REQUIRED
Incomplete applications will not be considered

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

AFTER SCHOOL CONTRACT

GREATER MISSOULA FAMILY YMCA

Application Date: ____/____/_____ Requested Start Date: ____/____/_____

Child's Name: _____ Gender: _____
Last First M.I.

School: _____ Grade: _____ Date of Birth: ____/____/_____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

For transportation safety, is your child over 60 lbs? Y / N

Any special needs, dietary restrictions, etc.: _____

Emergency Contact Information:

Guardian's Name: _____ Guardian's Name: _____

Relationship: _____ Relationship: _____

Primary Phone: _____ Primary Phone: _____

Work Phone: _____ Work Phone: _____

Custody of child is with: _____

	5 Days	4 Days	3 Days	2 Days
Monthly Tuition	$325	$275	$225	$175
August	$20	$20	$20	$20
December	$245	$210	$170	$135
March	$245	$210	$170	$135
June	$115	$105	$95	$85

All participants must set up an autodraft. A one-time, non-refundable $55 supply fee ($75 for families enrolling 2+ children) is required.

After School Days Attending: (please check) ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

In order to provide the safest childcare, families must commit to the same After School days each week.

UPDATED: MAY 2022

REQUIRED

Incomplete applications will not be considered

After School Contract (continued)

Please read the following statements and **initial**, indicating that you understand and agree to comply.

_____ I understand that there is a supply fee of $55 ($75 for families enrolling 2+ children) that is due upon submission of application/contract. I understand that this fee is non-refundable.

_____ I hereby give my consent for my child to participate in water activities.

_____ I hereby give my consent for my child to be transported by Greater Missoula Family YMCA staff to or from school.

_____ In the event of a medical emergency, I hereby authorize the Greater Missoula Family YMCA staff to administer First Aid, CPR, and/or seek out the appropriate, necessary medical attention.

_____ I understand that if my child needs medication that I must fill out the appropriate medication permission forms and provide them, any medication (in its original container), and appropriate administration instructions to the YMCA staff.

_____ I have reviewed and agree to abide by Greater Missoula Family YMCA policies.

_____ I agree not to hold the Greater Missoula Family YMCA liable if my child is injured while participating in Greater Missoula Family YMCA child care activities.

_____ I understand that I must contact the Director of School Age Programs by 12:00 p.m. if my child will be absent from a regularly scheduled program day.

_____ I understand that my child must be picked up by 6:00 pm.

_____ I understand that the Missoula Police Department will be called should my child not be picked up and should the Missoula YMCA be unable to reach me or our emergency contacts by 6:30 p.m.

_____ I understand my child's participation in the program may be temporarily or permanently discontinued without refund if their behavior becomes uncontrollable or violent.

_____ I completed the entire emergency form and have provided all available contact information.

_____ I understand that my child will not be released to anyone whose name is not listed on the emergency form. I understand proper identification must be presented at every pickup.

_____ If a parent of a child is not allowed custody or personal information of any kind, I will notify the Greater Missoula Family YMCA in writing and with proper court documentation.

_____ I understand that a written notice is required two weeks in advance for all schedule changes and/or cancellations.

Doctor's Name: _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: ____/____/_____

Parent/Guardian Name (please print): _____

REQUIRED
Incomplete applications will not be considered

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

PAYMENT AUTHORIZATION FORM

This form is required for all Y After School applicants

The adult listed on this form will be responsible for payments and will be the Missoula Y's point of contact for all payment-related correspondence.

Participant's Name: _____ Program: _____

Primary Adult: _____ Date: ____/____/_____
Last First M.I.

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Payment Method: (Please choose one)

_____ Monthly EFT/ Bank Draft (Please attach a voided check.)

_____ Monthly Credit/Debit (Please complete the information below.)

Type of Card: _____ Number: _____ Expiration Date: ____/_____

Payment Authorization:

_____ I authorize my financial institution to honor drafts drawn by the Greater Missoula Family YMCA on my account. Drafts from my account will be deducted as scheduled. The amount drafted will be the current amount due on my account.

_____ I understand that EFT/ bank drafts (if paying by voided check) are administered by a third-party company, Daxko, and that any unsuccessful draft will be charged a non-refundable fee of up to $30. If Daxko is unable to collect dues from my account after 30 days, it is my responsibility to make payment to the YMCA for all fees due, including any fee not covered by my financial institution.

_____ I understand that credit card drafts are administered by a third-party company, Daxko, and that any unsuccessful draft attempts will incur a non-refundable fee of up to $30. It is my responsibility to settle any past-due balances and incurred fees with the YMCA or Daxko upon notice.

_____ I understand that I will be notified of any monthly program rate changes. I understand all deposits are non-refundable.

_____ I understand that I must give the Greater Missoula Family YMCA a 30-day written notice for any changes to my account name, account number, and/or financial institution, and two weeks' written notice for changes to program enrollment status and/or termination of services.

I agree to all terms and conditions listed above.

Primary Adult Signature: _____ Date: ____/____/_____

Office Use Only:

Date of First Draft: ____/____/_____ Date Entered in Daxko: ____/____/_____ Staff Initials: _____

Financial Assistance: Yes, Family Yes, Individual No

UPDATED: APRIL 2021

REQUIRED FOR BEST BEGINNINGS FAMILIES ONLY

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

BEST BEGINNING SCHOLARSHIPS

GREATER MISSOULA FAMILY YMCA

Welcome to Missoula Y After School! Financial assistance is available to qualifying families. There are two types of assistance available: Best Beginnings Child Care Scholarships and Missoula Y Financial Assistance.

Best Beginning Child Care Scholarships

The Best Beginning Child Care Scholarship is a state program that provides assistance to qualifying families in need of child care. Best Beginnings scholarships must be completed and turned into Child Care Resources. Applications and information about Child Care Resources can be found online at **www.childcareresources.org/families/paying-for-child-care/.**

Missoula Y Financial Assistance:

Families interested in Missoula Y Financial Assistance **must apply** for Best Beginnings first. Families who do not qualify for Best Beginnings scholarships may qualify for Missoula Y Financial Assistance. Please submit a Best Beginnings scholarship application to Child Care Resources prior to seeking Missoula Y Financial Assistance.

To apply for Missoula Y Financial Assistance, please fill out a financial assistance application available at the Welcome Center or online at ymcamissoula.org/financial-assistance. Forms and all required documentation must be received a minimum of 7 days prior to the start of after school in order to be considered. For more information on financial assistance, please call the Missoula Y at 721-9622.

The following information applies only to families receiving Best Beginnings scholarships.

_____ I understand that I am responsible for setting up and paying all co-pays that Child Care Resources (CCR) and/or the Greater Missoula Family YMCA establishes for the After School Program.

_____ I understand that I am responsible for completing and returning all required paperwork to CCR prior to my child(ren) starting the After School Program.

_____ I understand that my Greater Missoula Family YMCA co-pay may be higher than the co-pay listed on my Best Beginnings certification plan.

_____ I understand that my co-pay will increased if my child's attendance does not meet the amount of approved hours on my certification plan.

Parent/Guardian Signature: _____ Date: ____/____/_____

Parent/Guardian Name (please print): _____

DPHHS-QAD/CCL-113
(Revision 7-2006)

State of Montana
Department of Public Health and Human Services
Quality Assurance Division – Licensure Bureau
Child Care Licensing

REQUIRED
Incomplete applications will not be considered

EMERGENCY CONTACT AND PARENTAL CONSENT

THIS FORM MUST BE TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED.

Child's Name: _____ **Birth Date:** _____

Address: _____

Mother / Legal Guardian's Name: _____ **Home Number:** _____

Address: _____ **Cell Number:** _____

Work Address: _____ **Work Number:** _____

Father / Legal Guardian's Name: _____ **Home Number:** _____

Address: _____ **Cell Number:** _____

Work Address: _____ **Work Number:** _____

Emergency Contact Person: _____ **Contact Number:** _____

Emergency Contact Person: _____ **Contact Number:** _____

Physician / Medical Care Source: _____ **Contact Number:** _____

Health Insurance Carrier & Policy Number: _____

Persons authorized to pick up child:

Name: _____ **Name:** _____

Name: _____ **Name:** _____

– SEE REVERSE SIDE –

REQUIRED

Incomplete applications will not be considered

WRITTEN CONSENT IS GIVEN FOR:

☐ Yes ☐ No EMERGENCY MEDICAL CARE

☐ ADMINISTRATION OF PRESCRIPTION MEDICATIONS — **Medication Authorization form and Medication Administration Log Must be completed**

☐ ADMINISTRATION OF NON-PRESCRIPTION MEDICATIONS — **OTC Medication Authorization Form and Medication Administration Log must be completed**

☐ ADMINISTRATION OF SPECIAL DENTAL OR DIETARY NEEDS:
Please Specify:

☐ TRIPS: ☐ Yes ☐ No TRANSPORTATION BY THE FACILITY FOR TRIPS

☐ Yes ☐ No DAILY TRANSPORTATION PROVIDED BY THE FACILITY (Facility Has the Option to Offer)

IF YOUR CHILD IS TRANSPORTED BY THE FACILITY, ARE THERE ANY INSTRUCTIONS FOR SPECIAL CARE FOR THE CHILD (I.E. MOTION SICKNESS, SEIZURES, ETC.) DURING TRANSPORTATION?

HEALTH HISTORY

	YES	NO		YES	NO
Hay fever, asthma, or wheezing	☐	☐	Chickenpox	☐	☐
Eczema or frequent skin rashes	☐	☐	Diabetes	☐	☐
Convulsions/Seizures	☐	☐	Trouble with passing urine / bowel movement	☐	☐
Heart condition	☐	☐	Frequent colds, sore throats, earaches, tonsillitis, pneumonia	☐	☐

	YES	NO
Allergies or reaction: (food or other)	☐	☐

Please Explain:

	YES	NO
Other Health Concerns (special disabilities):	☐	☐

Please Explain:

SIGNATURE OF PARENT OR GUARDIAN **DATE**

STATE OF MONTANA— CHILD CARE FACILITY/SCHOOL CERTIFICATE OF IMMUNIZATION

REQUIRED
Incomplete applications will not be considered

Complete immunization requirements and penalties for those who fail to meet the requirements are referenced in Section V. This form is required for ALL persons attending school or child care. See the reverse side for information about EXEMPTIONS and INSTRUCTIONS.

SECTION I *PLEASE PRINT CLEARLY*

Child/Student's Name	Birth Date	Sex	Primary Provider	
Name of Parent/Guardian	**Address**		**City**	**Telephone** **Home** **Work**

SECTION II IMMUNIZATION HISTORY

Valid only when filled out by School, Child Care or Medical Personnel (NOT to be filled out by the parent).

Required Vaccines (CC= Child Care Requirement; SR=School Requirement)	**Month, Day & Year of Each Dose** **1**	**2**	**3**	**4**	**5**
Diphtheria/Tetanus/Pertussis (DTaP)					
Booster Dose Tdap required prior to 7th grade entry					
Haemophilus Influenzae Type B (Hib) **(Only children less than 5 years)**					
Measles/Mumps/Rubella (MMR)					
or					
Measles vaccine only					
Mumps vaccine only					
Rubella vaccine only					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] ☐ **Check here if child has documentation of disease**					

ACIP* Recommended Vaccines *Advisory Committee on Immunization Practices, U.S. Centers for Disease Control and Prevention	**Month, Day & Year of Each Dose** **1**	**2**	**3**	**4**	**5**
Hepatitis A					
Hepatitis B					
Human Papillomavirus (HPV) - for adolescents					
Influenza- recommended annually for all over 6 mos.					
Meningococcal Conjugate Vaccine (MCV4) (Ages 11-12 & later)					
Pneumococcal Conjugate vaccine (PCV)					
Rotavirus					

NOT A COMPLETE IMMUNIZATION RECORD- CONTACT YOUR PROVIDER OR PUBLIC HEALTH AGENCY FOR MORE INFORMATION

If filled out by health department or health care provider:

To the best of my knowledge, this child has received the above immunizations.

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

Signed: _____
(Health Department/Health Care Provider) Date

If filled out by school or child care personnel:

I CERTIFY this information has been transferred from supporting documentation as stated in the Administrative Rules of Montana:

Signed: _____
(School or Child Care Official and title) *Date*

Signed: _____
(School or Child Care Official and title) *Date*

Signed: _____
(School or Child Care Official and Title) *Date*

Signed: _____
(School or Child Care Official and Title) *Date*

SECTION III INSTRUCTIONS

Health Department or Physician

1. For medical exemption purposes, a physician is a person licensed to practice medicine in any jurisdiction of the U.S. or Canada. This does not include chiropractic or naturopathic doctors, nurse practitioners or physician assistants.
2. In Section II, please include vaccine doses with month, day and year for each administered dose. Immunization dates, as specified in the administrative rules, are necessary. Please sign and date the form.
3. **If the child is completing a vaccine series,** a Conditional Attendance form can be used. The physician or health department will determine the date of each dose to be administered and put the schedule on the Conditional Attendance form. Please sign the Conditional Attendance form, and return to the school or child care facility.
4. Immunization forms can be obtained directly from the local health department or the Montana Immunization Program at immmunization.mt.gov.

School and Child Care Official

1. **Prior to attending**, all students and child care facility attendees must have either **a)** the required immunizations **and documentation** or **b)** have completed the appropriate exemption or conditional attendance documentation. This includes transfer students.
2. **Documentation** must meet the criteria of the Administrative Rules of Montana. This is **limited** to other school health records and certain documents from health departments and physicians.
3. **Transferring information from supporting documentation to this form** must be done by a school or child care official. The school or child care official must then sign and date the form (Section II) and attach the supporting documentation.
4. **Conditional Attendance** form, once completed and attached to this document, allows attendance so long as immunization continues as scheduled.
5. **School Transfer Students**.

There is no transfer period allowed. Transfer students must provide adequate documentation of immunization **PRIOR** to attending school.

a) **Transferring In:** Students who transfer into Montana from out of state must have their immunization information recorded on this form (*See number 2 above regarding acceptable documentation.)* Students must meet Montana immunization requirements.

b) **Transferring Out:** If students transfer out of your school, a **copy** of this record should be maintained for one year following the transfer. The Montana law requires schools to forward the original Certificate of Immunization to the school to which students transfer.

c) **Homeless Students:** All homeless students must be immediately enrolled in a Montana school to ensure compliance with the McKinney-Vento Act. Students should be assigned a liaison who can assist them in obtaining either appropriate documentation of immunization or in obtaining the required immunizations.

Parent

1. Montana law requires immunization information be recorded on this document for persons to attend Montana schools, preschools and child care facilities.
2. **ONLY school, child care and health officials can complete this form.** School and child care officials need documentation from physicians or health departments as described by the Administrative Rules of Montana (*examples: A completed Montana Certificate of Immunization; A signed Immunization record card)*. **It is the parent's responsibility to provide these documents to the school or child care facility.**
3. **Religious exemption and conditional attendance** may be used in accordance with the Immunization Law and Administrative rules. The Religious Exemption may be used in school settings and must be renewed annually. Religious exemption for child care only applies to Haemophilus influenzae type b (Hib), and must be renewed annually.
4. Montana law prohibits children from attending any Montana school or child care facility **prior** to meeting immunization requirements.
5. If your child transfers to another Montana school, a copy of this completed form will allow your child to enter that school. However, the original Certificate of Immunization must be provided to the new school within 30 days of transfer in order for the child to attend.

SECTION IV EXEMPTIONS

Please refer to the form HES101A at
immunization.mt.gov

SECTION V LEGAL REFERENCES

Montana Codes Annotated
20-5-101 - 410: Montana Immunization Law
52-2-735: Day Care Certification

Administrative Rules of Montana
37.114.701-721: Immunization of K-12, Preschool and Post secondary Schools
37.95.140: Day Care Center Immunizations
Group Day Care Homes – Health
Family Day Care Homes – Health

If you have any questions about: 1) the use of this form; 2) obtaining copies of immunization forms, laws, or rules; or 3) whether or not a person meets attendance requirements, please contact your local health department or the Montana Immunization Program, DPHHS, Cogswell Building, Helena, MT 59620. Phone (406)444-5580.

www.immunization.mt.gov

FORM No. IZ HES101 (Revised 07/2015)

REQUIRED

Incomplete applications will not be considered

23

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

Institution or Facility Name:

Part 1. Name of Child(ren) Enrolled:

	☐ CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT)
	* IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.
Full names of all household members	

Part 2. Benefits: If any member of your household received [SNAP], [FDPIR] or [TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, a migrant, or a runaway, call the State agency for instructions.

Part 4. Total Household Gross Income—You must tell us how much and how often (whole dollar amounts, please)

Total number in household: _____	**B. Gross income and how often it was received** *(if $0, please write $0. Any field left blank will be accepted as representative of "no income"*			
A. Name (List **only** household members with income)	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

This section required for all forms listing income in Part 4:

Last four digits of Social Security Number: X X X - X X - __ __ __ __ ☐ I do not have a Social Security Number

Part 5. Signature (Adult must sign)

An adult household member must sign this form.

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

REQUIRED

Incomplete applications will not be considered

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ American Indian or Alaska Native ❑ Black or African American ❑ White ❑ Native Hawaiian or Other Pacific Islander

Part 7. Decline to provide information

I choose not to provide information about my household size and income.

_____ _____

Signature of Adult Household Member Date

*****This Section is to be completed by the Child Care Institution – Determination of Eligibility*****

Completion of this section is required for the institution to claim meals at the free or reduced rate for the child/children listed in Part 1: Name of Child(ren) Enrolled.

Number of persons in the household: _____

Total income $ _____ Per: ❑Week ❑Every 2 Weeks ❑Twice A Month ❑Month ❑Year

(Annual Income Conversion: weekly x 52, every 2 weeks x 26, twice a month x 24, monthly x 12)

Categorical Eligibility: ❑Free ❑Reduced ❑Paid ❑Tier I ❑Tier II

Required: Determining Official's Signature: _____ Date: _____

Additional official signatures are recommended but not required.

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Food Distribution Program on Indian Reservations (FDPIR), or Temporary Assistance for Needy Families (TANF) case number for the participant or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: "In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by (1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider."

Head Start: Children who are enrolled in the Federal Head Start Program receive meal benefits in the CACFP without further application or eligibility determination. Acceptable documentation includes a current approved Head Start application or a written, signed and dated statement or roster from a Head Start official. [USDA Memos CACFP 7-2008 and CACFP 10-2008]

DPHHS-QAD/CCL-120
(Revision 06-07)

REQUIRED Incomplete applications will not be considered

NON-INGESTIBLE OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name_____Date of Birth_____/____/___
Program Name_____Today's Date_____/____/___

****

I give permission for the administration of following non-ingestible over the counter medications (mark all that apply):

- ☐ Diaper Rash Cream/Ointments
- ☐ Insect Repellent
- ☐ Sunscreen
- ☐ Cortisone/Anti-Itch Creams/Ointments
- ☐ Medicated Lip Treatments
- ☐ OTC Antibiotic Creams/Ointments
- ☐ Burn Creams/Sprays
- ☐ Other Non-Ingestible OTC's: (Please Specify)_____

_____

_____

_____

To administer a non-ingestible over the counter (OTC) medication:

- The OTC medication must be brought to the day care facility from the parent;
- The OTC medication must be in its original container, with a legible label, and expiration date of medication;
- The child's name must be on the original container

☐☐
Special handling/storage Instructions_____Refrigeration Y/N

Parent/Guardian Signature (required)_____

* **This document must be updated on an annual basis.**

☐☐
Unused Medication: Returned to Parent Y/N or ☐ Discarded Appropriately (circle one)

By:_____ Date_____/_____/_____

***Keep in the child's file when medication is finished.**

OPTIONAL

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA PHOTO/AUDIO VISUAL/NARRATIVE RELEASE

I am 18 years of age or older and, if not, my parent or legal guardian has also provided their consent by signing below.

Consent & License. For my participation in activities to be conducted by the National Council of Young Men's Christian Associations of the United States of America ("YMCA of the USA") or any of its chartered member associations in the United States (collectively "the Y"), and collaborating third parties, I consent, now and for all time, to the making, reproduction, editing, broadcasting or rebroadcasting of:

- video film or footage of me,
- sound track recordings of me
- photo reproductions of me
- any narrative account of my experience

My consent includes a perpetual license to the Y and collaborating third-parties for the use of the above materials for publication, display, sale or exhibition in promotions, advertising, education and commercial uses. Use includes reproductions in any form and media currently existing or later conceived, adaptations and/or revisions, throughout the world in perpetuity.

I understand and agree there may be no additional compensation for this license, and I will not make any claim for payment of any kind from the Y or collaborating third-parties. I may, or may not be, identified in such licensed uses; however, my name will not be used to endorse any particular products or services.

Ownership, Confidentiality, and Shared Use. With respect to any of the above uses, I further agree:

- All works shall belong to YMCA of the USA;
- The Y has no duty of confidentiality regarding any licensed uses;
- YMCA of the USA shall exclusively own all known or later existing rights to the uses throughout the world;
- The Y and collaborating third-parties may use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account for any purpose without additional compensation to me.

Release from Liability. I agree that my consent is irrevocable. I hereby release and discharge The Y and collaborating third-parties, from any and all claims, actions, lawsuits or demands of any kind arising out of my consent, license grants, uses, or the shared uses of any works or materials referenced herein.

Signature: _____ Date: _____

Printed Name: _____ Age: _____

Address: _____

_____

I am the parent or legal guardian of _____ (child's name).
I hereby consent and grant the licenses detailed in the foregoing on behalf of my minor child.

Signature of parent or legal guardian: _____

Printed name: _____

YMCA OF THE USA
101 N Wacker Drive, Chicago IL 60606
P 800 872 9622 F 312 977 9063 ymca.net

REQUIRED

Incomplete applications will not be considered

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

WAIVER, ACKNOWLEDGEMENT AND RELEASE [MINORS]

Read carefully and completely before signing

On behalf of my minor child/children, I hereby acknowledge and agree that participation in the sports, programs, activities and recreational opportunities at and through the Greater Missoula Family YMCA ("Missoula Y") comes with inherent risks. I understand and agree that the risks include, but are not limited to (1) slips, trips, falls, (2) aquatic injuries, (3) athletic injuries, and (4) exposure to bodily fluids, sweat, and/or illness caused by exposure due to bacteria or viruses. I understand and agree, pursuant to Montana Code Annotated ("MCA") Section 27-1-753, as participants in the sports and recreational opportunities offered at the Missoula Y, to assume the inherent risks in those sports or recreational opportunities, whether those risks are known or unknown and that the Missoula Y is not responsible for all injury, illness or death to my minor child/children or damage to their property that result from the inherent risks in those sports, programs, activities and recreational opportunities.

This Waiver, Acknowledgement and Release includes, but it not limited to, illness or damages arising from the novel coronavirus, and the disease it causes, COVID-19. I understand that this is a contagious virus, and governmental authorities recommend physical social distancing as a means to reduce the spread of this virus, which can lead to severe illness, injury, disability and death. Participating in Missoula Y programs and accessing Missoula Y facilities may incur exposure to viruses. The Missoula Y works to reduce the potential for exposure and spread, but exposure to viruses is an inherent risk of participation in the sports, programs, activities and recreational opportunities offered at and through the Missoula Y.

By signing this document, I am waiving my minor child/children's right to a jury trial to hold the Missoula Y legally responsible for any injuries, illness or damages resulting from risks inherent in the sports, programs, activities and recreational opportunities offered at or through the Missoula Y, and any damages they may suffer due to the Missoula Y's ordinary negligence that are the result of the Missoula Y's failure to exercise reasonable care.

Execution of this Waiver, Acknowledgement and Release [Minors] is in compliance with and not prohibited by or subject to the provisions of MCA Section 28-2-702. Nothing herein precludes an action based upon injury, illness, damages or death which results from something other than the inherent risk from participation in the sports, programs, activities and recreational activities as waived and released herein. In consideration of my participation in the sports, programs, activities and recreational opportunities at the Missoula Y, I hereby do release, on behalf of myself, my heirs, representatives, executors, administrators and assigns, to the extent allowed by law, the Missoula Y, and its officers, directors, employees, volunteers, agents, and insurers from any claims, causes of action or demands of any nature arising the inherent risk of my voluntary participation at and use of the facilities of the Missoula Y.

I certify that my date of birth is _____ (mm/dd/yyyy) and I am of lawful age and fully legally competent to sign this Waiver, Acknowledgement and Release on behalf of my minor child/children, all of whom are named below (add additional sheet if needed). I further understand that the terms of this agreement are legally binding and certify that I am signing this agreement, after having carefully read it, of my own free will.

Child/children's legal names and date of birth: (1) _____

(2) _____ (3) _____

IN WITNESS WHEREOF, this instrument is duly executed this date: _____

_____ _____

Parent/Guardian Signature Parent/Guardian Name (print clearly)