YMCA School Age Programs 2017
Child Information Forms

Today's Date _____ / _____ / _____

Please check the session your child will attend: ☐**AM only** ☐**PM only** ☐**AM and PM** ☐**Part-time 5 visit __ AM __PM**

Child's First Name ______________________ MI ___ Last Name ______________________ ☐Male ☐Female

Date of Birth _____ / _____ / _____ Grade (Fall '17) _____ Age _____ School Attending ______________________

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 ______________________________ Contact/Business Phone ______________

HEALTH INFORMATION:

Family Physician ______________________ Family Dentist ______________________

Address ______________________ Address ______________________

Phone ______________ Last Visit ______________ Phone ______________ Last Visit ______________

Insurance Company ______________ Policy # ______________ Insurance Company ______________ Policy # ______________

List of any prescribed or over the counter medications currently taking______________________________

List any allergy or dietary restrictions (please request Medication Form and/or Allergy Action Plan if needed).

____

Current physical, mental or psychological conditions requiring medication, treatment or special restrictions or considerations while at camp.

____

HAND SANTIZER AND/OR HAND WIPES:

If soap and water is not available for hand washing I give my permission for my child to use hand sanitizer or hand wipes. Yes ____ No ____

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 Year 2017

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 _____________

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

MEDICATION, SUNSCREEN & HAND SANITIZER PERMISSION

Medical Authorization

(Must be filled out by parent if child needs to be given medication at Day Camp.)

Name of Child ____ Date of Birth _____ / _____ / _____

Name of Mediation ____

Reason for Medication ____

Start Date _____________________ Stop Date _____________________

Times to be given _____________________ Amount to be given _______________________________

Possible Side Effects

____

____

To be given: Oral __ Topical __ Other _________ Requires Refrigeration: Yes__ No __
Above information must be consistent with label. Also medication must be prescribed by a health care provider and come in its original prescription container. No over the counter medications will be given.
Special Instructions ____

Other Information ____

Signature of Parent/Guardian ______________________________________ Date __________________

Daytime Phone Number ______________________ Cell Phone Number __________________________

Medication Record

(Must be filled out by the staff person who gives the medication.)

Date	Time	Dosage	Initials	Reason Not Given	Side Effects Observed

Signatures/initials that correspond to initials of persons giving medication:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Certificate of Immunization Status (CIS)

For Kindergarten-12th Grade / Child Care Entry

Office Use Only:
Reviewed by: Date:
Signed Cert. of Exemption on file? ❑ Yes ❑ No

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

Child's Last Name:	**First Name:**	**Middle Initial:**	**Birthdate** (MM/DD/YY):	**Sex:**

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required **Date**

I certify that the information provided on this form is correct and verifiable.

Parent/Guardian Signature Required **Date**

♦ Required for School and Child Care/Preschool
● Required Only for Child Care/Preschool

	Date MM/DD/YY	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**	**Date MM/DD/YY**
Required Vaccines for School or Child Care Entry						
♦ **DTaP, DT** (Diphtheria, Tetanus, Pertussis)						
♦ **Tdap** (Tetanus, Diphtheria, Pertussis)						
♦ **Td** (Tetanus, Diphtheria)						
♦ **Hepatitis B** ❑ 2-dose schedule used between ages 11-15						
● **Hib** (*Haemophilus influenzae* type b)						
♦ **IPV / OPV** (Polio)						
♦ **MMR** (Measles, Mumps, Rubella)						
● **PCV / PPSV** (Pneumococcal)						
♦ **Varicella** (Chickenpox) ❑ History of disease verified by IIS						
Recommended Vaccines (Not Required for School or Child Care Entry)						
Flu (Influenza)						
Hepatitis A						
HPV (Human Papillomavirus)						
MCV, MPSV (Meningococcal)						
MenB (Meningococcal)						
Rotavirus						

Documentation of Disease Immunity

Healthcare provider use only

If the child named in this CIS has a history of Varicella (Chickenpox) or can show immunity by blood test (titer) it MUST be verified by a healthcare provider

I certify that the child named on this CIS has:

❑ a verified history of Varicella (Chickenpox).

❑ laboratory evidence of immunity (titer) to disease(s) marked below. **Lab report(s) for titers MUST also be attached.**

❑ Diphtheria	❑ Mumps	❑ Other:
❑ Hepatitis A	❑ Polio	___________
❑ Hepatitis B	❑ Rubella	___________
❑ Hib	❑ Tetanus	
❑ Measles	❑ Varicella	

Licensed healthcare provider signature (MD, DO, ND, PA, ARNP) Date

Printed Name

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FOR SOCIAL RESPONSIBILITY

Food Allergy Statement & Medical Emergency Plan

Name of Child: ________________________________ Date of Birth _____ / _____ / _____

Name of Parent/Guardian: ______________________________Phone: __________________________

Asthma ☐ Yes ☐ No

Non-Food Allergy(s) ____

Food Allergies ____

Other ____

Signs of an allergic reaction

Systems:	**Symptoms:**
Mouth	Itching & swelling of the lips, tongue or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness & hacking cough
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lung	Shortness of breath, repetitive coughing, and/or wheezing
Heart	“Thready” pulse, “passing-out”

Action for Minor Reaction

If symptoms(s) are: ____

Administer: ____

Medication/dose/route

Then call: Parent/Guardian and Doctor
If condition does not improve within 10 minutes, follow steps for Severe Reaction below:

Action for Severe Reaction

If symptoms(s) are: ____

Administer: ____ **Immediately!**

Medication/dose/route

Call: 911, then Parent/Guardian, then doctor

Any other instructions:

____

____

____

Parent/Guardian ______________________________Phone ____________ Cell phone _____________

Parent/Guardian ______________________________Phone ____________ Cell phone _____________

Doctor ______________________________________Phone ____________________________________

Signature of Parent/Guardian ____________________________________ Date ___________________

Doctor’s signature (required) __________________________________ Date _____________________

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