SUMMER SCHOOL AFTER CARE 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

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 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