

Register NOW for school year activities.

No child is turned away because of the family's inability to contribute.

Father/Guardian Name: _____ Mother/Guardian Name: _____
 Address: _____ City/State/Zip: _____
 Home Phone: _____ Is this a new address or phone? Yes No E-mail: _____
 Father's Cell/Work Phone: _____ / _____ Mother's Cell/Work Phone: _____ / _____

Child's Name: _____ Male Female
Birth Date: _____

PROGRAM INFORMATION

Age: ____ School: Axtell Park Edison Memorial Patrick Henry Whittier Grade: 6th 7th 8th

Student Sign-in/Sign-out: Student must contact a staff member to properly sign-in/out; upon signing out early, student must leave the ASP immediately and has 10 minutes in which to leave the building and grounds; student may not return to the ASP that day; ALL students must leave the ASP by 5:45pm and the property by 6:00pm; violations of these time limits may lead to suspension &/or termination from the ASP; any student under "in-school" &/or "out-of-school" suspension may NOT attend the ASP on the day(s) of suspension. I have read and agree to uphold the guidelines as stated in the ASP brochure as well as abide by the rules established by the ASP staff.

Waiver and Consent: I am the parent/guardian of the above named child and do hereby give consent: to his/her participation in the above named ASP; to take part in ASP planned local field trips; to ride in any YMCA busses or other vehicles; to use participant photos for promotional use; and do hereby waive any claim for liability &/or damages against the Sioux Falls Family YMCA, any of its employees, or any person assisting in said activity for any damage &/or injury which may be sustained by the above named child during such activity. In case of emergency, every effort is made to contact the parent/guardian. If unavailable, I hereby give permission to the physician selected by the Program/Site Director to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for the above named child. I further accept responsibility for medical/surgical treatment charges, which may be incurred on the above named child's behalf.

PLEASE LIST ANY MEDICAL NEEDS OR CONCERNS THAT THE YMCA ASP STAFF NEEDS TO BE AWARE OF:

Child's Signature: _____ Date: _____

Parent/Guardian Signature _____ Date: _____



The ASP is made available through the cooperative efforts of the Sioux Falls Family YMCA and Sioux Falls Public Schools. We greatly appreciate the financial support received from the Sioux Empire United Way, City of Sioux Falls, SD Arts Council, Golf Classic Sponsors, JCPenney and 21st Century Community Learning Centers. However, their support does not cover all of this program's cost of operation.

YOU ARE IMPORTANT TO THIS PROGRAM!

This is a contribution based program. No child is turned away because of inability to contribute. However, if your family is able to contribute any amount please complete the box to the right. The suggested contribution for the program is **\$250 per child, per school year**. Although the actual cost per child is much higher, through family contributions, we will be able to continue to offer this valuable program to kids, families and the community.

TOTAL CONTRIBUTION \$ _____

Cash Check # _____ (Made payable to YMCA)

Credit Card: AM. EXPRESS DISCOVER

MASTERCARD VISA

Name: _____

Card #: _____ Exp. Date: _____

Signature: _____

*****OFFICE USE ONLY*****

Amount Paid:\$ _____ Date Paid: _____ YMCA Staff _____