



**FOR YOUTH DEVELOPMENT  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY**

# **WE DIG Y PRESCHOOL**

## **DISCOVER • IMAGINE • GROW**

### **Just for 2's**

2 days; T/Th  
9:00 -10:00 am

\$50 Registration Fee

Y Member: \$64 month  
Non-Member: \$84 month

### **Y Tykes Academy**

3-4 yr. olds  
4 days; M-Th  
9:00am -12:00pm

\$95 Registration Fee

Y Member: \$121 month  
Non-Member: \$159 month

**Parent's must bring in copy of their child's Birth Certificate.**



**2024-2025  
YMCA PreSchool  
Illinois Valley YMCA  
815.223.7904**





# Welcome

## To the Y Pre-School



Dear Parents,

We are delighted that you have chosen the Illinois Valley YMCA Pre-School Program for your child this year. It is our goal to make your child's preschool experience a memorable one that is filled with learning and fun!

You and your child are responsible for snacks. A list will be distributed the first week of school. We look forward to seeing you on the first day of school.

### Illinois Valley YMCA Part Time Preschool Registration **2024-2025**

#### Y Tykes Academy: 3 & 4 year olds

Y Tykes Academy: **Y Members (\$121) & Non-Members (\$159)** 9am to Noon / 4 days M.T.W.Th

Tykes Academy includes swimming and gym time.

Must be 3 yrs. old by Sept. 1<sup>st</sup>, 2024 - **NO EXCEPTIONS!**

**Registration & Supply Fee: \$95 (Non- refundable)**

#### Just for Two's

Just for Two's 2: **Y Members (\$64) & Non-Members (\$84)** 9am to 10am / 2 days T.Th

Must be 2 yrs. old by Sept. 1<sup>st</sup>, 2024 - **NO EXCEPTIONS!**

Not necessary to be toilet-trained, but we DO NOT change diapers.

**Registration & Supply fee: \$50 (Non- refundable)**

#### Requirements & Information

**Parents are required to provide physical exam records with all immunizations up to date.**

- New records must be provided each year. (Signed by the physician)
- Child's Birth Certificate (Certified)
- All full classes have 2 qualified instructors (1 teacher & 1 assistant)
- **All class tuition is to be paid by BANK DRAFT.**

## **CLASS BEGIN TUESDAY, SEPTEMBER 3, 2024**

**Respect**



**Caring**

**Responsibility**

**Honesty**



**Illinois Valley Y**  
**Child Enrollment Information**

**General Information:**

Child's Name \_\_\_\_\_ Name Used at Home \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Present Age \_\_\_\_\_ Sex: M/F \_\_\_\_\_

Email \_\_\_\_\_

<b><u>Parents</u></b>	Name	Address	Phone
-----------------------	------	---------	-------

Mother \_\_\_\_\_

Father \_\_\_\_\_

Legal Guardian \_\_\_\_\_

<b><u>Places of Employment</u></b>	Name	Address	Phone
------------------------------------	------	---------	-------

Mother \_\_\_\_\_

Father \_\_\_\_\_

Legal Guardian \_\_\_\_\_

**Family Status**

Marital Status:      Married/Divorced/Separated/Single

If divorced or separated, who has permanent custody of the child? \_\_\_\_\_

Do we have a copy of custody papers on file?      Yes/No

Names and Ages of Other Children at Home

Age

Relationship

Age

Relationship

Age

Relationship

Age

Relationship

Age

Relationship





## Illinois Valley YMCA Statement of Understanding

The following information is important for the safety and protection of your child. Please read the information, sign this form and return it to the Y's Montessori School. Keep and refer to your copy of the Montessori School Policies. Your signature below indicates that you have received and read them.

I understand that the YMCA Staff and Volunteers are not allowed to babysit or transport children at any time outside of the YMCA Program. **There will be immediate disciplinary action taken by the YMCA towards staff and volunteers if a violation is discovered.**

I understand that I am not to leave my child at the YMCA or program site unless a YMCA Staff or Volunteer is there to receive and supervise my child.

I understand that my child will not be allowed to leave the program with an unauthorized person. Any person authorized to pick up my child must either be listed with the YMCA or other arrangements must be made by calling the YMCA Montessori School to inform them of the change.

I understand that should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse to contact the police. Please DO NOT put Y Staff in a position where they have to make that decision, and we ask that you DO NOT put your child in an unsafe position.

I understand that the YMCA is mandated by state law to report any suspected cases of abuse or neglect to the appropriate authorities for investigation.

I have read and understood the statements above.

---

Mother's Signature/Legal Guardian

Date

---

Father's Signature/Legal Guardian

Date



## Emergency Medical Authorization

In the event of my child's sickness or accident, I expect to be contacted. However, if I cannot be reached, I, the undersigned, hereby give my consent for the attending YMCA Staff Member to provide emergency care and/or treatment for my child through a clinic, hospital or private doctor. I give my express consent for x-rays if the attending physician feels it is advisable or necessary.

I also agree to pay all costs and fees contingent upon any emergency medical care and/or treatment for my child as secured or authorized under this consent. This agreement shall continue as long as my child is enrolled at a program of the Illinois Valley YMCA.

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Parent's Name \_\_\_\_\_  
Father/Guardian Mother/Guardian

Insurance Company Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_

Physician's Name & Phone Number \_\_\_\_\_

I give my consent for emergency first aid to be administered to my child by a staff member certified in first aid. I understand that for an accident involving an injury of a more serious nature, an ambulance will be called.

\_\_\_\_\_  
Father's Signature Date

\_\_\_\_\_  
Mother's Signature Date

\_\_\_\_\_  
Guardian's Signature Date



## Pre-School Pick-Up Authorization

The following names are people I have entrusted the responsibility of picking up my child/children from the Illinois Valley YMCA Pre-School Program.

I understand that, if for some reason (i.e. family emergency), somebody else will be picking up my child. I must first notify the YMCA at 815.223.7904 and give the name of that person.

I also understand that the YMCA Staff, in my child's best interest, will not allow my child to leave with anyone who is not on the list or with anyone who appears to be intoxicated. The staff will notify the proper authorities of any problems that will put your child in danger of any kind.

Father's/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Mother's/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Authorized Persons

<u>Print name</u>	<u>Sign Name</u>	<u>Phone Number</u>
-------------------	------------------	---------------------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------

_____	_____	_____
-------	-------	-------



# State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED  
CHILD CARE FACILITIES  
CFS 600  
Rev 11/2013

Illinois Department of  
**DCFS**  
Children & Family Services

<b>Student's Name</b>				<b>Birth Date</b>		<b>Sex</b>		<b>Race/Ethnicity</b>		<b>School /Grade Level/ID#</b>					
Last		First		Middle		Month/Day/Year									
Address				Street		City		Zip Code		Parent/Guardian Telephone # Home Work					
<b>IMMUNIZATIONS:</b> To be completed by health care provider. Note the mo/da/yr for <i>every</i> dose administered. The day and month is required if you cannot determine if the vaccine was given <i>after</i> the minimum interval or age. <b>If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.</b>															
<b>Vaccine / Dose</b>	<b>1</b>		<b>2</b>		<b>3</b>		<b>4</b>		<b>5</b>		<b>6</b>				
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR			
<b>DTP or DTaP</b>															
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT					
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV					
<b>Hib</b> Haemophilus influenza type b															
<b>Hepatitis B (HB)</b>															
<b>Varicella</b> (Chickenpox)										<b>COMMENTS:</b>					
<b>MMR</b> Combined Measles Mumps. Rubella															
<b>Single Antigen</b> Vaccines	<b>Measles</b>		<b>Rubella</b>		<b>Mumps</b>										
<b>Pneumococcal Conjugate</b>															
<b>Other/Specify</b> Meningococcal, Hepatitis A, HPV, Influenza															
<b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.</b> If adding dates to the above immunization history section, put your initials by date(s) and sign here.)															
<b>Signature</b>				<b>Title</b>				<b>Date</b>							
<b>Signature</b>				<b>Title</b>				<b>Date</b>							
<b>ALTERNATIVE PROOF OF IMMUNITY</b>															
<b>1. Clinical diagnosis is acceptable if verified by physician.</b> *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)															
<b>*MEASLES (Rubeola)</b> MO DA YR <b>MUMPS</b> MO DA YR <b>VARICELLA</b> MO DA YR <b>Physician's Signature</b>															
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.															
<b>Date of Disease</b>			<b>Signature</b>			<b>Title</b>			<b>Date</b>						
<b>3. Laboratory confirmation (check one)</b> <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Varicella <b>Lab Results</b> Date MO DA YR (Attach copy of lab result)															

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN																
<b>Date</b>																<b>Code:</b>  <b>P = Pass</b> <b>F = Fail</b> <b>U = Unable to test</b> <b>R = Referred</b> <b>G/C =</b> <b>Glasses/Contacts</b>
<b>Age/ Grade</b>																
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	
<b>Vision</b>																
<b>Hearing</b>																



Student's Name			Birth Date		Sex	School	Grade Level/ ID #
Last	First	Middle	Month/Day/ Year				
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER							
ALLERGIES (Food, drug, insect, other)				MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during the night	Yes	No					
Birth defects?	Yes	No		Hospitalizations?	Yes	No	
Developmental delay?	Yes	No		When? What for?			
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.)	Yes	No	
Diabetes?	Yes	No		When? What for?			
Head injury/Concussion/Passed out?	Yes	No		Serious injury or illness?	Yes	No	
Seizures? What are they like?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Heart problem/Shortness of breath?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart murmur/High blood pressure?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Alcohol/Drug use?	Yes	No	
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Dental <input type="checkbox"/> Braces <input type="checkbox"/> •Bridge <input type="checkbox"/> •Plate Other			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)							
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis?	Yes	No		Parent/Guardian Signature _____ Date _____			
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA							
HEAD CIRCUMFERENCE		HEIGHT		WEIGHT		BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>							
LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Questionnaire Administered ? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ (Blood test required if resides in Chicago.)							
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>							
Skin Test: Date Read / /		Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		mm _____			
Blood Test: Date Reported / /		Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		Value _____			
LAB TESTS (Recommended)		Date	Results			Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)			
Urinalysis				Developmental Screening Tool			
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs			Normal	Comments/Follow-up/Needs	
Skin				Endocrine			
Ears				Gastrointestinal			
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>		Genito-Urinary		LMP	
Nose				Neurological			
Throat				Musculoskeletal			
Mouth/Dental				Spinal Exam			
Cardiovascular/HTN				Nutritional status			
Respiratory		<input type="checkbox"/> Diagnosis of Asthma		Mental Health			
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g.Short Acting Beta Antagonist ) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)				Other			
NEEDS/MODIFICATIONS required in the school setting				DIETARY Needs/Restrictions			
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
MENTAL HEALTH/OTHER Is there anything else the school should know about this student?							
If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal							
EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?							
Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.							
On the basis of the examination on this day, I approve this child's participation in				(If No or Modified,please attach explanation.)			
PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>				INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>			
Print Name		(MD,DO, APN, PA)		Signature		Date	
Address				Phone			
(Complete both sides)							



**Illinois Valley YMCA**  
**Facility User/Visitor Agreement**

Date\_\_\_\_\_

Name\_\_\_\_\_ Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_ Age\_\_\_\_\_ Sex\_\_\_\_\_

Home Phone\_\_\_\_\_ Work Phone\_\_\_\_\_ Email\_\_\_\_\_

**In Case of an Emergency, Please Notify:**

Name\_\_\_\_\_ Phone Number\_\_\_\_\_

Relation\_\_\_\_\_

I agree to follow all rules and regulations of the Illinois Valley YMCA while in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the IVYMCA without respect as to location, and understand and agree that I may be expelled at any time, with no refund of any monies paid, for failure to abide by such rules and regulations.

In consideration of being permitted to utilize the facilities, services and programs of the YMCA for any purpose, including but not limited to observation or use of facilities or equipment or participation in any program affiliated with the YMCA without respect as to location, I hereby agree to the following:

1. I understand that activities at the facility or elsewhere, including use of equipment and participation in programs, can involve movement, strain and other elements that create risk of serious injury or death. I hereby assume full responsibility for and risk of bodily injury, death or property damage or loss, regardless of the severity, that I or my minor child/ward may sustain from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the IVYMCA without respect as to location, except for any injury, damage or loss that is caused solely by the IVYMCA's gross negligence.
2. I, for myself, any personal representatives, assigns, heirs and next of kin, hereby fully release, waive, discharge and covenant not to sue the Illinois Valley YMCA, its operating centers, their respective officers, directors, Board of Managers, Trustees, members, volunteers, employees, or agents(the "Releases") and each of them from any and all claims for injuries, damages or loss that I or my minor child/ward may have or which may accrue to me or my minor child/ward from my and/or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program with the IVYMCA without respect as to location except for any injury, damage or loss that is caused solely by IVYMCA's gross negligence.
3. I hereby agree to indemnify and save and hold harmless the releases and each of them from any loss, liability, damage or cost they may incur from me or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the IVYMCA without respect as to location, except for any loss, liability, damage or cost that is caused solely by the IVYMCA's gross negligence.

I further expressly agree that the foregoing assumption of risk, release, waiver and indemnity agreement is intended to be as broad and inclusive as is permitted by the law of the State of Illinois and if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

This agreement applies to all past, present and future visits and uses by me to any YMCA facility or property.

I have read and voluntarily signed this assumption of risk, release, waiver and indemnity agreement, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

**DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE AGREEMENT. THIS AGREEMENT CONTAINS A WAIVER AND RELEASE.**

Signature\_\_\_\_\_ Date\_\_\_\_\_

(Participant's signature)

Signature\_\_\_\_\_ Date\_\_\_\_\_

(in case of a minor ONLY: Parent/Guardian's Signature)



## NATIONWIDE MEMBERSHIP WAIVER

"By participating in the YMCA Nationwide Membership Program, I agree to release the National Council of Young Men's Christian Associations of the United States of America, and its independent and autonomous member associations in the United States and Puerto Rico, from claims of negligence for bodily injury or death in connection with the use of YMCA facilities, and from any liability for other claims, including loss of property, to the fullest extent of the law."

**DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE AGREEMENT. THIS AGREEMENT CONTAINS A WAIVER AND RELEASE.**

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Participant's signature)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(in case of a minor ONLY: Parent/Guardian's Signature)





# Photography Release Form

I hereby authorize the Illinois Valley YMCA and the Mendota Area YMCA, hereafter referred to as "Company," to publish photographs taken of me during the 2024-2025-year and my name and likeness, for use in the magazine publication, Embody Health, online (including social media), and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless the Illinois Valley YMCA and the Mendota Area YMCA from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release the Illinois Valley YMCA and the Mendota Area YMCA, its contractors, employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participations.

## Authorization

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



## **Illinois Valley Y Pre-School Program Policies**

1. YMCA programs will be high quality programs, meeting all licensing regulations, YMCA quality guidelines or accreditation standards. Ratios of the number of staff to children should allow for easy supervision of all children in the program.
2. In every program the YMCA staff will insist on an "open door" policy. We encourage parents to visit any one, or all of the programs their child is attending any time of the day. We do not require any special invitation from the staff to visit. We are encouraged by parental involvement, and we recognize the parents as partners in our program.
3. The YMCA programs are committed to strengthening families and the values that they teach. We hope that through parental visits and discussion with the program staff, we can establish and nurture a sense of trust among parents and the YMCA.
4. A pick-up and release policy must be signed by the parents before the child is allowed into a program. Children will only be released to individuals whose names appear on the policy form. Staff unfamiliar with those adults picking up the child may ask for identification. This is only for the safety of your child.
5. At no time during a program will a staff member be alone with a single child unobserved by other staff. If staff finds themselves in this position, they will move to an area that is more open and public, within the program site area, so they can be seen by others.
6. Children will never be left alone in the bathrooms or locker rooms. If necessary, the group will move as a whole from activity to activity.
7. At least 2 staff members will be present at all times in our child care and development programs.
8. Staff and volunteers who work with the YMCA programs will wear name tags and/or staff shirts. This is done so the children will recognize the staff as a "safe haven" in case of a problem.
9. All YMCA programs will support appropriate behaviors, good manners and good sportsmanship.



## Illinois Valley Y/Mendota Area Y Voucher and Refund Policy

### Program Cancellation Information

1. Payment of class fee is required at time of registration in order to secure your enrollment.
2. Certain programs have a separate registration form.
3. Refunds/Credit Vouchers

### Definitions:

**Refund** – The YMCA will send a check for the amount owed to the member/participant.

Processing a refund may take up to two weeks.

**Credit Vouchers** – The YMCA will electronically deposit the credit amount into the member/participant's YMCA account (not a bank account).

It can be redeemed toward any program, product or service the Illinois Valley YMCA offers.

- a) The YMCA reserves the right to cancel, reschedule or combine classes that do not have sufficient enrollment. In the event of a canceled class due to lack of enrollment, a full refund or credit will be issued.
- b) A pro-rated refund will only be given if participation ceases due to medical reasons. A note from the doctor will enable one to receive a refund.
- c) There are no credits given for individual classes missed.
- d) No refunds/credits are given on individual classes cancelled due to weather.
- e) Some programs require a deposit/registration fee that is non-refundable. Participant cancellation in these programs will result in loss of the deposit.
- f) The YMCA will not make up or refund any programs (i.e. swim lessons, aerobic classes, camps, etc.) that fall on a holiday.
- g) For school age care, preschool, and/or camp payments, No refund or vouchers will be given. Example: If you pay for a week of camp/school age care and there is a day missed due to illness, vacation, etc. No refunds/vouchers will be issued for days missed unless there is a medical excuse with a note from your medical provider.

### Program Cancellations

In the event of insufficient enrollment, the YMCA may need to cancel a class. If this occurs, we will contact you and issue a full refund.

Parent / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_





## Bank Draft Payment Method for Pre-School Tuition

Your Pre-School Tuition is deducted through a checking or savings account, please fill out the card below and return it. **Please also provide a voided check or a deposit slip.** This is an easy way to make sure your Pre-School Tuition gets paid. Bank Drafts will run every month starting September 15, 2024. **Your Pre-School tuition will be deducted on the 15<sup>th</sup> of every month.** Your last draft would come out May 15<sup>th</sup>, 2025. If you have any questions, please feel free to contact Carmen Turigliatti at 815.223.7904 ext.036.

Please fill in all the information below and return with a voided check:

Child's First & Last Name \_\_\_\_\_

Pre-School Class Attending \_\_\_\_\_

### ILLINOIS VALLEY YMCA DRAFT AUTHORIZATION

MEMBER \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ City \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

NAME AND ADDRESS OF FINANCIAL INSTITUTION MAINTAINING ACCOUNT

BANK \_\_\_\_\_

TYPE OF ACCOUNT

☐ Checking

Address of bank \_\_\_\_\_

☐ Savings

Please pay & charge my account all drafts drawn by Illinois Valley YMCA -300 Walnut Drive-Peru, IL-61354 to its own order once each MONTH in the amount of:

\$ \_\_\_\_\_ beginning the 15<sup>th</sup> of month \_\_\_\_\_ and year is \_\_\_\_\_

I agree that your treatment of each such draft, & your rights in respect to it, shall be the same as if it were signed personally by me. (A voided check or account verification from your Financial Institution is required)

This authorization will remain in effect until cancelled by me in writing by the 10<sup>th</sup> of the month & until you actually receive such notice in writing. I agree that you shall be fully protected in honoring any such draft.

Bank Routing Number

Account Number

PRINT NAME

SIGNATURE