Sanford-Springvale YMCA

Kids Out Enrichment Program Registration | 2026/2027

The Sanford-Springvale YMCA (SSYMCA) offers the Kids Out program to the following schools:

Sanford School District: MCS, CJL, PRIDE ES, and Sanford Middle School (5th Grade)
RSU 60: Hussey, Knowlton/Noble Intermediate School, Hanson (at Lebanon), and North Berwick Elementary School
RSU 57: Waterboro Elementary School, Alfred ES, and Shapleigh ES

CHILD'S INFORMATION

School child is attending: _____

Sibling enrolled? ☐ Yes ☐ No

Name: _____ Date of Birth: _____ Nickname (if any): _____

Address: _____ City: _____ Zip: _____ Phone: _____

Grade: _____ Age at Time of Registration: _____ Gender: _____ Program Start Date: _____

I have read the Parent Handbook found on the Sanford-Springvale YMCA website. Initial

My child has previously attended Y-care with the SSYMCA: ☐ Yes ☐ No

Days Requested (check all that apply)

Before Care: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
After Care: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

PARENT/GUARDIAN 1

Name: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____ Email Address: _____

Employer: _____ Employer Phone: _____

Marital Status*: ☐ Single ☐ Married ☐ Divorced ☐ Separated

PARENT/GUARDIAN 2

Name: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____ Email Address: _____

Employer: _____ Employer Phone: _____

Marital Status*: ☐ Single ☐ Married ☐ Divorced ☐ Separated

EMERGENCY CONTACT / AUTHORIZED PICK-UP

At least 3 contacts; ALL fields MUST be completed.

The following people are authorized to pick up this child and may be contacted in the event of an emergency or illness if the primary parent/guardian contact cannot be reached. Each contact listed will be required to show photo identification when picking up this child.

Contact 1

Name: _____ Relation to child: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____

Contact 2

Name: _____ Relation to child: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____

Contact 3

Name: _____ Relation to child: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____

*Sanford-Springvale YMCA requires a copy of court orders stating that non-custodial parents are not allowed to have contact with or remove their child from the program. Please be sure to give a copy of this to your child's Site Leader or the School Age and Summer Day Camp Director so that we have a legal document stating the orders. If we do not have such a copy, we are required by law to release the child to the biological parent regardless of custody. It is our policy not to get involved in custody-related services unless required by an official third party.

AUTHORIZATION / RELEASE FORM

Please initial if you agree:

Field Trip / Swimming at the YMCA Permission: I hereby give my child permission to attend all Sanford-Springvale YMCA planned field trips and scheduled swimming times at the YMCA pool. By my signature, I understand that this serves as a blanket permission slip for the school year.

Initial

Photo Release: I hereby authorize the Sanford-Springvale YMCA to use photos or videos of my child.

Initial

Brightwheel Photo Sharing

Kids Out uses the Brightwheel app to share updates, photos, and videos of program activities with families. **Please check one:**

☐ **Yes:** My child may appear in photos and videos shared through Brightwheel, including group photos shared with the families of other children pictured.

☐ **No:** Please do not share photos or videos of my child through Brightwheel.

I agree not to post or share photos or videos from Brightwheel that show other children, on social media or elsewhere, without permission from those children's families.

Initial

Sunscreen: I permit YMCA staff to apply sunscreen and bug spray to my child as needed.

Initial

HIPAA Release

I, _____ (parent/guardian name), give my permission for the Sanford-Springvale YMCA to share with and receive from the _____ School District any information regarding my child's behavior, academics, emotional well-being, or mental health in order to best support and serve my child's needs.

Parent/Guardian Signature: _____

HEALTH AUTHORIZATIONS

Medical Authorization

I hereby give authorization to the Sanford-Springvale YMCA to obtain emergency medical treatment for my child in case of sudden illness or accident.

Child's Name: _____ Parent/Guardian Name: _____

Signature: _____ Date: _____

The State of Maine Childcare Licensing Department requires that every child enrolled has the following information on file. It is important that all information is filled out completely and accurately. If there are any changes to this information during the school year please be sure to give us that information so our files are accurate.

PEDIATRICIAN & FAMILY DENTIST

Maine State licensing requires a complete address and phone number.

Pediatrician

Name of Doctor/Office: _____ Phone Number: _____

Address: _____

Family Dentist

Name of Doctor/Office: _____ Phone Number: _____

Address: _____

I understand that I must update the Sanford-Springvale YMCA with my child(ren's) immunization records (faxed records will not be accepted). Initial

HEALTH HISTORY FORM

Child's First Name: _____ Last Name: _____

Does your child have any chronic or recurring illness? Please explain.

Does your child have any reactions to insect bites/stings? (If any, how severe is the reaction?)

Does your child have any allergies? Please explain. (If your child has a severe allergy, please also complete the Allergy Action Plan with your child's physician.)

Are there any activities your child should be exempt from because of health reasons?

Record of past medical treatment, if any:

HEALTH HISTORY (CONTINUED)

Does your child have Epilepsy? ☐ Yes ☐ No

If yes, date of last seizure & severity:

Does your child have Diabetes? ☐ Yes ☐ No

If yes, does your child take medications or insulin? ☐ Yes ☐ No

Details:

Does your child have Asthma? ☐ Yes ☐ No

If yes, does your child carry an inhaler?*** ☐ Yes ☐ No

Does your child carry an EpiPen?*** ☐ Yes ☐ No

Will your child be taking medications while in our care?*** ☐ Yes ☐ No

***NOTE: If you answered yes to any of these questions, please provide a signed note from the parent(s) AND the child's physician authorizing your child to self-administer medications if needed. If yes, an Authorization to Dispense Medication form is required.

Hospital Preference:

SPECIAL NEEDS / ADDITIONAL FAMILY INFORMATION

Does your child have any known behavior or health concerns? We provide reasonable accommodations to qualified individuals with disabilities. All our participants must be able to participate safely in our programs. We do not provide one-on-one supervision and retain the discretion not to enroll or to remove a participant from our program if that participant is not able to participate safely in the program. If yes, please explain below.

☐ Yes ☐ No

Please list any significant factors that may currently be impacting your child (divorce, death in the family or loss of family pet, recently moved or switched schools, a new fear or phobia) that may need special attention.

ALLERGY ACTION PLAN

Complete this page only if your child has a severe allergy (food, insect sting, medication, latex, or other). This plan must be completed and signed by your child's physician and a parent/guardian. Please attach a recent photo of your child. A copy will be kept with your child's medication at their program site.

Attach photo here

Child's Name: _____ Date of Birth: _____

Weight (lbs): _____ Program Site/School: _____

Allergic to: _____

Asthma? ☐ Yes (higher risk for a severe reaction) ☐ No

For the physician to check, if applicable:

☐ Give epinephrine immediately if the allergen was **LIKELY** eaten or contacted, for **ANY** symptoms.

☐ Give epinephrine immediately if the allergen was **DEFINITELY** eaten or contacted, even if no symptoms are apparent.

SEVERE SYMPTOMS: Any of these

- **Lungs:** shortness of breath, wheezing, repeated coughing
- **Heart:** pale or bluish skin, faintness, weak pulse, dizziness
- **Throat:** tight or hoarse throat, trouble breathing or swallowing
- **Mouth:** significant swelling of the tongue or lips
- **Skin:** many hives over the body, widespread redness
- **Stomach:** repeated vomiting, severe diarrhea
- **Other:** feeling that something bad is about to happen, anxiety, confusion
- **Or a combination** of mild symptoms from different body areas

WHAT TO DO

1. **Give epinephrine immediately.**
2. **Call 911.** Tell them the child is having anaphylaxis.
3. Lay the child flat with legs raised. If breathing is hard or they are vomiting, let them sit up or lie on their side.
4. A second dose of epinephrine may be given 5 minutes or more after the first if symptoms do not improve or come back.
5. Contact the parent/guardian and emergency contacts.
6. The child should be taken to the emergency room even if symptoms improve.

MILD SYMPTOMS

- **Nose:** itchy or runny nose, sneezing
- **Mouth:** itchy mouth
- **Skin:** a few hives, mild itching
- **Stomach:** mild nausea or discomfort

WHAT TO DO

1. Give antihistamine, if ordered by the physician below.
2. Stay with the child and watch closely.
3. Contact the parent/guardian.
4. **If symptoms get worse or symptoms from more than one body area appear, give epinephrine and call 911.**

Medications & Doses

Epinephrine (brand or generic): _____ Dose: ☐ 0.1 mg ☐ 0.15 mg ☐ 0.3 mg

Antihistamine (brand or generic): _____ Dose: _____

Other (e.g., inhaler): _____

May this child carry and self-administer epinephrine? ☐ Yes ☐ No

Physician Signature: _____ Phone: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

HEALTH HISTORY FORM WAIVER

This health history form is correct to the best of my knowledge, and my child described herein has permission to engage in all prescribed program activities except as noted. I hereby permit the medical personnel selected by the School Age and Summer Day Camp Director to order X-rays, routine tests, and treatment, to release any records necessary for insurance purposes, and to provide or arrange necessary related transportation for my child. If I can't be reached in an emergency, I would like to allow the physician selected by the School Age and Summer Day Camp Director to secure and administer treatment, including hospitalization, for my child named above.

Parent/Guardian Signature: _____ Date: _____

DISCIPLINARY PHILOSOPHY

Our Core Values: Caring, Honesty, Respect, Responsibility

We expect all children, staff, and parents who are part of our program to follow the core values of our YMCA at all times when engaged in the program.

These core values are the basis of our disciplinary philosophy and must be followed and practiced by all program participants and staff.

We will work with children and families in a consolidated effort to help children learn the importance of putting these values into practice. The work will include helping them understand the effects of not following the core values on themselves & others around them.

We have a firm line on three non-negotiable behaviors that we cannot tolerate in any manner and will take immediate action on. The actions taken will be in a three-step process and handled on a case-by-case basis. The final step is the termination of childcare services for the remainder of the program period.

- **Causing physical harm to others:** We do not tolerate behaviors that cause physical harm to other program participants, whether during daily activities, in transitions, or during in-water activities (e.g., hitting, kicking, pushing, biting, grabbing, dunking, or holding underwater).
- **Causing physical harm to staff:** We do not tolerate behaviors such as hitting, kicking, spitting on, or otherwise attempting to harm program staff.
- **Unsafe behaviors putting a child at immediate risk:** We do not tolerate behaviors that put the child at immediate risk of injury (e.g., running from the program area or staff, refusing to respond to staff directions in a safety-critical moment, or spitting).

Parent Signature: _____ Date: _____

Please initial your understanding of and agreement to the statements below:

I understand that the Y does not provide one-on-one supervision. Initial _____

I understand the Y retains discretion to remove a child if they are unable to safely participate. Initial _____

Parent Signature: _____ Date: _____

CHILD CARE AGREEMENT FORM

Child Care Registrations will only be accepted with a COMPLETED and SIGNED Fee Agreement Form. This serves as a financial contract that verifies your tuition fees. **ALL DHHS-sponsored program participants MUST provide us with a current contract agreement.** Contract expirations are the parent/guardian's responsibility. Expired contracts will result in a complete tuition application to the parent/guardian effective immediately after the DHHS contract expiration date. Failure to pay the assessed parent/guardian fees will result in the application of total tuition fees or termination of childcare services. We reserve the right to change our fees when deemed necessary.

Canceling Services or Withdrawing Your Child Mid-Year

If, for any reason, a child is removed from the program, their slot will be filled immediately. If you wish to re-enroll the child at a later date, and a slot is available, the child may return, but their slot is not guaranteed.

> **NOTE: Two weeks' notice to change enrollment status or withdraw the child from the program must be given to the YMCA in writing or you will be charged accordingly.** Extended absences from the program MUST be coordinated with the Youth Development Administrator, Michelle Hunter (mhunter@sanfordymca.org).

Kids Out Enrichment Program

I hereby enroll my child in this facility's childcare program. I will require this program's services for the hours and days listed below. My payment will be made by the Friday prior to the week in which services are rendered. **Payment is due in advance on Fridays. Failure to follow the payment policy will result in immediate termination from all childcare programs and YMCA program services. NO EXCEPTIONS.**

2026-2027 Weekly Rates

	YMCA MEMBER (weekly)			NON-MEMBER (weekly)		
Days per Week	**Before Care Only**	**After Care Only**	**Both**	**Before Care Only**	**After Care Only**	**Both**
1-3 days	$80	$90	$110	$85	$95	$115
4-5 days	$90	$100	$120	$95	$105	$125

DO YOU RECEIVE 3RD PARTY CHILDCARE ASSISTANCE?

If no, please skip this page.

Please indicate which program you are using:

☐ Voucher, Child Care Subsidy Program
Contact person: Glenna Belanger

☐ Child and Family Services (Fostering/Adoption)

Contact Name: Phone: Email Address:

☐ Aspire/Transitional Care/FedCap

Contact Name: Phone: Email Address:

***Until confirmation of payment from the State is received, the FAMILY is responsible for ALL Child Care fees. Please be aware that this confirmation process can take two or more weeks to finalize. If you prefer to postpone enrollment until you receive confirmation, please keep in mind that a spot in the program is not guaranteed.

I have read and understand the above statement. Initial

Parent/Guardian Full Name: Child Full Name:

Phone Number: Email:

DEBIT/CREDIT CARD AUTHORIZATION FORM

Total weekly fee for child to be paid by parent/guardian: $

Families with 3 or more children enrolled in the program receive a 10% benefit applied to the lowest tuition among the children registered.

This contract is a binding agreement between the Sanford-Springvale YMCA (Childcare provider) and the signed party below.

Initial

Parent/Guardian Name:

Parent/Guardian Name:

Date:

I authorize the Sanford-Springvale YMCA to charge the debit/credit card listed below for program payments each week, as indicated below. Should any payment not be honored by said processor when received, then it is understood that I am to make the payment in the amount of said payment plus any service charge. It is further understood that if such payment is not honored by the debit/credit card institution, the Sanford-Springvale YMCA, at its discretion, may resubmit the amount due for payment on a future date.

Childcare Payments

I understand that Childcare payments will be submitted on the Friday before the week of service unless otherwise specified. I know that if I withdraw my child, I must give two weeks' written notice and that I will be charged for those two weeks automatically.

Initial

Debit/Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Card Holder Name:

Card Number:

Exp. Date:

Billing Address:

Amount charged weekly: $

Authorized Signature:

Date: