Muskingum Family YMCA 2018 Day Camp Information Form

Child's Name_____

Address_____ City_____ Zip_____

Parent/Guardian Name_____

Home Phone_____ Cell_____ Work_____

Child: *(please circle):* Male or Female Age: _____ Grade Entering _____

Child's Date of Birth: _____/_____/_____ Child's School_____

****

Day Camp runs June 4th through August 10th, 2018

What will your child start camp? Day_____ Date_____,2018

Will you need ***Part- Time*** (1-2 days a week) or ***Full Time*** (3-5 days a week) for camp?

(Please Circle): PART TIME or FULL TIME

Will your child need ***Extended Care***? *(Please Circle)* AM Only PM Only Both AM & PM

Will your child need to take ***Medication*** while at camp? *(Please Circle)* YES or NO

****

Weekly Day Camp Rates: **(Monday-Friday, 9:00am-4:00pm)**
$90.00/week for member
$110.00/week for non-member

Daily Rates: **(9:00am-4:00pm)**
$25.00/per day for member
$30.00/per day for non-member
$5 extra if Extended Care needed

Day Camp Extended Care: **AM Session** (6:30am- 9:00am) & **PM Session** (4:00pm- 6:00pm)
AM Only: $20.00 per week
PM Only: $20.00 per week
Both: $30.00 per week

For Office Use

Amount Paid: $_____ Date_____/_____/ 2018 Check #_____ Cash CC MO

☐ Membership $_____

☐ DOJFS ☐ Bedford Pl. ☐ Full Pay ☐ Scholar ☐ CRE-OPT.

☐ Other_____

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth	First Day at Program/Home
Home Address			City
State	Zip Code	Home Telephone Number	

Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name	Relationship to Child	
Home Address	Home Telephone Number	
City	State	Zip
Email Address *(if applicable)*	Cell Phone	
Parent's Work/School Telephone Number	Parent's Work/School Name	
Parent's Work/School Address	City	

Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name		Name	
City	State	City	State
Telephone Number	Relationship to Child	Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*		Other numbers where emergency contact can be reached *(if applicable)*	

Name of Physician or Clinic/Hospital		
Street Address		
City	State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - check all that apply ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

☐ N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

☐ N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No (If no, fill out the following)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**Do Not Give *Permission* to Transport**	
Program or Home Name Muskingum Family YMCA		**OR** **Do not sign both**	Program or Home Name	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.			**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No
(check one)

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Muskingum Family YMCA Emergency Medical Authorization

The purpose of this form is to enable parents to authorize emergency treatment for children who become ill or injured while under the care of the Muskingum Family YMCA when parents cannot be contacted.

Child's Name_____ Home Phone_____

Address_____ City_____ Zip_____

Date of Birth_____ Mother's Cell_____ Father's Cell_____

Mother's Name_____ Place of Work/Phone_____

Father's Name_____ Place of Work/Phone_____

Please list 3 other emergency contacts:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Medical History:

Date of Last Measles/Mumps/Rubella (MMR)_____ Tetanus_____

Current Medications_____

Medical Problems_____

I hereby give consent for the following medical care providers to be called:

Physician_____ Phone_____

Dentist_____ Phone_____

Hospital_____ Phone_____

In the event reasonable attempts to contact me or other designated persons are unsuccessful, I hereby give the YMCA consent for (1) the administration of any medical treatment deemed necessary by the above medical care providers, or in the event the designated preferred provider is not available, by another licensed provider. (2) The transfer of the child to a preferred hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Parent/Guardian Signature_____ Date_____

Do Not Complete Unless Refusing Authorization

I DO NOT give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish for the Muskingum Family YMCA to take no action or the following action:

_____

_____

Parent/Guardian Signature_____ Date_____

Policy for the Release of Children

The Muskingum Family YMCA will NOT release a child to anyone other than the designated adults listed below. All children must be signed in and out daily on the sign in and out sheet.

We must have written authorization for the release of_____
to anyone other than these adults listed below. Child's Name

If the parent/guardian needs to change the designated adults for the release of their child, it must be done in writing.

Please list all authorized adults who have permission to pick up your child below.

Adult Name's- Authorization (Including Parent/Guardian Names)	Address	Relationship	Phone Number

Parent/Guardian Signature_____

Date_____

*If there's an emergency and someone other than the persons on this list must pick up your child, you MUST inform us. Your emergency pick up person will need to have a driver's license with them in order to pick up your child. If you neglect to call us concerning this change, your child will NOT be released until we can verify your authorization.

Ohio Department of Job and Family Services

PERMISSION TO PARTICIPATE IN SWIMMING ACTIVITIES FOR CHILD CARE

Written parental permission is required for the water activities your child will be engaging in (check all that apply for this activity)

- ☑ Child swimming in water 18 inches or more in depth
- ☐ Child participating in activities near water 18 inches or more in depth (no water activities planned)
- ☐ Infants and toddlers using wading pools

I give permission for my child to participate in the following swimming/water activities

Swim Site

Muskingum Family YMCA and the Muskingum Recreation Center (MRC)

Date(s)

June 4, 2018 - August 10, 2018

Departure/Arrival Times from Center

Pool is onsite at the Muskingum Family YMCA 1-3 pm/ MRC from 1-3 pm certain days of the week

Mode of Transportation (parent's driving, provider vehicle, public transportation, school bus, etc.)

Onsite pool/Walking to the MRC

Child's Name	Child's Date of Birth

My child is a ☐ Swimmer ☐ Non swimmer

Parent's Signature	Date

Ohio Department of Job and Family Services

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information

Routine Trip Destination(s)

OUZ, Zane State College, Muskingum Recreation Center, Adams Lane Care Center, Animal Shelter

Date of Permission *(valid for one year)*

June 4, 2018 - August 10, 2018

Mode of Transportation (*walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*

Walking

During this trip children will have access to water that is 18 inches or more in depth.

☑ Yes ☐ No

Are water activities planned in water that is 18 inches or more in depth? ☑ Yes ☐ No

(if yes, a swimming permission slip is required)

Child's Information

Child's Name

My child is

☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 8 years and/or over 4' 9"

Signature

I grant permission for my child to participate in the routine trips described above.

Parent's Signature	Date

SUNSCREEN

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

Box 1	The following section must always be completed by the parent/guardian.

Check all that apply and complete all of the information.

☐ Prescription Medication ☐ Nonprescription Medication ☐ Food Supplement

☑ Topical Product or Lotion ☐ Refrigeration Required ☐ Modified Diet

Name of Child	Date of Birth	Weight

Name of Medication Sunscreen Brand:	Exact Dosage As Directed on Label

To be administered at the following times Before Swimming-1:00 pm	For the following period of time Monday-Friday June 4th - August 10th, 2018

☑ I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).

Signature of Parent/Guardian	Date

Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of child	Name of medication, vitamin, diet, supplement

Dosage	Possible side effects to watch for are

Expiration date

(May not exceed twelve months from the date of this request for medications of food supplements).

Instructions

This child is under my care and should receive the above medication as written.

Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant

Date of signature	Phone number

Name of child	Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.