BEFORE & AFTER SCHOOL ENRICHMENT REGISTRATION FORM
Ferndale School District 2018–2019 (Grades K–5)

Child's Name: _____ M F Birthdate: ___ /____/ ____ Grade in Fall:_____

Address:_____ City:_____State:_____ Zip:_____

Parent's Email:_____

Primary email used for newsletters, program updates & billing.

Child Resides with: ☐Both ☐Mother ☐Father ☐Legal Guardian

Parent/Guardian #1

Name:_____

Home/Cell Phone: _____

Work Phone:_____

Employer: _____

Responsible for Payment/Copay: ☐Yes ☐No

Parent/Guardian #2

Name:_____

Home/Cell Phone: _____

Work Phone:_____

Employer: _____

Responsible for Payment/Copay: ☐Yes ☐No

SCHOOL	AFTER SCHOOL FEE SCHEDULE	BEFORE SCHOOL FEE SCHEDULE
	☐ 4–5 days/wk ☐ 2–3 days/wk ☐ 1 day/wk	☐ 4–5 days/wk ☐ 2–3 days/wk ☐ 1 day/wk
	DAYS OF THE WEEK	**DAYS OF THE WEEK**
DATE STARTING	☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri	☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri
	Auto-draft payments? ☐ Yes ☐ No	**NOTES:**

Complimentary Youth Membership included. *** The Annual Registration Fee is a one time charge, valid from September 2017–August 2018.**

EMERGENCY MEDICAL INFORMATION

Physician:_____ Phone: _____ Date of Last Physical Exam: _____

Address:_____ Immunizations Current (please circle): Yes No On file at:_____

Dentist:_____ Phone: _____ Date of Last Dental Exam: _____

Address:_____

Insurance Co: _____ Policy #: _____ Policy Holder: _____

ALLERGIES: 1. _____ Reaction: _____

2. _____ Reaction: _____

OTHER MEDICAL CONDITIONS OR SPECIAL NEEDS: (please describe)

_____

If special needs exist, please meet with Program Director before finalizing registration.

Does your child have an IEP or 504 plan ? Yes No

Does your child require an aide or participate in specialized instruction in the classroom? Yes No

EMERGENCY PICK-UP & SIGN OUT AUTHORIZATION: The following adults 16 years of age or older have my permission to sign out the above named child from YMCA and should be contacted in an emergency when I cannot be reached. I accept responsibility for informing the YMCA when the below information changes. **AT LEAST TWO NAMES ARE REQUIRED!**

1. Name: _____ 2.Name: _____ 3.Name _____

Relationship to child:_____ Relationship to child:_____ Relationship to child: _____

Home/Cell Phone: _____ Home/Cell Phone: _____ Home/Cell Phone:_____

Work Phone:_____ Work Phone: _____ Work Phone: _____

Parent/Legal Guardian Signature:_____ **Date:**_____

Desk Use only: ____ Reg Form ____ IMM Form ____ In Daxko ____ Reg Fee ____ DSHS

SACC Office use only: ____ Daxko ____ Reg Fee ____ IMM ____ MR ____ DSHS ____ No Photo ____ Site

Additional forms may be required for other programs.

- I hereby certify that my child _____ is in normal health and capable of safe participation in the program in which he or she is enrolling.
- I further give my permission for my child _____ to be given emergency medical treatment by a qualified Whatcom Family YMCA staff until parents can be reached and be present and/or emergency care arrives for treatment. In case of emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resources deem it necessary. In the event that I cannot be contacted, I further consent to the medical, surgical and hospital care to be performed for my child by a licensed physician or hospital when deemed immediately necessary by the physician to safeguard my child's health. It is understood that in some medical situations, the staff will need to contacted the local emergency resources before the parents, child's physician and/or other adults acting on the parent's behalf.
- I, the below signed person, having legal custody/guardianship of said minor, give permission for said minor to attend any YMCA program activities supervised by authorized YMCA staff.
- I have enclosed the appropriate deposit and registration fee as indicated above. I understand that these are both **NON-REFUNDABLE AND NON-TRANSFERABLE**. I understand that final payment is due according to the Parent Handbook & that failure to pay balances by the due date may result in the cancellation of this registration.
- **MEDICAL AUTHORIZATION & LIABILITY RELEASE:** As a parent/legal guardian, I hereby agree to hold harmless the YMCA staff, directors and volunteers from liability for any accidents resulting from participation and consent to the YMCA to secure emergency care as needed or prescribed at my expense for my child. This care may be given under whatever conditions are necessary to preserve life, limb or well being of my child. I also give permission to the YMCA to provide transportation as needed for my child in case of emergency, at my expense. I understand that it is my responsibility to inform the YMCA of any changes to my child's health.
- **SWIMMING ABILITY:** I understand that on my child's first visit to YMCA pools, my child will participate in a swim test. He/she will be placed into the appropriate swim level according to the lifeguard's evaluation as described in the parent handbook. Life jackets are available for those who require them based on swim test.
- **CLIMBING WALL RELEASE:** In consideration of the YMCA allowing the above named child to use the Climbing Wall, I the undersigned user, agree to indemnify & hold harmless the YMCA, its officers, directors, agents & employees, from all causes of action, claims, demands, losses & consequence of the neglect of the YMCA in safeguarding my use of the Climbing Wall, or because of any act, neglect or misconduct of the YMCA, its officers, agents & employees.
- **CONCUSSION INFORMATION:** Anyone who is suspected of sustaining a concussion or head injury in a practice or a game shall be removed from competition at that time and may not return to play until the participant is evaluated by licensed health care provider trained in the evaluation and management of concussions and received written clearance to return from that health care provider. You should also inform your child's coach/teacher if you think that your child may have a concussion. Remember that it is better to miss one practice/game than to miss the whole session. WHEN IN DOUBT, THE PARTICIPANTS SITS OUT. For more information go to http://www.ede.gov/concussion/HeadsUP/youth.html.

Please initial each box to <u>accept</u> the options below:

☐ **PHOTO RELEASE:** I do hereby grant permission for the YMCA (local, national and international) to use, without limitation or obligation, photographs or other media that may include my child's image or voice to promote or interpret YMCA programs.

☐ **TRANSPORTATION / FIELD TRIPS:** I understand that field trips are part of the School Age Child Care experience. I agree to allow my child to attend all field trips and to having my child transported via YMCA vehicles (owned or rented), WTA bus or walking.

☐ **STAFF BABY SITTING:** I understand that it is a YMCA policy to not allow staff to care for my child outside the YMCA camp day. I agree not to approach staff to baby-sit my child.

LIABILITY WAIVER: In consideration of being permitted to utilize the facilities, services and programs of the Whatcom Family YMCA ("YMCA") for any purpose including, but not limited to observation or use of facilities and equipment and participation in any program affiliated with the YMCA without respect to location. I, on behalf of myself and any children, dependent or personal representatives, hereby:

1. Acknowledge that I have (a) read this release and waiver of liability; (b) had the opportunity to inspect the YMCA's facilities and equipment or will immediately upon entering or participating will inspect and carefully consider such premises, facilities or program; (c) accept the facilities, equipment and program as being safe and reasonably suited for the purposes intended; (d) voluntarily sign this release and waiver of liability.
2. Release the YMCA, its directors, officers, employees, agents and volunteers (collectively "YMCA Releases") from all liability to me for any loss or damage to property or injury or death to person, whether caused by the ordinary negligence of the YMCA Releases or any other person, and while I am in, upon or about any YMCA branch or any facilities or equipment therein or participating in any program or service affiliated with the YMCA.
3. Agree not to sue the YMCA Releases for any loss, liability, damage, injury or death described above and I agree to indemnify and hold harmless the YMCA Releases and each of them from any loss, damage or cost they may incur due to my child's participation in, upon or about any YMCA branch or any facilities or equipment therein or my child's participation in any program or service affiliated with the YMCA whether caused by the ordinary negligence of the YMCA Releases or by any other person. I assume full responsibility for the risk of such loss, liability, damage, injury or death.

I intend for this release and waiver of liability to be as broad and inclusive as is permitted by the laws of the state of Washington if any portions hereof is held invalid, I agree that the balance shall continue in full force and effect.

1. Each year, a one time, non-refundable registration fee of $75 per child, $30 for second child, $0 for any additional children in the same family is required. Valid September through August and required for each new school year.
2. After School Enrichment is in operation ONLY when your child's school is in session. SEE WHEN SCHOOL IS NOT IN SESSION IN Handbook.
3. The following forms need to be completed in full PRIOR to enrollment:

   Registration
   Parent Contract
   Registration/Emergency Consent
   Immunization Record
4. For after school programs there is a minimum monthly charge of one day per week. Variable schedules must be billed within either Full Time or Part Time fee schedule. Part Time not available at all sites. Months with school vacations of 5 or more consecutive days will be charged 3/4 of all monthly fees. We reserve the right to increase fees due to school district schedule changes after May 2017.
5. All fees are due on or before the 5th day of the month of service. Care starting on or after the 8th of the month fee is pro-rated for that month and are due at time of registration. Full fees for the next month are due at time of registration, if registering after the 15th of the month.
6. Payment for your registered slot is due until written notice of cancellation is received by the Family Enrichment Office. Discontinued attendance without prior notice of cancellation will not result in credit. Cancellation after first day of the month requires a two week notice in order to receive billing credit.
7. Accounts not paid within 10 days of due date may result in termination of care. If space is available, care may be restarted upon payment of accounts past due amount and the next month's fees.
8. Late fees will be charged as of 6:00pm and may increase with frequency.
9. The schools do not notify us of absences. If your child is absent from after school care on a scheduled day, you need to notify the Bellingham YMCA before 1:00pm or a $5.00 "No Call" fee will be charged.
10. Absences due to illness, behavior issues or other unforeseen circumstances do not result in credit or make-up time.
11. Vacation credit or credit due to schedule changes may be given when we receive TWO WEEKS prior notice in writing (vacation credit given for 5 or more consecutive days within the school year). Credits will be applied to next bill.
12. Program participants paid through Department of Social & Health Services are responsible for all the above policies and additional fees and co-payments monthly.
13. The YMCA works closely with all Whatcom County Schools and Health Care Providers and reserves the right to communicate with your schools' personnel or physician regarding your child's individual needs. By signing below, you are giving the Whatcom Family YMCA your permission to contact your school to discuss your child's needs.

I have read, and understand this contract and the policies and procedures in the Parent Handbook and Supplemental. I agree to abide by the policies and know that if I would like a copy of either, the handbook or this contract, that they are available to me upon request or at www.whatcomymca.org. I also understand that I am responsible for all information in the monthly newsletter.

Parent/Legal Guardian Signature:_____Date:_____

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:	
Reviewed by:	Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No	

Please print. See back for instructions on how to fill out this form or get it printed from the Washington Immunization Information System.

Child's Last Name: **First Name:** **Middle Initial:** **Birthdate** (MM/DD/YY)**:** **Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY
Required Vaccines for School or Child Care Entry						
♦ **DTaP, DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV, MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	_____
❑ Hepatitis B	❑ Rubella	_____
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Information System (IIS) or filling it in by hand.

To print with immunization information filled in: Ask if your healthcare provider's office enters immunizations into the WA Immunization Information System (Washington's statewide database). If they do, ask them to print the CIS from the IIS and your child's immunization information will fill in automatically. You can also print a CIS at home by signing up and logging into MyIR at https://wa.myir.net. **If your provider doesn't use the IIS, email or call the Department of Health to get a copy of your child's CIS: waiisrecords@doh.wa.gov or 1-866-397-0337.**

To fill out the form by hand:

#1 Print your child's name, birthdate, sex, and sign your name where indicated on page one.

#2 Vaccine information: Write the date of each vaccine dose received in the date columns (as MM/DD/YY). If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

#3 History of Varicella Disease: If your child had chickenpox (varicella) disease and not the vaccine, **a health care provider must verify chickenpox disease to meet school requirements**.

- ❑ If your healthcare provider can verify that your child had chickenpox, ask your provider to check the box in the Documentation of Disease Immunity section and sign the form.
- ❑ If school staff access the IIS and see verification that your child had chickenpox, they will check the box under Varicella in the vaccines section.

#4 Documentation of Disease Immunity: If your child can show positive immunity by blood test (titer) and has not had the vaccine, have your healthcare provider check the boxes for the appropriate disease in the Documentation of Disease Immunity box, and sign and date the form. **You must provide lab reports with this CIS**.

Reference guide for vaccine abbreviations in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A	Hepatitis A	MCV / MCV4	Meningococcal Conjugate Vaccine	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B	Hepatitis B	MenB	Meningococcal B	PCV / PCV7 / PCV13	Pneumococcal Conjugate Vaccine	VAR / VZV	Varicella
DTP	Diphtheria, Tetanus, Pertussis	Hib	*Haemophilus influenzae* type b	MPSV / MPSV4	Meningococcal Polysaccharide Vaccine	PPSV / PPV23	Pneumococcal Polysaccharide Vaccine		
Flu (IIV)	Influenza	HPV (2vHPV / 4vHPV / 9vHPV)	Human Papillomavirus	MMR	Measles, Mumps, Rubella	Rota (RV1 / RV5)	Rotavirus		
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	MMRV	Measles, Mumps, Rubella with Varicella	Td	Tetanus, Diphtheria		

Reference guide for vaccine trade tames in alphabetical order For updated list, visit https://fortress.wa.gov/doh/cpir/iweb/homepage/completelistofvaccinenames.pdf

Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB®	Hib	Fluarix®	Flu	Havrix®	Hep A	Menveo®	Meningococcal	Rotarix®	Rotavirus (RV1)
Adacel®	Tdap	Flucelvax®	Flu	Hiberix®	Hib	Pediarix®	DTaP + Hep B + IPV	RotaTeq®	Rotavirus (RV5)
Afluria®	Flu	FluLaval®	Flu	HibTITER®	Hib	PedvaxHIB®	Hib	Tenivac®	Td
Bexsero®	MenB	FluMist®	Flu	Ipol®	IPV	Pentacel®	DTaP + Hib + IPV	Trumenba®	MenB
Boostrix®	Tdap	Fluvirin®	Flu	Infanrix®	DTaP	Pneumovax®	PPSV	Twinrix®	Hep A + Hep B
Cervarix®	2vHPV	Fluzone®	Flu	Kinrix®	DTaP + IPV	Prevnar®	PCV	Vaqta®	Hep A
Daptacel®	DTaP	Gardasil®	4vHPV	Menactra®	MCV or MCV4	ProQuad®	MMR + Varicella	Varivax®	Varicella
Engerix-B®	Hep B	Gardasil® 9	9vHPV	Menomune®	MPSV4	Recombivax HB®	Hep B		

If you have a disability and need this document in another format, please call 1-800-525-0127 (TDD/TTY call 711).

Washington State Department of Health

DOH 348-106 Jan 2015

Certificate of Exemption

SIDE A:
For Religious, Personal, Philosophical, and Medical Exemptions[1]

FOR OFFICE USE ONLY CHILD'S LAST NAME _____ FIRST NAME _____ M.I. _____

PART 1: PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be valid for religious, personal, philosophical, or medical reasons, please:

Step 1: Fill in your child's information in Boxes 1-4
Step 2: Read the Parent/Guardian Declaration
Step 3: Provide your initials where indicated
Step 4: Print your name, sign, and date in Boxes 5-6
Step 5: Have a provider complete Part 2 of this form

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy) _____/_____/_____

4. Gender
☐ Male
☐ Female

I am the parent or legal guardian of the above named child. One or more required vaccines are in conflict with my personal, philosophical, or religious beliefs.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from any or all required vaccine(s) may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

5. Print Parent/Guardian Name

6. Parent/Guardian Signature and Date _____/_____/_____

PART 2: HEALTHCARE PROVIDER INSTRUCTIONS

In order for this form to be valid, please:

Step 1: Mark which disease(s) and what type of exemption is requested. If medical write a **T** for Temporary or **P** for Permanent.
Step 2: Discuss the benefits and risks of immunizations with the parent or guardian
Step 3: Read the Provider Declaration
Step 4: Print your name, credentials, sign, and date in Boxes 7-8

Vaccine	Personal/ Philosophical	Religious	Medical (T/P)**	Expiration Date for Temporary Medical
Diphtheria				
Hepatitis B				
Hib				
Measles				
Mumps				
Pertussis				
Pneumococcal				
Polio				
Rubella				
Tetanus				
Varicella				
All				

***A provider may grant a medical exemption only if there is a medical contraindication to a vaccine.*

Provider Declaration

I declare that:

- *I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child.*
- *I am a qualified MD, ND, DO, ARNP or PA licensed under Title 18 RCW.*
- *The information provided on this form is complete and correct.*

7. Print Provider Name and Credential **(MD, ND, DO, ARNP, PA)**

8. Provider Signature and Date _____/_____/_____

[1]RCW 28A.210.080-090 "Before or on the first day of every child's attendance at any public and private school or licensed child care center in Washington State, the parent or guardian must present proof of either: (1) full immunization, (2) the initiation of and compliance with a schedule of immunization, as required by rules of the State Board of Health, or (3) a certificate of exemption signed by a parent or guardian and is either A) signed by a licensed healthcare provider or B) demonstrates membership in a church or religious body that precludes healthcare practitioners from providing medical treatment to children."

Washington State Department of Health

Certificate of Exemption

SIDE B:
For Religious Membership Exemption ONLY

FOR OFFICE USE ONLY CHILD'S LAST NAME FIRST NAME M.I.

NOTICE: Complete this side if you belong to a church or religion that objects to the use of medical treatment.[1]

If you have a religious objection to vaccinations, but the beliefs or teachings of your church or religion allow for your child to be treated by medical professionals such as doctors and nurses, then you must use Side A of this Certificate of Exemption.

PARENT OR GUARDIAN INSTRUCTIONS

In order for this form to be legally valid for religious membership reasons, please:

Step 1: Fill in your child's information in Boxes 1-4
Step 2: Read the Parent/Guardian Declaration and provide your initials where indicated
Step 3: Provide the name of the church or religion of which you are a member, and print your name, sign, and date in Boxes 5-7

1. Child's Last Name

2. Child's First Name and Middle Initial

3. Birthdate (mm/dd/yyyy)
_____/_____/_____

4. Gender
☐ M ☐ F

I am the parent or legal guardian of the above named child and I am exempting my child from all required vaccinations.

Parent/Guardian Declaration

I understand that:

- *My child may not be allowed to attend school or child care during an outbreak of the disease that my child has not been fully vaccinated against.* _____ ***(initial)***
- *Exempting my child from all required vaccines may result in serious illness, disability, or death to my child or others. I understand the risks and possible outcomes of my decision to exempt my child.* _____ ***(initial)***
- *The information provided on this form is complete and correct.* _____ ***(initial)***

I affirm that I am a member of a church or religion whose teachings preclude healthcare practitioners from providing any medical treatment to my child.

5. Name of Church or Religion of Which You Are a Member

6. Print Parent/Guardian Name

7. Parent/Guardian Signature and Date
_____/_____/_____

[1]RCW 28A.210.090 "The parent of legal guardian demonstrates membership in a religious body or a church in which the religious beliefs or teachings of the church preclude a health care practitioner from providing medical treatment to the child."

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Membership Enrollment Form

WHATCOM FAMILY YMCA

MEMBER ID NUMBER

HOME BRANCH

☐ BELLINGHAM ☐ FERNDALE ☐ LYNDEN

BILLING PARTY

FIRST NAME	MI	LAST NAME	M / F	BIRTH DATE (MM/DD/YYYY)
				/ /

MAILING ADDRESS	PRIMARY EMAIL	PRIMARY PHONE NO.
CITY, STATE, ZIP	ALTERNATE EMAIL	ALTERNATE PHONE NO.
EMERGENCY CONTACT NAME	RELATIONSHIP TO BILLING PARTY	EMERGENCY CONTACT PHONE NO.

HOUSEHOLD MEMBER INFORMATION (IF JOINING)

FIRST NAME	MI	LAST NAME	M / F	BIRTH DATE (MM/DD/YYYY)
1.				/ /
2.				/ /
3.				/ /
4.				/ /
5.				/ /

PLEASE ADD THE FOLLOWING SERVICES TO MY MEMBERSHIP

☐ TOWEL SERVICE	NAME	☐ LOCKER SERVICE #1	☐ LOCKER SERVICE #2
☐ TOWEL SERVICE	NAME	LOCKER #1	LOCKER #2
☐ TOWEL SERVICE	NAME	COMBO #1	COMBO #2

I would like to make a donation to the YMCA Annual Campaign to help those who cannot afford YMCA Programs or Memberships. I authorize the YMCA to add the following amount to my monthly bank draft to support financial assistance. ☐ ANNUAL CAMPAIGN ☐ $25 ☐ $15 ☐ $10 ☐ OTHER_____

EMPLOYER (S)

FIRST ADULT	SECOND ADULT

MONTHLY BILLING

DRAFT DATE	MEMBERSHIP TYPE:	STAFF ONLY:
☐ 1st OF EACH MONTH ☐ 15th OF EACH MONTH		FA/EXPIRES

PAYMENT OPTION (SELECT ONE)

☐ **Automatic Transfer System: Checking or Savings Account** ☐ **Automatic Transfer System: Debit or Credit Card**

MY SIGNATURE, BELOW, CERTIFIES I HAVE READ AND UNDERSTAND THE FOLLOWING:

I authorize an Automatic Transfer System (ATS) membership payment each month from the specified checking/savings account or debit/credit card, on or after the date specified. Returned debit/credit card charges may be assessed a $5 fee by the YMCA. The Y makes two attempts to collect the funds from your account.

I understand changes (includes membership cancellation) to my membership account must be received in writing two (2) weeks before my next draft date in order to take effect on my next draft date. I also understand the amount charged may change (with a 30-day notification) as a result of dues increase or membership type change. I am responsible for notifying the YMCA if my address changes.

SIGNATURE OF RESPONSIBLE PARTY	DATE	STAFF INITIALS

PLEASE COMPLETE BOTH SIDES OF THIS FORM TO ENSURE ENROLLMENT IS COMPLETE

The YMCA, as a not-for-profit organization, receives funding from the United Way and other foundations that require statistical information on our membership. The following information is optional, confidential & collect only for this purpose.

RACE

- ☐ Asian/Pacific Islander
- ☐ African American/Black
- ☐ Alaskan Native
- ☐ Caucasian/White
- ☐ Hispanic
- ☐ Multiracial
- ☐ Native American
- ☐ Other

HOW DID YOU HEAR ABOUT JOINING THE YMCA?

- ☐ Active Member Update
- ☐ Billboard
- ☐ Drove By
- ☐ Former Member
- ☐ Friend/Family
- ☐ Medical Referral
- ☐ Movie Theater Ad
- ☐ Newsletter
- ☐ Other
- ☐ Newspaper
- ☐ Pandora Radio Ad
- ☐ ParentMap Magazine
- ☐ Place of Employment
- ☐ Postcard
- ☐ Social Media
- ☐ Web Search Engine
- ☐ Website

PRIMARY LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Other -please write below:

WHAT ARE YOUR **ADULT** AREAS OF INTEREST?

- ☐ Adult Dance
- ☐ Adult Swim Lessons
- ☐ Adult Team Sports
- ☐ Cardio
- ☐ Cardio Strength
- ☐ Cycling
- ☐ Diabetes Prevention
- ☐ Family Activities
- ☐ Exercise & Thrive
- ☐ Flexibility, Balance & Core
- ☐ Healthy Lifestyles Programs
- ☐ Low Impact
- ☐ Martial Arts
- ☐ Mind-Body/Yoga
- ☐ Personal Training
- ☐ Small Group Exercise Classes
- ☐ Social Activities
- ☐ Strength
- ☐ Volunteer Opportunities
- ☐ Water Exercise

WHAT ARE YOUR **YOUTH** AREAS OF INTEREST?

- ☐ Academic Enrichment
- ☐ ACT! Actively Changing Together
- ☐ Adaptive Activities
- ☐ Camp
- ☐ Child Care
- ☐ Climbing Wall
- ☐ Competitive Activities
- ☐ Games & Activities
- ☐ Gymnastics
- ☐ Leadership
- ☐ Volunteer Opportunities
- ☐ Youth Dance
- ☐ Youth Fitness
- ☐ Youth Martial Arts
- ☐ Youth Sports
- ☐ Youth Swim Lessons

ARE YOU INTERESTED IN VOLUNTEERING AT THE YMCA?

- ☐ Aerobics/Group Exercise
- ☐ Aquatics
- ☐ Board Member
- ☐ Child Care
- ☐ Climbing Wall
- ☐ Coaching
- ☐ Family Recreation
- ☐ Fundraising
- ☐ Parent-Child Programs
- ☐ Resident Camp
- ☐ Senior Programs
- ☐ Social Activities
- ☐ Spinning
- ☐ Sports
- ☐ Strength Training
- ☐ Summer Camp
- ☐ Teen Activities
- ☐ Volunteerism
- ☐ Other

ACTIVITY LEVEL

- ☐ Already Active
- ☐ Previously Active
- ☐ First Time Exerciser

WOULD YOU LIKE TO VOLUNTEER TO HELP WITH THE YMCA ANNUAL CAMPAIGN?

- ☐ Yes - area of interest _____
- ☐ Yes - please contact me: _____
- ☐ No

CONDITIONS OF MEMBERSHIP

Member Health: The applicant represents that he/she is in physically sound condition and understand participation in aerobics and other exercise weight training, recreational sports and use of pools, saunas, steam rooms and fitness equipment carry a potential risk of injuries or illness. The applicant understands the Whatcom Family YMCA assumes no responsibility for any such injury or illness.

Member Conduct and Right to Use the Facility: Applicant agrees to abide by all policies and procedures of the Whatcom Family YMCA and its branches and understands failure to act in accordance with these rules may result in expulsion from the YMCA and revocation of the membership.

Criminal History: The applicant acknowledges it is the policy of the Whatcom Family YMCA to deny membership to any individual registered as a sex offender.

Property Loss: The applicant understands the Whatcom Family YMCA is not responsible for personal property lost, damaged or stolen while using YMCA facilities for participating in YMCA programs.

Photograph Permission: The applicant hereby grants permission for the YMCA to use, without limitation or obligation, photographs or other media that may include the member's image or voice to promote or interpret YMCA programs.

Insurance: The applicant understands the Whatcom Family YMCA does not provide any accident or health insurance for its members of participants and further understands it is the applicant's responsibility to provide such coverage.

Membership Billing: Any discrepancies to membership billing must be brought to the YMCA's attention within 90 days. The YMCA is not liable for any discrepancies to membership billing issues past 90 days.

RELEASE OF WAIVER & LIABILITY

I am aware that participation in YMCA programs and use of the YMCA facilities may involve certain hazards associated with equipment, physical exertion, games, sports and other programs/activities offered by the YMCA. In consideration of, and as part payment or, the right to use YMCA facilities and participate in YMCA programs, I will hold harmless the YMCA ("YMCA" includes its employees, volunteers, directors, officers and agents) for damages of any type, including permanent physical injuries or death, arising out of the ordinary negligence of the participation in YMCA programs. I fully understand and agree I am waiving all claims I may have against the YMCA arising out of the ordinary negligent acts by the YMCA, and I agree I will not bring a lawsuit against the YMCA arising out of its ordinary negligence. If any portion of the Release is held invalid, I agree the remainder shall continue to be enforceable.

SIGNATURE OF RESPONSIBLE PARTY	DATE	UNIT ID NO.
SIGNATURE OF ADDITIONAL ADULT APPLICANT	DATE	