date

I have read and agree to all terms of the YMCA payment terms and conditions.

Signature of Responsible Party	Date

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

SFSP ENROLLMENT FORM FOR CAMPS AND CLOSED ENROLLED SITES

PERMISSION TO PARTICIPATE

I (Parent/Guardian Name) _____ give permission for my child(ren) listed below to participate in the enrolled SFSP site:

(Site Name) _____ located at

(Site Address) _____

and to receive SFSP meals from:

(Sponsor name) _____

CHILD(REN)

FIRST/LAST NAME	AGE

PARENT/GUARDIAN CONTACT INFORMATION

FULL NAME			
ADDRESS			
CITY	STATE	ZIP CODE	COUNTY
PHONE NUMBER			
EMAIL ADDRESS			

Parent/Guardian Signature: _____ Date: _____

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

MEDICATION AUTHORIZATION

MEDICATION REQUIREMENT

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

I AUTHORIZE CHILD CARE PERSONNEL TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD:

(PROPER NAME OF MEDICATION)

CHILD'S FULL NAME	**DATE MEDICATION TAKEN FROM**	**UNTIL**
DOSAGE	TIME(S) OF DAY	
POSSIBLE SIDE EFFECTS		
SIGNATURE OF PARENT(S) OR GUARDIAN		DATE

RECORD OF ADMINISTRATION

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME

FORM TO BE RETAINED IN CHILD'S RECORD