



TIME TO EXPLORE SEE YOU THERE!

Mat-Su B&A School 2026-2027 Childcare Program

INFORMATION

STUDENT INFORMATION

Name:			Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Date of Birth:	/	/	Has IEP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
School Site:			Start Date:	/	/
Optional YMCA Membership:	<input type="checkbox"/> Youth	<input type="checkbox"/> Single Parent	<input type="checkbox"/> Family	Military:	<input type="checkbox"/> Yes <input type="checkbox"/> No

REGISTERING PARENT'S INFORMATION

Registering Parent's Name:		
Parent's Date of Birth:	/	/
Registering Parent's Mailing Address:		Zip:
Home #:	Work #:	Cell #:

AFTER SCHOOL COST OF CARE:

Before & After Rate: \$480.00	After Rate: \$380.00
Before Rate: \$300.00	

FEES PAID BY THE FOLLOWING

Registering Parent
 CCAP
 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

- Check Sheet
- Information Sheet
- Emergency Contact Record and IEP (if there is one)
- Automatic payment withdraw form for membership and childcare
- Current shot record or Legal Exemption
- Current Physical

PLEASE READ FOLLOWING STATEMENTS

I understand that fees must be paid by the 1st of the current month before attendance. 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: _____
 Staff Signature: _____

Date:	/	/
Date:	/	/

FAMILY INFORMATION

Student 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

AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL OF FUNDS

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

CONTRIBUTION INFORMATION

Your contributions to the YMCA will help provide a scholarship for lower income children to participate in this program (Please indicate your contribution amount and frequency):

Contribution Amount: \$

- Weekly
 Semi Monthly (1st and the 15th)
 Monthly
 Please make an ongoing contribution effective from: _____ to _____

AUTHORIZATION

I authorize the YMCA of Alaska to process debit entries from my account according to the:

- Membership (withdraw information above)
 Childcare (withdraw information above)

I understand that this authorization will remain in effect until I provide notification of its termination.

Signature: _____

Date: / /

HALF DAYS/HOLIDAY CAMPS

In-service days, Winter Break, and Spring Break – The fee is \$75 per day. If you know ahead of time that you will need care for these days, sign up now. The fee will be charged with your monthly bill. There will not be any refunds without a 2-week notice. Space is limited, so don't wait. Programs will be open 7:00 am–6:30 pm.

Half days, Winter Break and Spring Break will be at Dena'Ina Elementary school and Tanaina Elementary School.

2026 - 2027 WINTER BREAK

Please check location needed: Dena'Ina Elementary Tanaina Elementary

Please check dates needed:

- | | |
|---|---|
| <input type="checkbox"/> December 21 st , 2026 | <input type="checkbox"/> December 28 th , 2026 |
| <input type="checkbox"/> December 22 nd , 2026 | <input type="checkbox"/> December 29 th , 2026 |
| <input type="checkbox"/> December 23 rd , 2026 | <input type="checkbox"/> December 30 th , 2026 |

2026 - 2027 SRPING BREAK

Please check location needed: Dena'Ina Elementary Tanaina Elementary

Please check dates needed:

- | | |
|---|--|
| <input type="checkbox"/> March 8 th , 2027 | <input type="checkbox"/> March 10 th , 2027 |
| <input type="checkbox"/> March 9 th , 2027 | <input type="checkbox"/> March 11 th , 2027 |
| | <input type="checkbox"/> March 12 th , 2027 |

2026 - 2027 HALF DAYS

The fee is \$45 per day. If you know ahead of time that you will be needing care for these days, sign up now. The fee will be charged with your monthly bill. Care will take place at your regular school location. Please circle the dates you will need care.

Please check dates needed:

- | | |
|--|---|
| <input type="checkbox"/> November 2 nd , 2026 | <input type="checkbox"/> February 8 th , 2026 |
| | <input type="checkbox"/> February 15 th , 2026 |

Student's Name (First/Last): _____

I, _____, understand that the additional fee per date circled above will be charged with my monthly childcare bill.

Signature: _____

Date: / /