



Summer Camps and Clubs 2024

Child Information Forms

Submit these forms to YMCA.SAC@ymcainw.org

The YMCA of the Inland Northwest & Washington State Licensing requires all documents included in the registration packet be completed prior to accepting a child into any licensed program. Please write N/A when applicable					
Location & Enrollment Information					
Grade in Fall 2024 <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> 5 th <input type="checkbox"/> 6 th <input type="checkbox"/> 7 th	Location <input type="checkbox"/> Central YMCA <input type="checkbox"/> North YMCA <input type="checkbox"/> South Y location: Manito United Methodist Church <input type="checkbox"/> Valley YMCA			First day of attendance <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	
Child's Information Form must be filled out completely in order for the child to attend					
Child First Name	M	Legal Last Name	Date of Birth	Age	
Home Address	City		State	Zip	
Parent/Guardian Information					
Name (Primary Contact)	Home Phone #	Cell Phone #	Email		
Address	Work Phone	*Authorized to pick up Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name (Secondary Contact)	Home Phone #	Cell Phone #	Email		
Address	Work Phone	*Authorized to pick up Yes <input type="checkbox"/> No <input type="checkbox"/>			
* Appropriate court documentation must be in place and a copy must be provided to deny parent/guardian access.					
Emergency Contact-authorized to pick up and other Authorized Pick up Persons (at least one must be provided, must be local and at least 16 years of age)					
Emergency Contact	Contact #	Address	Relationship to Child		
Name (authorized pickup only)	Contact #	Address	Relationship to Child		
Name (authorized pickup only)	Contact #	Address	Relationship to Child		
Child Health Information					
Physician/Clinic Name	Contact #	Date of last visit			
Dentist/Clinic Name	Contact #	Date of last visit			
Please explain any health conditions your child has, such as allergies bee stings and current medications, please notify your onsite director of any special circumstances. A Medical Allergy form will also need to be filled out.					
Allergy	Symptoms	Other			
Please list any limitations on activities or any other information our staff should be aware of					
Activity Limitations	Important Information				
Parent/Guardian Signature				Date	

Statement of Understanding, Field Trip and Transportation/Media Medication Permission and Compliance

PLEASE READ AND INITIAL EACH STATEMENT

Initial
Below

	I understand that YMCA Summer Camps and Clubs include both indoor and outdoor activities.
	To be Registered -You must, provide payment arrangement, complete the Child Information Packet (including the immunization form) others if applicable. Once all required forms/items are received, you will be notified via email, please bring confirmation email on the first day of day camp.
	Transportation -I give my permission for my child to go on supervised field trips in our YMCA Bus, YMCA Vans, or YMCA owned or leased vehicles. Children cannot be transported by YMCA staff in their personal vehicles.
	Immunization - I understand that for my child/ren to remain in the day camp, they must be up to date on all immunizations required by the DOH, given the established deadlines by DCYF and the YMCA.
	Safety and Behavior - I understand my child is expected to follow all safety instructions, remain in areas designated by staff and refrain from behavior that is harmful to oneself or others. I understand that failure to adhere to our program and behavior policies could be cause for my child's dismissal without refund of program fees. <i>I also understand it is my responsibility to ensure myself and any person authorized to pick up or drop off my child will abide by the values of the YMCA and be caring and respectful in all interactions. Failure to do so may result in dismissal.</i>
	I have read and agreed to the YMCA General Waiver Child Care-Day Camps and Clubs. I may also request a copy of the waiver as needed (this can also be found online).
	Medical Permission for Sunscreen -I give my permission for YMCA to apply or assist in applying sunscreen on, upon my request. <i>The YMCA will provide sunscreen unless your child has an allergy. You will then need to provide your own and fill out an allergy and medication form.</i> <input type="checkbox"/> Yes, I give permission <input type="checkbox"/> No, I do not give permission
	Consent for photo and/or video -by initialing here I give permission to the YMCA of the Inland Northwest to take picture or videos of my child during YMCA School Age and Summer Camps and Clubs Programs. <i>I understand that pictures may be used for testimonials, videos or photos of activities and/or for marketing purposes for the YMCA of the USA.</i> <input type="checkbox"/> Yes, I give consent <input type="checkbox"/> No, I do not give consent
	Photo Consent -I give consent for my child's picture to be taken for activities only, photos will <i>not</i> be used on Social Media or for marketing purposes. <input type="checkbox"/> Yes, I give consent <input type="checkbox"/> No, I do not give consent
	Emergency/Medical Care Treatment - I give permission that my child may be given emergency/first aid treatment by a qualified staff member of the YMCA of the Inland Northwest. 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 necessary as advised by the physician to safeguard my child's health. <input type="checkbox"/> Yes, I give permission <input type="checkbox"/> No, I do not give permission
	Field Trips -I give permission for my child to attend planned filed trips. There will be written notice posted at the site prior to the field trip date. <input type="checkbox"/> Yes, I give permission <input type="checkbox"/> No, I do not give Permission
	Medical Permission for Hand Sanitizer or Hand Wipes -I give my permission for my child to use hand sanitizer or hand wipes if soap and water is not available <input type="checkbox"/> Yes, I give permission <input type="checkbox"/> No, I do not give permission
	Parent/Guardian Signature With my signature below, I agree to the policies and permissions outlined in this form and the Parent Handbook (this can be found online or on site) Date:



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Certificate of Immunization Status (CIS)

Reviewed by:	Date:
Signed COE 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 Washington State Immunization Information System.

Child's Last Name:	First Name:	Middle Initial:	Birthdate (MM/DD/YYYY):
I give permission to my child's school/child care to add immunization information into the Immunization Information System to help the school maintain my child's record.		Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.	
X _____ Parent/Guardian Signature		X _____ Parent/Guardian Signature Required if Starting in Conditional Status	
Date		Date	

▲ Required for School	● Required Child Care/Preschool	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY	MM/DD/YY
Required Vaccines for School or Child Care Entry							
●▲ DTaP (Diphtheria, Tetanus, Pertussis)							
▲ Tdap (Tetanus, Diphtheria, Pertussis) (grade 7+)							
●▲ DT or Td (Tetanus, Diphtheria)							
●▲ Hepatitis B							
● Hib (<i>Haemophilus influenzae type b</i>)							
●▲ IPV (Polio) (any combination of IPV/OPV)							
●▲ OPV (Polio)							
●▲ MMR (Measles, Mumps, Rubella)							
● PCV/PPSV (Pneumococcal)							
●▲ Varicella (Chickenpox)							
<input type="checkbox"/> History of disease verified by IIS							
Recommended Vaccines (Not Required for School or Child Care Entry)							
COVID-19							
Flu (Influenza)							
Hepatitis A							
HPV (Human Papillomavirus)							
MCV/MPSV (Meningococcal Disease types A, C, W, Y)							
MenB (Meningococcal Disease type B)							
Rotavirus							

Documentation of Disease Immunity (Health care provider use only)		
If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.		
I certify that the child named on this CIS has:		
<input type="checkbox"/> A verified history of varicella (chickenpox) disease.		
<input type="checkbox"/> Laboratory evidence of immunity (titer) to disease(s) marked below.		
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Hib	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Rubella	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Varicella
<input type="checkbox"/> Polio (all 3 serotypes must show immunity)		
▶		
Licensed Health Care Provider Signature		Date
▶		
Printed Name		

I certify that the information provided on this form is correct and verifiable.	Health Care Provider or School Official Name: _____ Signature: _____ Date: _____
	If verified by school or child care staff the medical immunization records must be attached to this document.



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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 Medication _____

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:



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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 _____



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

Individual Food Plan

Plan must be updated annually or when there is a change in the child's special needs

This Food Allergy/Intolerance Care Plan is a general guideline to facilitate safety in a child care setting. It is required that the parent/guardian is to ensure that this form is complete and addresses the child's specific needs for managing an allergy or intolerance while participating in a child care program. This document contains personal health information and will be kept confidential.

Federal law and USDA regulation require nutrition programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal diet preferences.

Child's Full Name	Today's Date
Parent/Guardian's Names	Phone #

List suggested special skills training/education for the school age program staff.
Other special dietary requirements due to health condition.
Add any additional information or comments as needed.

List the food	Describe how the child reacts to this food	List appropriate food substitutes
	Severe or potentially severe reaction: Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Severe or potentially severe reaction: Yes <input type="checkbox"/> No <input type="checkbox"/>	

Parent/Guardian Signature	Date