



BEST TIME EVER!

FRIENDSHIP, ACCOMPLISHMENT, BELONGING YMCA of Alaska 2026 Leaders In Training Summer Day Camp Packet

INFORMATION

WHO

LIT
7th Grade & 8th Grade

CAMPER INFORMATION

Name: _____ Gender: Male Female

Date of Birth: / / Has IEP? Yes No

Time: 7:15am - 6:30pm Start Date: / / Grade: _____

Optional YMCA Membership: Youth Single Parent Family Military: Yes No

REGISTERING PARENT'S INFORMATION

Registering Parent's Name: _____

Parent's Date of Birth: / /

Registering Parent's Mailing Address: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

SUMMER DAY CAMP COST OF CARE:

Member Rate: \$380.00 Non - Member Rate: \$400.00 Non-Refundable Registration Fee: \$50.00

FEES PAID BY THE FOLLOWING

Registering Parent CCAP CITC OCS YMCA MFA

Payment method needed at the time of registration.

(Must attach a copy of assistance authorization or parent is responsible for childcare payment until we receive it.)

WE MUST HAVE THE FOLLOWING

- Summer Day Camp Registration Packet
- Parent Authorization Form
- Emergency Contact Record and IEP (if there is one)
- Medical Information Form
- Field Trip Authorization
- Automatic payment withdraw form for membership and childcare
- Current shot record or Legal Exemption
- Current Physical

PLEASE READ FOLLOWING STATEMENTS

I understand that the first Summer Day Camp payment must be paid by the 15th of May 2026.

If on assistance my portion of the bill must be paid by this date also.

I have received a Parent Packet and agree to abide by all policies and procedures in it.

A 2 week notice is required to change enrollment.

I understand that I am responsible for keeping my assistance authorizations current as I am ultimately responsible for all payments.

Permission is granted to the YMCA to use photographs of my child taken at the program for publicity and promotions.

Parent Signature: _____

Date: / /

Staff Signature: _____

Date: / /

FAMILY INFORMATION

Camper Information

Child's Full Name:

Nickname:

Does your child have an IEP? Yes No If so why?

Number of brother:

Number of sisters:

Any siblings enrolled in the School Age Program?

Who lives in the home?

Has your child been in a childcare setting before this?

How does your child feel about joining the School Age Program?

Does your child swim?

What does your child like to do during free time?

What type of discipline works best for your child?

What is your child's primary language?

Race/ethnicity (optional for grant info)

Please check all that apply:

- White
- Black
- Native
- Asian
- Hispanic
- Pacific Islander
- Other

ANNUAL INCOME

Please check your family's annual income:

- \$0 - \$25,000
- \$25,001 - \$35,000
- \$35,001 - \$45,000
- \$45,001 - \$55,000
- \$55,001 - \$65,000
- \$65,001 - \$75,000
- More than \$75,001

EMERGENCY RECORD CARD

Name (First/Last): _____

Date of Birth: / /

Siblings enrolled: Yes No

Start Date: / /

Custody Agreements: Yes No N/A

PARENT(S)/LEGAL GUARDIAN(S) INFORMATION

Name (First/Last): _____

Relationship: _____

Place of employment/Other: _____

Work phone: _____

Physical Address: _____

City: _____

State: _____

Zip: _____

Home #: _____

Cell #: _____

OK to send text: Yes No

Name (First/Last): _____

Relationship: _____

Place of employment/Other: _____

Work phone: _____

Physical Address: _____

City: _____

State: _____

Zip: _____

Home #: _____

Cell #: _____

OK to send text: Yes No

PERSONS AUTHORIZED TO PICK-UP CHILD

Name (First/Last): _____

Daytime #: _____

Cell #: _____

Emergency Routine

Name (First/Last): _____

Daytime #: _____

Cell #: _____

Emergency Routine

Name (First/Last): _____

Daytime #: _____

Cell #: _____

Emergency Routine

Name (First/Last): _____

Daytime #: _____

Cell #: _____

Emergency Routine

MEDICAL INFORMATION AND RELEASE FOR MEDICAL CARE

Name (First/Last): _____

Child Care Facility: _____

My child has ongoing health concerns: Yes No

If you checked yes please explain below:

Allergies (List): _____

Asthma Diabetes Seizures/Epilepsy Other (List): _____

My child takes the following medications (List): _____

Physician's Name: _____

Physician's #: _____

Preferred Hospital: Providence Regional ANMC JBER Other: _____

I, _____ the parent or legal guardian of _____, am verifying that this medical information is correct and complete. I hereby give the above named facility permission to seek emergency medical treatment, including necessary emergency paramedic transport for my child. I understand that every effort will be made to locate me or my child's other parent or legal guardian as soon as possible. I understand my obligation to keep my child care provider informed of my whereabouts. I will assume the cost of necessary medical or surgical care and any related medical transportation costs.

Parent/Guardian Signature: _____

Date: / /

MEDICAL INFORMATION AND RELEASE FOR MEDICAL CARE

Date & Initial

Date & Initial

Date & Initial

Date & Initial

Date & Initial

WHO

LIT's - Entering 7th and 8th grade

WHAT

Come experience our YMCA Day Camp. It is our goal to make camp an exciting and active learning experience for all. During Day Camp each counselor plans activities that focus on developing skills and clarifying values resulting in personal growth. Our values of caring, respect, honesty and responsibility are emphasized in all activities. Weekly Activities include: Archery, Hiking, Swimming, Field Trips, Community Service Projects, Nature Crafts, Arts and Crafts, and STEM Activities.

WHEN

Please check the weeks that you want your child to attend this summer:

- Week 1: June 1st -5th
- Week 2: June 8th - 12th
- Week 3: June 15th - 19th *
- Week 4: June 22th - 26th
- Week 5: June 29th - July 3rd *
- Week 6: July 6th- 10th
- Week 7: July 13th - 17th
- Week 8: July 20th - 24th
- Week 9: July 27th - 31st
- Week 10: August 3rd - 7th

*No Camp Friday Due to June 19th Holiday, Pro-Rated Week Non-Member \$320.00 Member \$300.00

*No Camp Friday Due to July 4th Holiday, Pro-Rated Week Non-Member\$320.00 Member \$300.00

WHERE

Northern Lights ABC School 2424 E Dowling Rd Anchorage, AK 99507

DATE OF PAYMENTS

<u>Pay by Date</u>	<u>For Camp Weeks</u>	<u>Member</u>	<u>Non - Member</u>
05/15/2026	06/01/2026 - 06/05/2026	\$380.00	\$400.00
05/15/2026	06/08/2026 - 06/12/2026	\$380.00	\$400.00
05/30/2026	06/15/2026 - 06/19/2026	\$300.00	\$320.00
05/30/2026	06/29/2026 - 06/26/2026	\$380.00	\$400.00
06/15/2026	06/29/2026 - 07/03/2026	\$300.00	\$320.00
06/15/2026	07/06/2026 - 07/10/2026	\$380.00	\$400.00
07/01/2026	07/13/2026 - 07/17/2026	\$380.00	\$400.00
07/01/2026	07/20/2026 - 07/24/2026	\$380.00	\$400.00
07/15/2026	07/27/2026 - 07/31/2026	\$380.00	\$400.00
07/15/2026	08/03/2026 - 08/07/2026	\$380.00	\$400.00

DISCOUNT AVAILABILITY

Please check the discount that apply (you may receive one or the other discount not both):

- 15% for active duty military families with proof of ID
- 10% for each additional sibling

BILLING

I hereby authorize the YMCA of Alaska to initiate debit transactions to my account indicated below, and for the financial institute named below to debit the same such account between the end of month (30th) and the (5th) of each month for my membership. Should the YMCA receive a NSF (non-sufficient funds) on my bank account, credit card or a returned check, a non-refundable Returned Payment Fee of \$30 will occur for any payments that do not process. Failure to address any NSF will result in termination of my membership. All Members, Non-Members, and Program Participants agree to pay a Service Fee on all payments made by credit card, 3%, and ACH, .32%. There are no Service Fees on payments made by debit card, cash, or check.

NAME OF ACCOUNT HOLDER OR DEBIT/CREDIT CARD

Name (first/last):

Address:

Phone:

EFT DRAFT

Financial Institution/Routing #:

Account #:

Account Type: Checking Savings

DEBIT/CREDIT CARD

Card #:

Expiration #:

3-digit Code:

Card Type: Visa Mastercard Discover

PRESCRIPTION MEDICATION

PARENT AUTHORIZATION FORM

I authorize _____ to administer the following prescription medication to _____
(Name of Facility)
(Child's Name)

Name of medication as listed on the label:

Medication	Dosage	Times Taken	Start Date	Stop Date	Parent's Int.

Parent Name (print): _____

Parent Signature: _____

Date: / /

Documentation of Administration of Medication:

Start Date	Times	Dosage	Staff Int.	Comments

According to AMC 16.55.370 the following requirements apply to the administration of prescription medications. It is not a requirement to complete the following, but highly recommended by the Department.

- | | |
|---|--|
| Packaged in original container <input type="checkbox"/> Yes <input type="checkbox"/> No
Clear dosage instructions <input type="checkbox"/> Yes <input type="checkbox"/> No
Expiration date checked <input type="checkbox"/> Yes <input type="checkbox"/> No | Child's name clearly listed on medication <input type="checkbox"/> Yes <input type="checkbox"/> No
Permission matches label directions <input type="checkbox"/> Yes <input type="checkbox"/> No
Pharmacy label attached <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

Staff Name (print): _____

Staff Signature: _____

Date: / /

LIT'S (7TH & 8TH GRADE) FIELD TRIPS & OUT AND ABOUT

TBA in April

Field Trips
06/05/2026
06/12/2026
06/19/2026
06/26/2026
07/03/2026
07/10/2026
07/17/2026
07/24/2026
07/31/2026
08/07/2026

Note: If there are any changes made to a scheduled field trip due to unforeseen circumstances you will be notified when you drop your child off for the day and a permission slip for the new field trip will need to be signed and dated by the parent. Field trips and out/about with a \$ listed next to them will have an additional charge of \$8.00 to \$10.00 be paid at the time of registration.

Parent/Guardian Signature: _____

Date: / /