Safe N' Sound
2018-2019 School Year
Registration Form

Please print your Child's information clearly. Use one form per child.

____

Last Name **First Name** **School** **Grade**

☐ ______ **Before School** ☐ ______ **After School** ☐ ______ **Both AM and PM Program**

Start Date: __________________

Birth Certificate
Please note in order to register a copy of your student's birth certificate is required at the time of enrollment, along with the completed State of Illinois DHS Medical Form.

Ethnicity (Please check the box)-Optional

☐ Pacific Islander ☐ Native American ☐ Asian

☐ Hispanic ☐ African American ☐ Caucasian ☐ Bi-Racial

Please let us know of any special observances_____________________________

Name of Sibling(s) in Program: ______________________________________

Please select primary person responsible for payment:

- ☐ **Mom pays Full amount**
- ☐ **Dad pays Full amount**
- ☐ **Other arrangement(please list)**____

  ____

Registration: I understand that the registration fee is non-refundable. If for any reason my child is dropped from the Safe 'n Sound Program, I will need to re-register my child and that registration fee will be subject to availability.

Monthly Payments: I understand that monthly payments are due on the 15th of the month prior for Child Care for the following month. Payments must be made for my child to attend.

2-Week Notice- I understand that if I drop my child from the program and don't provide a 2 week notice, I will be responsible for paying those 2 weeks.

2018-2019 Y Safe 'n Sound
Payment Agreement

We are thrilled that you have chosen to enroll your child for the 17-18 school year at Safe 'n Sound! To ensure proper communication, we have outlined our policy related to Safe 'n Sound payments. If you have questions please feel free to contact us at 630.585.2207.

PLEASE READ CAREFULLY

1. A $125.00 registration fee is due at the time of registration.
2. **Registration Fees are non-refundable**.
3. All Payments are due on the 15th of the month prior to month your child is attending.
   - Example: For the Month of September all payments are due August 15th. All fees are paid over 9 months August-April. All payments including Bank and Credit Card Drafts occur on the 15th of the month prior to Child Care.

   An account is considered past due if payment has not been received by the 16th of the month prior to Child Care. A child will not be able to attend the program beginning on the 1st of the month if payment has not been received for that month. ***Past due fee** of $25 will be assessed if payments are not paid by the 25th of the month for the upcoming month.
   - Example: If payment is not received by August 16th your child cannot attend after September 1st until payment is made. If the fees are not paid by the August 25th you will be assessed a $25 past due fee. In order to stay active in the program your fees have to be current or you may risk losing your spot in the program.
4. If you wish to cancel your child's enrollment in the program, 2 weeks' paid notice is required and we must have it in writing by email at sns@ymcachicago.org.
5. There are no credits or refunds for missed days.
6. **Payment Options**: Payments cannot be made on site at individual schools
   - **Bank draft**: If you are interested in drafting a Draft Authorization needs to be completely **annually**. Please contact the office at 630-585-2207 to receive a Draft Authorization form.
   - **On-Line Payments** - visit www.ymcachicago.org/sns
   - **Pay in person** at any Naperville YMCA with check, cash, debit or credit card
   - **Pay over the phone** with debit or credit card 630.585.2207
   - **Mail check:** Safe 'n Sound 34 S Washington St., Naperville, IL. 60540

Late Pick-Up Fee-Children enrolled for Y safe and sound must be picked up by 6:00 p.m. Late fees are as follows:

TIME OF LATE PICK-UP (please check reflecting above time)	**AMOUNT TO BE CHARGED**
☐ UP TO 10 MINUTES	$5.00
☐ UP TO 15 MINUTES	$10.00
☐ UP TO 20 MINUTES	$15.00
☐ UP TO 25 MINUTES	$20.00
☐ UP TO 30 MINUTES	$25.00
☐ UP TO 35 MINUTES	$30.00
☐ UP TO 40 MINUTES	$35.00
☐ UP TO 45 MINUTES	$40.00
☐ UP TO 50 MINUTES	$45.00
☐ UP TO 55 MINUTES	$50.00
☐ UP TO 60 MINUTES	$55.00
☐ 5 or more times late picking up (Flat rate charge in addition to the late fee above for each additional offense)	$10.00

Late fees cannot be paid at the site. You will receive notification by email of the amount owed. Late fees must be paid before attending future weeks.

If you will be late picking up, please contact our office on 630-585-2207 and/or arrange for an alternative pick up to pick up your child if necessary. This, however, will not excuse the parent from paying the appropriate late fee. After the fifth time that a child is picked up late, the fee will increase to a $10.00 flat rate and include the late fee above. If a child is still at the site at 6:30 p.m. we reserve the right to notify the proper authorities.

7. I have read and understand the above statements. I fully understand my responsibility for payment of my child's enrollment fees. I also understand that my child may be released from the program if I have not met my financial obligations. Please read, sign, and date this form. Return this form along with your child's registration information.

Child's Name: ___________________________ **School Site:** ___________________

Parent's Signature: ______________________ **Date**: ___________________

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of Metro Chicago
PARTICIPANT EMERGENCY INFORMATION PACKET

PERSONAL INFORMATION PLEASE PRINT

Child's name:____ Birthdate:__________ Age:_____ Gender:______

Address:__________________________________ City:_____________________ State: ________ Zip: ______

Family e-mail address: ____

Name of School child attends: ____

Parent/Guardian #1:____________________________ Relationship:_________ Age:____ Cell phone:________________

Address:_____________________________________ City:______________________ State:_______ Zip:__________

Employer:________________________ Title:_______________ Work hours:___________ Work phone: ______________

Parent/Guardian #2:____________________________ Relationship:________ Age:_____ Cell phone:________________

Address:_____________________________________ City:______________________ State:_____ Zip:____________

Employer: ________________________ Title:_______________ Work hours:____________ Work phone:______________

Child lives with: oBoth Parents oMother oFather oOther ______________________

ADULTS AUTHORIZED TO PICK-UP MY CHILD/EMERGENCY CONTACTS OTHER THAN PARENT/GUARDIAN

(minimum of 2 are required)

	Name/Age	Relationship	Address	Preferred Phone
1.				
2.				
3.				
4.				
5.				
6.				

UNAUTHORIZED PICK-UP: People who CANNOT pick up your child from YMCA Session program:

1. Name____ Relationship: ______________________________

2. Name____ Relationship: ______________________________

AUTHORIZED PICK-UP/EMERGENCY PICK-UP: I,_______________________________ authorize the people listed above to pick up my child and be contacted in the event of an emergency from the _______________________________________ YMCA. In doing so, I relieve the YMCA of Metropolitan Chicago, its centers and employees of all responsibility for my child after he/she has been released from the program. Attempts will be made to reach the parent/legal guardian first. Initials_________

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? oYes oNo

If yes, indicate carrier or plan name:_________________ Group#:______ Doctor name:________________________

Phone number:______ Carrier address City/State/Zip:______________ Name of insured:_____ Relationship to participant:____

The following questions are asked so that we may best serve your child in programs.
Any information that you choose to disclose is confidential.

While in program, are there any health conditions that you would like us to be aware of?

o No o Yes, ______________________________

While in program, will your child need to take medication?

o No o Yes, ______________________________

While in program, are there allergies that we should be aware of?

o No o Yes, ______________________________

Allergic reaction (describe) ______________________________

Treatment ______________________________

Does your child require a modification, due to disability, in order to participate?

o No o Yes If you have any questions, please contact inclusion@ymcachicago.org

Are there activities that your child should be exempt from due to health reasons? ______________________________

Are all immunizations up to date?

o No (please provide exemption letter) o Yes Date of last Tetanus ______________________________

MEDICAL RELEASE:

I do hereby give permission for the YMCA of Metropolitan Chicago staff to transfer child named above off property for the purpose of medical care as deemed appropriate by the Director and in the event that I cannot be reached in an EMERGENCY, I hereby give my permission to the physician selected by the Director, to hospitalize, to secure proper treatment for and to order injection, anesthesia or surgery for my child as named above. Initials________

Please describe your child's interactions with children of the same age ______________________________

How would you describe your child's personality? ______________________________

SWIMMING ABILITY

o Non Swimmer o Fair Swimmer o Good Swimmer

Does your child have any fears that we should be aware of? ______________________________

Is there any other information that you would like to share so that we may better understand and work with your child? ______________

YMCA PARENT HANDBOOK

I/We have read and understand and adhere to the policies and procedures set forth in the Parent Handbook. Initials ________________

YMCA CHARACTER PLEDGE

My child and I have read and understand the character pledge found in the Parent Handbook. Initials________________

TALENT RELEASE FORM

In consideration of my participation in activities to be conducted and/or sponsored by the YMCA, the receipt and sufficiency of which is hereby acknowledged, I hereby freely and without restraint consent to and grant the YMCA of Metropolitan Chicago and its agents, successors, licensees, assigns, and affiliated entities (collectively, the "YMCA") the right to publish, print, photograph, videotape, record or otherwise reproduce my voice, appearance, opinions, statements, biographical information, name, place of residence (city and state) and other personal information concerning me, to own all the results thereof as a work for hire for copyright purposes, and to exhibit, display distribute, transmit and/or otherwise exploit any and all such reproductions containing my voice, opinions, statements, appearance, and/or other contributions, altered as the YMCA may see fit, in any and all media now or hereafter known, including without limitation by means of internet, email, still photography, billboard, radio, television, video, soundtrack recordings, printing, merchandising, public displays, exhibitions, and in advertising and/or publicity in connection therewith, and the right to use my name, city and state of residence in any connection with any of the foregoing. The rights granted by me hereunder are granted for the entire universe and shall inure in perpetuity and no further compensation shall be payable to me at any time in connection there with.

I hereby release the YMCA from any and all claims and demands arising out of or in connection with the uses stated above, including without limitation any and all claims for libel, slander, invasion of privacy, infringement of my right of publicity, defamation, copyright or trademark violation, and any other personal and/or proprietary rights, and I agree that I shall not now or in the future assert or maintain any such claim against the YMCA with respect to the subject matter herein. The release shall be governed by Illinois law without regard to its conflict of laws principles.

SIGNATURE OF PARENT/LEGAL GUARDIAN: ______________________________ DATE: ______________

PARENT CONSENT FOR ASSESSMENT

The YMCA of Metropolitan Chicago ("YMCA" or "we") is asking to collect assessments (i.e. surveys) from your child during the program day. We use these measures to evaluate how our programs currently serve the academic and social needs of your child and to plan ways to continue nurturing their development. Assessments often happen in the beginning and the end of the programming session, this way we can measure the growth of your child's development. The results of the assessment will be used to inform how YMCA staff trains and plans to best support your child.

We will use assessments widely utilized in child and youth programming that can provide reliable, valid scores to tell us more about a child's development across our mission anchors: Academic Readiness, Character Development, Violence Prevention, and Fitness and Healthy Living.

To allow your child to participate in the assessment, please fill in the form below. Results will be stored anonymously with the YMCA. Your child's name and any other identifying information will never be shared with parties outside the YMCA or published with information identifying your child. Results will not impact your child's participation or enrollment in YMCA programs.

Thank you for your participation!

I (Print your name) ______________________________, the parent/guardian of (print child's name) ______________________________ give my consent to YMCA's Learning and Evaluation staff and other professionals secured by the YMCA to conduct the assessments:

Parent/Guardian Signature ______________________________ Date ______________

Staff Signature ______________________________ Date ______________

Program Staff: Please return to Learning and Evaluation at lande@ymcachicago.org

FACILITY USER/FIELD TRIP AGREEMENT:

I agree to follow all rules and regulations of the YMCA of Metropolitan Chicago ("YMCA") while in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, and understand and agree that I may be expelled at any time, with no refund of any monies paid, for failure to abide by such rules and regulations.

IN CONSIDERATION OF BEING PERMITTED TO UTILIZE THE FACILITIES, SERVICES AND PROGRAMS OF THE YMCA FOR ANY PURPOSE, INCLUDING BUT NO LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT OR PARTICIPATION IN ANY PROGRAM AFFILIATED WITH THE YMCA WITHOUT RESPECT AS TO LOCATION, I HEREBY AGREE TO THE FOLLOWING:

1. I UNDERSTAND THAT ACTIVITIES AT THE FACILITY OR ELSEWHERE, INCLUDING USE OF EQUIPMENT AND PARTICIPATION IN PROGRAMS, CAN INVOLVE MOVEMENT, STRAIN AND OTHER ELEMENTS THAT CREATE RISK OF SERIOUS INJURY OR DEATH. I ALSO UNDERSTAND THAT PROGRAM ACTIVITIES INCLUDE FIELD TRIPS TO LOCATIONS OUTSIDE THE YMCA PREMISES, AS DESCRIBED IN DETAIL IN THE PROGRAM MATERIALS, AND THAT PUBLIC OR PRIVATE TRANSPORTATION MAY BE UTILIZED TO TRANSPORT PARTICIPANTS TO AND FROM THESE FIELD TRIP LOCATIONS. I HEREBY ASSUME FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE OR LOSS, regardless of severity, that I or my minor child/ward may sustain from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any Facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, or while being transported to and from field trip locations outside the YMCA premises, except for any injury damage or loss that is caused solely by the YMCA's gross negligence.
2. I, FOR MYSELF, ANY PERSONAL REPRESENTATIVES, ASSIGNS, HEIRS AND NEXT OF KIN, HEREBY FULLY RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE the YMCA or Metropolitan Chicago, its operating centers, their respective officers, directors, Board of Managers, Trustees, members, volunteers, employees or agents (the "Releasees") and each of them from any and all claims for injuries, damage or loss that I or my minor child/ward may incur whether in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA premises, except for any injury, damage or loss that is caused solely by the YMCA's gross negligence.
3. I HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS the Releasees and each of them from any loss, liability, damage or cost they may incur

from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, or while being transported to and from field trip locations outside the YMCA premises, except for any loss, liability, damage or cost that is caused by the YMCA's gross negligence.
I further expressly agree that this Agreement is intended to be as broad and inclusive as is permitted by the law of the State of Illinois and if any portion thereof is held invalid, it is agreed that the remaining Agreement shall, notwithstanding, continue in full legal force and effect.

THIS AGREEMENT APPLIES TO ALL PAST, PRESENT AND FUTURE VISITS AND USES BY ME TO ANY YMCA FACILITY OR PROPERTY.

I HAVE READ AND VOLUNTARILY SIGNED THIS FACILITY USE/FIELD TRIP AGREEMENT, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE AGREEMENT. THIS AGREEMENT CONTAINS A WAIVER AND RELEASE.

Signature of Parent/Legal Guardian____Date ______________________

Printed name of Parent/Legal Guardian ____

AUTHORIZATION FOR SUNSCREEN

By signing this form, I acknowledge that I will sufficiently apply sunscreen to all of my child's exposed skin, and agree that YMCA of Metropolitan Chicago Staff may reapply the sunscreen that I provide, labeled with my child's name.

Parent/Guardian Name:____

Parent/Guardian Signature:____

Date__________________________________Daytime Phone Number____

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																			Code:
Age/ Grade																			P = Pass
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	F = Fail U = Unable to test R = Referred
Vision																			G/C =
Hearing																			Glasses/Contacts

Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor ______ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐

Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** ______________

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** ______________

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)

Bill Payment Information and schedule
2018-2019 School year

We are asking that all payments are made prior to the program session.
Fees have been determined by spreading the total cost of the program into nine equal monthly installments based on about 180 days of school. Therefore, the monthly payment amount is always the same no matter how many program days occur in a month. Billing begins August 7th and ends April 5th. We bill in advance for tuition. Bills will be mailed to you after the 5th day of each month.

Program Session	Bill Release Date	Bill Due Date
September	August 6, 2018	August 15, 2018
October	September 4, 2018	September 17, 2018
November	October 5, 2018	October 15, 2018
December	November 5, 2018	November 15, 2018
January	December 5, 2018	December 17, 2018
February	January 7, 2019	January 15, 2019
March	February 5, 2019	February 15, 2019
April	March 5, 2019	March 15, 2019
May	April 5, 2019	April 15, 2019

Payments:
Bills are processed **in advance** on the 1st of each month and **are due on the 15th of every month** beginning August 15th**.** Example - August bill is for September service and is due August 15th. Nine equal monthly payments are billed. Last bill will be in April for May.
Credit card and checking account drafts are available and the draft occurs on the 15th of each month beginning August 15th. A Draft Authorization form is included in this packet.
An account is considered past due if payment has not been received by the due date as noted on the bill schedule. If a past due exists after the 25th of the month for the month ahead you will be charged a $25 past due late charge, the child will not be able to participate in the program beginning the first of the month if the account is not paid.
Any non-sufficient fund checks or returned bank or credit card payments will result in a $25.00 charge per check or return.

Payment options:

- Pay in person check, cash debit or credit card, at any YMCA
- Pay over the phone with a debit or credit card
- Pay online by visiting www.ymcachicago.org/sns Click on "Quick Links" then click on "Make Payment", Log In and go to my account and view balances
- Mail check to: 34 S Washington St., Naperville, IL, 60540
- Sign up for auto draft via credit card, checking or savings account
- Payments cannot be made on site at individual schools for those centers that have off site locations.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of Metro Chicago
DRAFT FORM – PROGRAM PARTICIPANT

OFFICE USE

Participant Last Name ________ Participant First Name ________ Center Initials ________ Member Number ________ Account Holder Name ________

AUTHORIZATION AGREEMENT FOR THE AUTOMATIC PAYMENT PLAN

This payment plan (the "Payment Plan") is provided at NO EXTRA CHARGE to you.

AUTOMATIC DEDUCTION FROM FINANCIAL INSTITUTION

I hereby authorize the YMCA of Metropolitan Chicago ("YMCA") and the Financial Institution designated below to begin automatic deductions from the account designated below in the amount of my monthly Program Fees as set forth below. I acknowledge that the organization of deductions from my account must comply with provisions of U.S. law.

☐ FOR AUTOMATIC PAYMENTS USING MY CREDIT OR DEBIT CARD

Charge my Credit/Debit Card ☐ Visa ☐ Discover ☐ Mastercard ☐ Amex Last Four Digits of Account Number ☐☐☐☐

Expiration Date ____/____ Security Code ________ Name as it appears on card ________________

☐ FOR AUTOMATIC PAYMENTS FROM MY CHECKING OR SAVINGS ACCOUNT

Financial Institution ________________ ☐ Savings ☐ Checking

Financial Institution Routing Number (9 digit number at the bottom of checking or savings deposit slip) ________________

Account Number ________________

City ________________ State ________________ Zip ________________

I understand that I may be required to attach a voided check or savings deposit slip to insure the accuracy of the account number and my financial institution identification transit/routing number if authorizing automatic debit.

AUTOMATIC DEDUCTIONS AND AUTOMATIC CHARGES

Program Type ☐ Aquatics ☐ Sports ☐ Swim Team ☐ Health & Fitness Program ☐ VEEP Session ________ Program Code ________

Total Program Fee ________ # of Months to Draft ________ of Months to Draft ________

The first draft of first charge will occur on the **1st** or **15th** (circle one) of ________ (month) ________ (year). The deduction or charge will occur on this day of each month or the first business day thereafter and the subsequent automatic deductions or automatic charges will occur on the same cycle.

I UNDERSTAND...

- I can cancel my program registration at any time by notifying the YMCA in person, by fax, by postal mail or by email with confirmation of receipt a minimum of 5 business days prior to my monthly payment date. Initials ____
- My monthly bank/credit card statement should show the amount and date payment was made to the YMCA. I understand that I am responsible for ensuring that the account designated above has sufficient funds/credit on my automatic payment due date to allow for the automatic deduction/charge of my payment.
- I need to supply the YMCA with **5 business days** notice of any changes I would like made to my account.
- I will receive written notice from the YMCA in advance of any changes to the date of my payments or the amount due, and I authorize the YMCA to use such changed dates or amounts after the written notice is sent to me, unless I cancel or change my payment plan using one of the methods listed above with proper notice.
- I am responsible for making sure my contact information is up-to-date, including any changes in my name, address, financial institution or account information.
- I will need to complete a new Draft Form if I would like changes to my financial institution or account information.
- The YMCA has the right to cancel my participation in the program if it is unable to collect payment due, and that I am liable for any uncollected payments, fees or penalties imposed by the YMCA or my financial institution.
- If my program draft is canceled for any reason, I must make arrangements to pay any outstanding balance due, fees or penalties by the YMCA and my family will not be allowed to register for program until those balances are paid.
- The YMCA will charge a $25 service charge for any returned checks and any denied attempts to draft from my credit/checking account.
- My financial institution may provide the YMCA with updated account information including account number and expiration date. I authorize to allow my membership payment to continue.
- By signing my name below, I agree that I have read, understand and accept these terms and will receive a copy for my reference

Printed Name of Account Holder ________________ **Signature** ________________ **Date** ___/___/___

Staff Signature entering into CCC ________________ **Date** ___/___/___