



# School Age 2016 Child Information Forms

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Before and/or Afterschool Program please check:

Kindergarten Program please check:

AM only                       PM only                       AM and PM

Kindergarten AM     Kindergarten PM     KinPlus AM

KinPlus                       KinPlus AMPM

Kindergarten home school \_\_\_\_\_

Child's First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Grade (Fall '14) \_\_\_\_\_ School Attending \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Custodial Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

Custodial Father's Name \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_

Person Responsible for Child's Account \_\_\_\_\_ Signature \_\_\_\_\_

Person(s) other than parent who may pick up child:

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

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

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

In Case of **EMERGENCY** when unable to reach parent, call:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last Physical \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Family Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

List of any prescribed or over the counter medications currently taking \_\_\_\_\_

List any allergy or dietary restrictions (please request a severe Allergy Care Plan if needed)

Current physical, mental or psychological conditions requiring medication, treatment or special restrictions or considerations while in program.

List any camp activities your child should not participate in due to health reason along with the health condition. \_\_\_\_\_

### Consent for Emergency Treatment

I hereby give permission that my child \_\_\_\_\_, may be given emergency treatment by a qualified staff member of the YMCA of the Inland Northwest. I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.  **I do not want emergency treatment for my child, please refer to plan.**

In the event that I cannot be contacted, I further consent to the medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



## SCHOOL AGE AND DAY CAMPS 2016

### Consent Agreements & Parent Statement of Understanding

Child's name \_\_\_\_\_

**My child has my permission to participate in the YMCA sponsored Day Camp & School-Age Care Programs.**

1. I will be responsible for all fees accumulated as a result of my child's registration and participation in YMCA programs. I understand that all fees are payable in advance and that program participation will be denied if payments are past due. All past due accounts will be referred to collection.
2. I have received a Parent Handbook and understand the program's policies and fees.
3. I give my permission for my child to go on supervised field trips with the YMCA's Day Camp & School-Age Care Programs.
4. I give permission for my child to participate all activities, including swimming, to be supervised by YMCA staff or qualified lifeguards. If I do not want my child to participate I will give written notice.
5. To the best of my knowledge, my child is in good health. I understand that the YMCA has safety standards in its programs and that all activities will be properly supervised. The YMCA does not provide individual accident insurance; therefore, I will provide the necessary coverage in the event of an accident.
6. The YMCA cannot be held responsible for problems related to a child's failure to receive the required immunizations.
7. PHOTO RELEASE-I give permission for my child to be involved in photograph's or other media to promote or interpret YMCA programs.

**Initial:** Yes \_\_\_\_\_ No \_\_\_\_\_

8. While in the YMCA's care, YMCA staff and volunteers will not transport a child in a private vehicle without the parent's specific permission.
9. When leaving a child at the YMCA or program site, he/she must be signed in and make sure a program staff or volunteer is available to receive and supervise your child. The YMCA staff will not call to verify absences when a child is not signed in.
10. The YMCA will release children only to people authorized by the parent/guardian. If a parent/guardian desires to have a YMCA employee provide childcare or other services outside of the YMCA program or check their child in or out of the program; they must first sign a disclaimer/waiver statement. In these situations, it is the parent(s) who are responsible for implementing the appropriate child abuse prevention measures. The YMCA is not responsible for the independent acts of its employees outside of the work place.
11. Day Camp & School-Age Care staff and volunteers are required by state law to report suspected child abuse. This will be handled confidentially through a staff person's supervisor and the program director.
12. If the person picking up a child appears to be under the influence of drugs or alcohol, for the child's safety, that person will be asked to allow someone else on the authorized list to pick up the child. If that person insists on taking the child, the YMCA will make a report to the police and Child Protective Services. Please do not put our employees and volunteers in a position where they have to make this judgment call.
13. Parents/Guardians may drop in and visit with their children at any time.
14. The YMCA takes all accusations of child abuse seriously. To protect **children**, staff and/or volunteers accused of abuse may be suspended from the program. To protect **staff and volunteers**, children and/or parents making false accusations of abuse may be suspended from the program.
15. The YMCA has a comprehensive disaster plan for each site. The plan will be posted on the parent board for your review and signature.
16. Weapons, including but not limited to, knives and or firearms are not allowed at day camp and may result in suspension.

**I have received a copy of the Parent Information Packet and I have read, understand and agree with the Consent Agreements.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



# Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

<b>Office Use Only:</b>	
Reviewed by: _____	Date: _____
Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

<b>Child's Last Name:</b> _____	<b>First Name:</b> _____	<b>Middle Initial:</b> _____	<b>Birthdate (mm/dd/yyyy):</b> _____	<b>Sex:</b> _____	<b>I certify that the information provided on this form is correct and verifiable.</b>
Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only				<b>Parent/Guardian Name (please print):</b> _____	

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Hepatitis B (Hep B)</b>				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
<b>Rotavirus (RV1, RV5)</b>				
	1			
	2			
	3			
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
	1			
	2			
	3			
	4			
	5			
<b>◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)</b>				
	1			
	2			
<b>● Haemophilus influenzae type b (Hib)</b>				
	1			
	2			
	3			
	4			
<b>● Pneumococcal (PCV, PPSV)</b>				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date			
		Month	Day	Year	
<b>◆ Polio (IPV, OPV)</b>					
	1				
	2				
	3				
	4				
<b>Influenza (flu, most recent)</b>					
<b>◆ Measles, Mumps, Rubella (MMR)</b>					
	1				
	2				
<b>◆ Varicella (chickenpox) or verify disease 1-4 ▶</b>					
	1				
	2				
<b>Hepatitis A (Hep A)</b>					
	1				
	2				
<b>Meningococcal (MCV, MPSV)</b>					
	1				
<b>Human Papillomavirus (HPV)</b>					
	1				
	2				
	3				
<b>Office Use Only: Immunization information updated and verified with parent/guardian permission:</b>					
Printed Staff Name _____		Date _____		Printed Staff Name _____	
Printed Staff Name _____		Date _____		Printed Staff Name _____	
Printed Staff Name _____		Date _____		Printed Staff Name _____	
Printed Staff Name _____		Date _____		Printed Staff Name _____	

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

**1)  Chickenpox disease verified by printout from CHILD Profile Immunization Registry**  
Must be marked by printout (not by hand) to be valid.

**2)  Chickenpox disease verified by Health Care Provider (HCP)**  
If you choose this box, mark 2A OR 2B below.  
 2A)  Signed note from HCP attached OR  
 2B)  HCP signed here and print name below:  
 \_\_\_\_\_  
 Licensed health care provider (HCP) Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)  
 HCP Printed Name: \_\_\_\_\_

**3)  Chickenpox disease verified by school staff from CHILD Profile Immunization Registry**  
If you choose this box, staff must initial that parent or guardian approves: \_\_\_\_\_ (initial) \_\_\_\_\_ (date)

**4)  Chickenpox disease verified by parent\***  
If you choose this box, fill in the date or child's age when he or she had the disease:  
 Age/Date of disease: \_\_\_\_\_  
 \*Can ONLY verify for some grades, see back #5 (4).

**If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.**  
**Documentation of Disease Immunity**

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. **Signed lab report(s) MUST also be attached.**

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	_____

Licensed health care provider (HCP) Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)  
 HCP Printed Name: \_\_\_\_\_

**Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.**

**#1 To print with info filled in:** First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

**EXAMPLE**

**#2 To fill in by hand:** Print your child's name, birthdate, sex, and your own name in the top box.

**#3** Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
DTaP	<b>1</b>	01	12	2011
DTaP	<b>2</b>	03	20	2011
DTaP	<b>3</b>	06	01	2011

**#4** If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

**#5** If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

- 1)  If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2)  If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3)  If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4)  If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

**#6** Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

**#7** Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

**#8** If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Vaccine Trade Names in alphabetical order									
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menaetra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqa	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order							
DT	Diphtheria, Tetanus	Hep A (HAV)	Hepatitis A	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hep B (HBV)	Hepatitis B	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	Hib	<i>Haemophilus influenzae</i> type b	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	HPV	Human Papillomavirus	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	IPV	Inactivated Poliovirus Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

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