FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

White Plains YMCA
Pee Wee Summer Camp Registration

☐ New child ☐ Returning Child ☐ Male ☐ Female

Child's Name: _____D.O.B:_____ Age: _____

Address: _____ Apt: _____ City/Zip Code: _____

Program Enrollment:

Hours: ☐ Regular Hours 9:00am to 3:00pm ☐ Early Bird Hours 7:30am to 9:00am ☐ Extended Hours 3:00pm to 6:30pm

Dates: ☐ Whole Summer (7/1 – 8/16) ☐ First Quarter (7/1 – 7/26) ☐ Second Quarter (7/26 – 8/16)

Family Information & Communication

Emails are used for emergency information, newsletters and program updates

Parent/Guardian Name: _____

Primary Email: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Parent/Guardian Name: _____

Primary Email: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Do parents live together? _____ If no, with whom does the child reside? _____

If parents are divorced/separated, please give specific instructions and a copy of court order concerning visits and pickup by non-custodial parent as needed. Restrictions on pickups or visitation ☐ No ☐ Yes*, attach court order.*

Emergency Information & Release of Children

Emergency contacts may include neighbors, family friends, or relatives located within close proximity of the school. If I am unable to pick up or be reached regarding important matters pertaining to my child, I authorize these people to pick up my child or answer questions. These may not be parent/guardian. **Must be 18 or older.**

Name: _____Relationship: _____

Primary Phone Contact: _____ ☐ home ☐ cell ☐ work

Secondary Phone Contact: _____ ☐ home ☐ cell ☐ work

Name: _____Relationship: _____

Primary Phone Contact: _____ ☐ home ☐ cell ☐ work

Secondary Phone Contact: _____ ☐ home ☐ cell ☐ work

Name: _____Relationship: _____

Primary Phone Contact: _____ ☐ home ☐ cell ☐ work

Secondary Phone Contact: _____ ☐ home ☐ cell ☐ work

Health Information *

Copy of physical & immunizations required

Family physician & phone: _____ Date of last physical exam: _____

☐We are exempt from immunizations due to medical or religious reasons.

☐My child is on a delayed immunization schedule.

Check all that apply

☐ ADD/ADHD ☐ Autism/Asperger ☐ Asthma ☐ Diabetes ☐ Heart Defect/Disease ☐ Seizure Disorder

☐ Other _____

☐ Allergies _____

*operations or serious injuries; chronic or recurring illness; specific activities to be encouraged or limited by physician's advice or special needs (physical, mental or psychological) for staff awareness.

If your child has special health care needs (Allergies, Asthma included) – A doctor approved Written Medication Consent Form & Allergy Action Plan is needed. Children cannot attend program until these are returned with medication. *

New York State Office Of Children And Family Services Day Care

PHOTO OF CHILD (Optional)	Child's Full Name:
	Does your child have any allergies? ☐ Yes ☐ No If Yes, what is your child allergic to?
	Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name of Medical Care Facility/Hospital:	Telephone Number:
Would you like information on Child Health Plus? ☐ Yes ☐ No	

EMERGENCY DATA

RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
			☐Pager ☐Cell ☐Other
			☐Pager ☐Cell ☐Other
			☐Pager ☐Cell ☐Other
			☐Pager ☐Cell ☐Other

Provider/Day Care Facility Name and Address:
White Plains YMCA

CHILD'S FULL NAME:			Gender ☐Male ☐Female
CHILD'S HOME ADDRESS:			DATE OF BIRTH:
City:	State:	Zip:	HOME TELEPHONE NUMBER:
DATE OF ACCEPTANCE:		DATE OF DISCHARGE:	
NAME OF PERSON APPLYING FOR CHILD:	☐Parent ☐Guardian ☐Caretaker ☐ Relative ☐Other [_____]	Home Telephone Number:	Daytime Telephone Number:
Address of Person Listed Above: (If different from child's):			

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. ☐ Yes ☐ No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. ☐ Yes ☐ No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. ☐ Yes ☐ No

I agree to review and update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE	DATE:

Parent Policy Agreement

Activities: I, the undersigned, give permission for my child to participate in the camp for the days he/she attends. My child is in good health and is able to fully participate in all activities offered at the White Plains YMCA.

Billing: I understand the non-refundable deposit of $560.00 is due when submitting my child's application, and that I cannot combine the 10% Sibling Discount with any other discounts, such as: scholarship, early bird discount, or third party. I understand no camper will be able to attend camp with a balance due on their account. I understand that camp must be paid in full by the deadline or my child will not be able to attend and I will be charged a $35.00 late fee per week. I understand if I decide to switch my child camp weeks after submitting this application I am aware there is a $35.00 swap fee per week.

DSS participants only: I understand that my child will not be able to start the program until the White Plains YMCA receives a confirmation in writing that my case/authorization is approved.

Handbook: I have received, read, and understand the Summer Camp Parent Handbook which includes the Agreement Contract, Termination of Agreement, Procedure, and Basic Discipline Policy.

Non-Medical Consent: I give consent to having over-the-counter products administered to my child during summer camp. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant. I must also provide their own sun screen and repellent labeled with their name and group. This will be kept by the Camp Staff for the duration of camp weeks. I give my permission to the Y staff to administer any standard first aid as needed.

Parental Consent/Emergency Authorization: I understand that in the event of an emergency affecting my child while participating in the White Plains YMCA programs, a designated employee of the White Plains YMCA will attempt to contact me and inform me as soon as possible. I give permission for any medical personnel selected by the camp to provide needed care and transportation to any emergency room for care. In the event I cannot be reached, I hereby give permission for my child to be treated or hospitalized by a licensed physician or hospital selected by the White Plains YMCA. In an emergency, when either I, 2nd parent/guardian or the authorized emergency contact listed cannot be reached, I hereby give permission for the YMCA of Central Northern Westchester/White Plains YMCA to take any action deemed necessary for the best interests for my child.

Photo Consent: I understand and approve for my child to be photographed, or otherwise recorded during any events and activities, for the purpose of: promotional materials to be displayed by the White Plains YMCA, publicity, including print in newspapers and social media.

Refund Policy: I understand and agree that I shall not be entitled to any reduction, refund or allowance in the event of my child's absence, sick, suspended or withdrawal from the program. This includes holiday closures.

Registration: I am aware that to reserve a space, I must make a deposit of $560.00 non-refundable fee and submit a complete registration form. In addition, I am aware that a completed medical form signed by a physician is required before my child can begin program. I understand that my child is responsible for all his/her possessions and the YMCA of Central Northern Westchester/White Plains YMCA not replace anything that is broken, lost or stolen. I understand that I must label all of my child's belongings.

Release Statement: I release all employees of the YMCA of Central Northern Westchester/White Plains YMCA from all claims of liability for any damages or injuries that may be sustained while my child is in camp.

Trips: I fully understand and approve the White Plains YMCA staff to transport my child when necessary. All camp trips follow the New York State regulation on staff to child ratios. All group leaders have gone through training and background checks. A travel first aid kit will be taken for routine medical care and travel files with medical contact information will be brought on the trip. Each group leader will have a cell phone and there will be assigned meeting times and areas to maintain constant communication. All campers are required to bring their own lunches on camp trips in separate containers clearly labeled with their name. Lunches will be stored in a cooler until consumption

By signing below, I have read, acknowledge, approve and fully understand to all of the statements above that applies for my child. / Al firmar a continuación, he leído, reconozco, apruebo y entiendo completamente a todas las declaraciones anteriores que se aplican a mi hijo/a.

_____ _____

Parent/Guardian's Signature /Firma del Padre/Guardián Date /Fecha:

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care ☐ Yes ☐ No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd Date	3rd Date	4th Date **OR** 1st Date (if given on or after 15 months of age)	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

_____

_____

_____

_____

_____

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner _____ Address _____

Please Print Name _____ City, State, Zip _____

Title _____ ( ) Phone _____ Date _____

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth:	3. Child's Known Allergies:

4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized:	15. Date to be Discontinued or Length of Time in Days to be Given:

16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

MEDICATION CONSENT FORM
CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm*): _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized:

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:
White Plains YMCA	41713	(914) 949-8030 EXT. 216

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent:

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on _____

(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: _____

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X