FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

EMILSON YMCA
April Vacation Program
Registration Form

We welcome your child to join us for our April Vacation Program. Together with friends, they will get to participate in swimming, sports, games, crafts, and more all while enjoying the beautiful Emilson campus of the South Shore YMCA in Hanover! Watch your child boost their confidence, make new friends, and expand their social skills in the care of our highly trained youth development team.

Grades: K-6
Fee: $92/day
Hours: 8am-5pm
Registration deadline: Friday, April 10th, 2026 @ 9AM for families using state vouchers or Wednesday, April 15, 2026 @ 9AM for families using self-pay *(registration is first come, first serve as space is limited)*

Child's Name: _____

Date of Birth: _____/_____/_____ Age: _____ Grade: _____

Parent/Guardian's Name: _____

Primary Phone: _____E-mail: _____

Please check off the day(s) your child will be attending:

☐ Monday, April 20th
☐ Tuesday, April 21st
☐ Wednesday, April 22nd
☐ Thursday, April 23rd
☐ Friday, April 24th

Payment Status:

☐ Payment Attached ☐ Financial Aid ☐ Child Care Voucher ☐ Account on File _____ (last 4 digits)

- **I understand that enrollment is limited and is on a first come, first serve basis.**
- **I understand that once I register my child, my payment is non-refundable/non-transferable regardless of whether or not my child attends the program.**

Parent/Guardian Signature: _____ Date: _____

SOUTH SHORE YMCA
ssymca.org

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Child Information Form

Child's Name: _____Telephone #: _____

Home Address: _____

Date of Birth: _____/_____/_____ Primary Language: _____

Gender Identity: _____Skin Color: _____ Eye Color: _____ Hair Color: _____

Identifying Marks: _____

Parent/Guardian Information:

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Parent/Guardian D.O.B. _____ Parent/Guardian D.O.B. _____

Relationship to Child: _____ Relationship to Child: _____

Home Address: _____ Home Address: _____

Primary Phone #: _____ Primary Phone #: _____

E-mail: _____ E-mail: _____

Bus. Name: _____ Bus. Name: _____
Bus. Address: _____ Bus. Address: _____

Bus. Phone #: _____ Bus. Phone #: _____

Working Hours: _____ Working Hours: _____

Additional Information:

Allergies/Special Diet: _____

Medications: _____

Chronic Health Conditions/Special Limitations: _____

☐ **I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements is on file at my child's school.**

Parent/Guardian Signature: _____ Date: _____

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First Aid and Emergency Medical Care Consent Form

Child's Name: _____

I authorize staff in the vacation camp program that is trained in the basics of first aid to give my child first aid when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or to _____, and to secure necessary medical treatment for my child.

Child's Physician Name: _____Telephone #: _____

Address: _____

Emergency Contacts (In order to be contacted)

Name: _____ Address: _____

Relationship to Child: _____ Telephone #: _____

Do you give permission for your child to be released from the program at the end of the day to this person?
Yes ☐ No ☐

Name: _____ Address: _____

Relationship to Child: _____ Telephone #: _____

Do you give permission for your child to be released from the program at the end of the day to this person?
Yes ☐ No ☐

Name: _____ Address: _____

Relationship to Child: _____ Telephone #: _____

Do you give permission for your child to be released from the program at the end of the day to this person?
Yes ☐ No ☐

Parent/Guardian Signature: _____ Date: _____

Please contact Samantha Blumberg-McSweeney at smcsweeney@ssymca.org, or call 781-826-7900 ext. 5240 with any questions. Make checks payable to the South Shore YMCA.

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PHOTO CONSENT AND RELEASE FORM

I, the undersigned, consent to the use of my (and/or my child's) likeness (photographic, video or otherwise), actions and appearance by the SOUTH SHORE YMCA in connection with any publication, program or in any and all media, including the SOUTH SHORE YMCA website, authorized by, made or published by the SOUTH SHORE YMCA, and to the advertising and publicity in any and all media now known or hereafter devised. The results and proceeds of my services in connection with any photographs, tapes, films or drawings shall be and remain solely the property of the SOUTH SHORE YMCA. I hereby release all rights or claims in law or equity for any injuries, loss or damage, which I may have now or in the future against the SOUTH SHORE YMCA, and any other person or entity connected with these media products.

I hereby acknowledge that I have read and fully understand and accept the foregoing by signing this consent and release on _____, 20____.

_____
Name of Child (Please Print)

_____
Name of Parent/Guardian

_____
Address/Phone Number

If the foregoing is a minor, one parent or legal guardian must sign the following:

I have read and understood and agreed with the provisions of the foregoing release and give my consent for my aforementioned minor child or ward to be photographed, taped, filmed or drawn in connection with the SOUTH SHORE YMCA for the use set forth in the foregoing release and consent.

_____
Signature of Parent or Guardian

……

I do not give _____permission to have pictures taken.

_____
Signature of Parent or Guardian

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Automatic Payment Deduction Responsibilities

Authority to Draw ACH Debits or Drafts for Childcare/Camp Payments

Your Name:
Address:
City, State and Zip:

Please circle "yes" and initial to give permission to charge the enrollment/registration fee from this account. YES ☐ Initial_____

Child's Name:	*Site:	Amount:$
Child's Name:	*Site:	Amount:$

*Site – Where is your child attending the program? (ex: ELC, GNC, Cole, etc.)

Checking/Savings Account:

Full Name Of Your Bank:	
Bank Transit Routing No:	Choose One: ☐ checking account ☐ saving account
Depositor's Account No:	Signature of Bank Depositor:

or

Credit/Debit Card:

Card Number:		
Expiration Date:	CVV:	Full Name on Card:

Authorization:

I hereby authorize the SOUTH SHORE YMCA to charge the amount based on my payment schedule to the Checking/Savings Account or Credit/Debit Card listed above.

- It is my responsibility to notify the YMCA immediately of any account changes or account closing and to provide the YMCA with the current account information.
- The YMCA reserves the right to refuse entrance into the program if payments are delinquent. Full payment of delinquent balance will be required for reinstatement into the program.
- The Childcare Business Office will contact you for payment if your automatic payment is declined. A service charge will be applied by the YMCA to my bank or credit card company.

I have reviewed the above rules and understand the responsibilities of the Automatic Payment Deduction.

Authorized Payer's Signature: _____

Effective Date of Change:_____ Today's Date:_____

EEC Individual Health Care Plan Form

Name of child: Date of Birth:
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Who has been trained and will be administering this treatment while the child is at the program (to be completed by program staff):
Potential side effects of treatment:
Potential consequences if treatment is not administered:
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)

Name and Phone Number of Licensed Health Care Practitioner (please print):_____

Parental/Guardian Signature: _____Date:_____

Program Administrator Signature: _____ Date:_____

For Older Children ONLY (9+ years of age)

In accordance with 606 CMR 7.11(3)(b-c) and with written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _____ Date of birth: _____ Back-up medication received ☐ YES ☐ NO

Parent's Signature: _____ Date: _____

Program Administrator's Signature: _____Date: _____

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: ☐ Oral/Non-Prescription: ☐

Unanticipated Non-Prescription for mild symptoms ☐

Topical Non-Prescription (**applied to open wound/ broken skin)** ☐

My child has previously taken this medication ☐

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan ☐

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature* _____ **Date** _____

I, _____, (parent or guardian) gives permission
(print name)
to authorize educator(s) to administer medication to my child as indicated above.

***You may include your doctor's up to date medication action plan (signed) in place of this signature.**

Parent/Guardian Signature _____ **Date** _____
For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**