YMCA CHILD CARE PARTICIPANT INFORMATION FORM

GENERAL PARTICPANT INFORMATION:

Participant's Name: _____

Grade Entering: _____ Birth Date: _____ Age: _____

Gender: _____ T-Shirt Size: _____

Address: _____

City/State/Zip: _____

Name of Parent(s)/Guardian(s):

_____

Primary Daytime Contact Person: _____

Cell phone: _____
Work Phone: _____

Secondary Daytime Contact Person: _____

Cell phone: _____
Work Phone: _____

Email Address: _____

MEDICAL INFORMATION:

Please check those that apply and give approximate dates:

___Hypertension	___Heart Disease	___Diabetes
___Mononucleosis	___Seizures	___Asthma
___Clotting Disorder	___Behavior Disorder	

Disability or chronic / recurring illness: _____

Known allergies we should be aware of:

_____

Please fill out attached Allergy Form to give us more info about your child's allergy.

Other medical problems / diseases (please give dates):

_____

Medications child is currently taking: _____

If your child needs medication administered during camp hours, please fill out the attached Medication Form.

Insurance Company: _____

Name of Child's Physician / Clinic: _____

Physician / Clinic Phone: _____

Name of Child's Dentist: _____

Dentist Phone: _____

Does your child have any special needs requiring an accommodation?

_____

_____

_____

I do hereby consent & authorize Marshall Area YMCA staff to take any & all action, including use of emergency medical transportation, medical services, & hospital facilities as they deem appropriate in the event my child should become ill or otherwise injured under the care of the Marshall Area YMCA.

_____ _____

Signature *Date*

I understand that any medical expenses resulting from any illness or injury my child may incur while attending this YMCA program are my responsibility. I understand that the Marshall Area YMCA is not responsible for anything that may happen as a result of false information given by a parent or guardian.

_____ _____

Signature *Date*

Turn page

AUTHORIZATION TO PARTICIPATE:

_____ YES _____ NO — I give my permission for my child to be included in pictures associated with the program.

_____ YES _____ NO — I give my child, _____, permission to swim or otherwise participate in water activities in bodies of water two or more feet in depth. During any scheduled swimming activity, a certified lifeguard or water safety instructor will be on duty.

_____ YES _____ NO — I would like my child to swim in shallow water only.

_____ YES _____ NO — My child has permission to swim in deep water and can successfully perform the following skills: can jump feet first into water and can tread water for 10 seconds & continue to swim for 1 length of the pool. I understand that the YMCA reserves the right to re-evaluate all deep-water swimmers and may move them to shallow water if deemed necessary.

_____ YES _____ NO — I give my permission for my child to have spray sunscreen and insect repellant applied to them for outdoor activities.

Next four must be "yes" in order for child to attend.

_____ YES _____ NO — My Child can change into and out of swim clothing on their own and is potty trained.

_____ YES _____ NO — I give my permission for my child to participate in all trips or excursions. I understand that transportation for these trips or excursions may be by YMCA van, walking, public transportation, or leased bus.

_____ YES _____ NO — I give my permission for my child to use all the equipment & participate in all activities of the program

_____ YES _____ NO — I understand my child may be send home if they show signs of illness.

_____ _____

Signature *Date*

The following persons are **emergency contacts** and are allowed to sign out my child (listed above)

Please Print

Name	Relationship	Phone Number

PAYMENT OPTIONS

☐ **Automatic weekly draft**; of payment methods on file. Weekly payments **will be drafted the Monday before each new week starts**. *Please see the Parent Handbook for cancellation policies.*

☐ **In house/online** weekly payments will be made each week by the parent/guardian.

☐ **Special Arrangement** Please let us know if you're unsure if your circumstances fall within this category.

_____ _____

Signature *Date*

Staff Use Only:

Date Received: _____

Received by: _____

Date entered in system: _____

Check if turned in:

Code of Conduct _____

Immunization history _____

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Youth Code of Conduct
Marshall Area YMCA Child Care Programs

Purpose of Code of Conduct:
We want our child care to be an enjoyable environment and a fun experience for all. This code of conduct will help guide us in building our core values. We ask that parents read through the code of conduct with their child. Please join us in explaining what these values are and open a discussion about how to show our values at the YMCA.

Our Expectations:

Be caring...

Do not physically or verbally hurt others. This means that you should not bully, hit, gossip about, throw something at, or make fun of another person.

Be honest...

Display the core value of honesty by telling the truth

Be responsible...

Help to keep our program area clean by picking up after yourself

At no time should a participant wander off without adult supervision or prior permission

Be respectful...

Always treat fellow participants, counselors, visitors, and any guest speakers with respect.

Taking another youth or leader's property is unacceptable unless permission has been given to you by the owner of the object

Participant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

By signing this document you agree to abide by the above expectations and understand that failing to abide by said expectations can and will result in consequences as outlined on the reverse of this document. Participants who choose not to sign this document will not be permitted to attend any off-campus camp activity and will still be subject to the consequences for misbehavior at regular activities.

Consequences for Misbehavior

The consequences for misbehavior outlined below aim to exemplify grace and forgiveness. It is our goal that any participant who receives any offense takes responsibility, learns from it and returns to the program with a clean slate. We desire to have all participants participating in all activities and will not hold prior offenses against those who have already completed the consequences for such (assuming that a pattern does not emerge).

Consequences for Offenses:

1st Offense: The participant will receive a verbal warning. Reasoning and redirection will be applied here. 2-5 minute break depending on the offense.

2nd Offense: The participant will be pulled aside by a counselor to discuss the offense. Continued reasoning and redirection will be applied. Parent(s)/guardian will be alerted of the offense by a counselor at pick up time.

3rd Offense: The participant will be pulled aside by a counselor and sent to talk with the Camp Coordinator or Director. Afterwards, there are a few routes that may transpire. The Camper may be asked to call his/her parents, where they would explain why they are calling (i.e. what actions got them into trouble), and may ask to be picked up immediately. (severity dependent). Or the camper may lose the privilege to participate in an activity. The camper may receive a pink slip.

4th Offense: The participant will receive a pink slip. Will be sent to talk with the Camp Director. Depending on the severity the camper may be sent home. Parents will be notified at pick up or given a call during the day about the behavior.

- 3 Pink Slips: the camper will lose out on participating on a big activity.
- 5 Pink Slips: the camper will be suspended for 2 days.
- 8 Pink Slips: the camper will be suspended for 1 week.

5th Offense & after a pink slip suspension: his/her parent(s)/guardian will be notified that the participant will not be allowed to return to the program.

Staff and the Director of Community Programs reserve the right to determine the severity of misbehavior and may choose to skip or modify any of the above stated consequences.

Participants who reach 4th Offense multiple times may lose privileges including, but not limited to field trips and/or special events/activities.

Additionally, participants who reach 4th Offense multiple times may also be subject to required parent/guardian meetings with the Director, prior to being allowed back at any above stated events or activities.

Consequences for repeat offenses up to discontinuation of participation (depending on severity).

If you have any questions or concerns, please contact our Director of Community Programs, Jacob Benson, at jbenson@marshallareaymca or 507-532-9622.

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA Participant Allergy Information:

Participant Name: _____

Description of Allergy:

_____

Specific Triggers:

_____

_____

Avoidance Techniques:

_____

_____

Symptoms of Allergic Reaction:

_____

_____

Procedures for responding to an allergic reaction:

_____

_____

Do you plan to have YMCA staff administer medication if needed?

NO YES (please fill out medication form)

YMCA Child Care Medication Form

Note: YMCA Staff cannot administer medication (prescription or over-the-counter) unless this form is completed and signed.

Prescription Medications: must be signed by a parent or guardian and physician. The prescription bottle serves as the physician's signature. All prescriptions must be in the original container.

Staff will hold any medication in a locked cabinet and dispense medication according to physician instructions or instructions on over-the-counter medication. The YMCA will retain the medication for the duration of the session and return any unused medication at the end of each session (each week). Only send enough medication for ONE WEEK with your camper.

Over-The-Counter Medications: to be signed by the parent or guardian.

Name of Child:_____ Date:_____

Medicine:_____ Dosage:_____

Method of Administering (i.e., oral, inhaler, etc.)_____

Does Medication Require Refrigeration? ___ Yes ___ No

Diagnosis:_____ Is condition contagious? ___ Yes ___ No

Dates to be administered:

From _____ To _____ Time(s):_____

(Note: we will only dispense medication as per labeled instructions)

Parent/Guardian Signature:_____ Phone #:_____

Valid for one week at a time for the length of the prescription as stated by the physician,

e.g.: antibiotic 10 days, unless otherwise stated by physician.

We will not administer medication without this completed form					
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Time to be given: _____AM					
Staff Signature:					
Time to be given: _____PM					
Staff Signature:					

Immunization Form

Name_____ Birthdate_____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on _____ (date)

by _____
(name of parent or guardian)

Notary Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)