

YMCA "Club Y" (K-3) After School Registration Checklist

_____ Completed and signed all registration papers (front and back)

_____ Attached a copy of your child's most recent physical and picture

_____ Paid \$25 activity fee

_____ Payment for the first week your child will attend

(Payment for your child for the first week your child will attend must be paid before your child can start the program. West Central Child Care Connection co-pays must be paid at the beginning of the month. Any other exceptions must be approved prior to the start of the school year.)

Child's Name _____

**QUINCY FAMILY YMCA
CLUB Y (K-3)
AFTER SCHOOL PROGRAM
2009-10 REGISTRATION FORM**

NAME _____ BIRTHDATE _____

SCHOOL _____ GRADE _____

TEACHER _____ SCHOOL PHONE _____

YOUR CHILD WILL BE ATTENDING THE MADISON SCHOOL SITE.

_____ FULL-TIME (4-5 days/week) _____ PART-TIME (2-3 days/week)

CIRCLE DAYS ATTENDING: MON TUES WED THURS FRI

SCHOOL'S OUT (FULL DAY)? YES _____ NO _____

Y FAMILY MEMBER? YES _____ NO _____

MOTHER _____ ADDRESS _____

PHONE (h) _____ WORK _____

CELL PHONE _____

FATHER _____ ADDRESS _____

PHONE (h) _____ WORK _____

CELL PHONE _____

QUINCY FAMILY YMCA

WEEKLY FEE for YMCA Club Y (K-3):

Full-time (4-5 days) or Part-time (2-3 days)
\$65 (\$50 - Y member) \$53 (\$40 – Y members)

20% discount for each additional sibling (YMCA members)
Also due: \$25 Activity Fee (paid one-time only during the school year)

1. Payments must be made for each week in a timely manner. Late payments may lead to suspension or termination from the program.
2. A late charge of \$5 for each quarter hour or any portion thereof for not picking up your child by 6:00 p.m. will be added to your fee and must be paid before the next week of attendance.
3. Special payments arrangement can be made if needed. Financial assistance is also available. Our goal is that no child be turned away because of financial need. However, arrangements must be made prior to attendance.
4. Please notify the program director or site coordinator when your child will be absent.
5. The YMCA Club Y at the **Madison School Site will be at the YMCA on Friday afternoons for the purpose of swimming.** Please bring your swimsuit, towel, etc. on these days. Please pickup your child at the YMCA on Fridays.
6. SCHOOL CLOSINGS

Unscheduled/Emergency – when school is closed due to inclement weather (heat or cold), the program will be held at the Quincy Family YMCA. **Refunds will not be given for missed days because of a bad weather school closing.** The program will begin at 7:30 (am (later if extreme weather requires a delayed opening; call ahead if questions). Please send swimsuit, towel and sack lunch with your child.

Scheduled (holidays, conferences, etc.) – School's Out Days will also be held at the Quincy Family YMCA. Children should arrive no later than 8:00 a.m. with a lunch and a swimsuit, etc. There is an additional fee for these days since they involve all day care. If your child is a full-time School Age Child Care Program participant, the fee per day is \$17 for Y Members or \$23 for program participants. There is a flat fee is \$25 per day for anyone not enrolled in the School Age Child Care Program.

Early Out Days – Early Out Days (or half-days) will be held at the Quincy Family YMCA. Children will be picked up from school in the YMCA mini-bus and transported to the YMCA building. They can bring their swimsuit, etc. There is an additional fee for these days since they require additional hours of child care. If your child is a full-time School Age Child Care program participant, the fee is \$13.50 for Y members, and \$15 for program participants. A flat fee of \$25 per day for anyone not already enrolled in the School Age Child Care Program.

QUINCY FAMILY YMCA PARTICIPATION AGREEMENT

In consideration of participating in the Club Y After School Child Care Program (herein after "Program"), the undersigned agrees as follows:

- (1) Consent to participating in the Program as well as follow all of the rules, regulations and guidelines set down by the program organizers.
- (2) Release the YMCA, an Illinois not-for-profit corporation, (hereinafter "Organization"), their agents, officers, directors, action whatsoever, arising out of or related to any loss, damage or injury to person or property that may be sustained by the undersigned as a result of any of the undersigned's participation in the aforesaid Program.
- (3) If one of the undersigned is a minor (under eighteen years of age), then their parent and/or guardian, as next friend and guardian of the minor, does expressly agree to indemnify and hold harmless the aforesaid Organizations, their agents, officers, directors, employees and volunteers, from any and all claims or actions in law or equity that may hereafter come or at any time be brought by said minor, or the minor's administrator for any reason whatsoever.
- (4) The undersigned acknowledges and understands the Organization is not responsible for the health care cost and/or insurance needs of the participant when involved in the Program.
- (5) Written consent shown to attend activity and name of activity away from the YMCA before time of said activity is required.

IN WITNESS WHEREOF, the undersigned have set their hand and seal

This _____ day of _____, 20____.

(Witness)

(Participant)

(Witness)

(Parent or Guardian)

(Parent or Guardian)

Parent and/or guardian signatures required for minors.

APPLICATION/RECORD OF CHILD INFORMATION

Name of Child _____ Birthdate _____ Sex _____

Address _____

Date Child Received _____ Date Child Left _____

PARENT OR OTHER PERSONS(S) PLACING THE CHILD

Name _____ Name _____

Relation to child _____ Relation to child _____

Home address _____ Home address _____

Phone Number _____ Phone Number _____

Place of employment _____ Place of employment _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Working hours _____ Working hours _____

OTHER PERSON TO NOTIFY IF PERSON PLACING THE CHILD CANNOT BE REACHED

Name _____ Address _____

Phone Number _____ Relationship _____

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name _____ Address _____

Phone Number _____ Hospital or Clinic _____

PROGRAM

Days per week _____ Hours of care _____

Rate of pay (optional) _____

Signature of parent or other person placing child

Signature of caregiver

Date

If the child has any of the following, please explaining:

Medical problems _____

Physical handicaps _____

Restrictions for play—outdoors _____

Restrictions for play—indoors _____

Allergies _____

Food likes _____

Food dislikes _____

Fears _____

Does the child take a nap? _____ Time _____ Length _____

Is the child toilet trained? _____

Does the child have special names for objects? (potty, cookies, drinks, etc.) _____

Does the child regularly take medication? _____ If so, what kind and directions _____

If the child is an infant, what are the feeding instructions? _____

Time _____ Amount _____ Temperature _____

Diaper changes: Powder _____ Ointment _____

Other information that will help in caring for the child _____

Comments:

ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY

State of Illinois
Department of Children and Family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD _____

THESE CONSENTS ARE FOR NON-DCFS WARDS ONLY AND MAY ONLY BE USED FOR DAY CARE SERVICES.

Parent(s) or legal guardian placing the child may sign any or all of the following consents:

EMERGENCY MEDICAL CARE

This authorizes _____
to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will
be responsible for the emergency medical charges upon receipt of the statement. _____
is the preferred doctor/clinic/hospital.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

I/we authorize _____ to administer prescribed medicine to my/our child as
specified in the prescription's directions for administration.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

ADMINISTER OVER-THE-COUNTER MEDICINE
(Administer only in accord with the appropriate standards for licensure)

I/we authorize _____ to administer over-the-counter medicine to my/our
child as specified in written instructions.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

CHILD PICKUP

(Use additional sheet of paper if more than 3 people are authorized to pick up child)

I/we authorize _____	Name	Address	Phone
and/or	Name	Address	Phone
and/or	Name	Address	Phone

to pick up my/our child when I am/we are unavailable.

Date _____	Signature of parent/guardian
	Relationship to child
Date _____	Signature of parent/guardian
	Relationship to child

TRIPS, EXCURSIONS, AND PUBLIC PARK FACILITIES

I/we authorize _____ to take my/our child on walking trips, special excursions, and to nearby public park facilities. I/we also authorize the child to ride as a passenger in the vehicle owned or leased by the above-named person(s). I/we understand all such trips are under the supervision of the above-named person(s) and that health and safety precautions are taken in compliance with DCFS standards for licensure.

Date _____	Signature of parent/guardian
	Relationship to child
Date _____	Signature of parent/guardian
	Relationship to child

SWIMMING

I/we consent to my/our child using the swimming pool of _____
Name of Provider

at _____
Address

Date _____	Signature of parent/guardian
	Relationship to child
Date _____	Signature of parent/guardian
	Relationship to child



STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION



Please Print

Student's Name Last	First	Middle	Birth Date	Sex	Grade Level	ID#
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Address Street	City	ZIP code	Parent/ Guardian	Telephone # Home	Work
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IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given after the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1			2			3			4			5			6			
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																			
Diphtheria and Tetanus (Pediatric DT or Td)																			
Inactivated Polio (IPV)																			
Oral Polio (OPV)																			
Haemophilus influenzae type b (Hib)																			
Hepatitis B (HB)																			
Varicella (Chickenpox)																			Comments
Combined Measles, Mumps and Rubella (MMR)																			
Measles (Rubeola)																			
Rubella (3-day measles)																			
Mumps																			
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			
Check specific type (PCV7, PPV23)	Date																		
Other (Specify hepatitis A, meningococcal, etc.)																			

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease Signature Title Date

3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella

Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA																		
Pre-school – annually beginning at age 3; School age – during school year at required grade levels																		
Date																		
Age/Grade	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																		
Hearing																		

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Printed by Authority of the State of Illinois
(Complete Both Sides)

Student's Name			Birth Date	Sex	School	Grade Level/ ID #
Last	First	Middle	Month/Day/ Year			

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)				
Diagnosis of asthma?	Yes	No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during the night coughing?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Birth complications/prematurity?	Yes	No	Surgery? (List all.) When? What for?	Serious injury or illness?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.	
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No		
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No	Alcohol/Drug use?	
Seizures? What are they like?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No		
Heart problem/Shortness of breath?	Yes	No	Dental	9 Braces	9 Bridge	9 Plate	Other
Heart murmur/High blood pressure?	Yes	No	Other concerns?				
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.				
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____	Parent/Guardian Signature						
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)	Date						
Ear/Hearing problems?	Yes	No					
Bone/Joint problem/injury/scoliosis?							

Entire section below to be completed by MD/DO/APN/PA

PHYSICAL EXAMINATION REQUIREMENTS	HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (Not required for daycare.) BMI >85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>					
LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Blood Test Result _____ (If child resides in Chicago, blood test is required.)					
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. <input type="checkbox"/> No Test Needed <input type="checkbox"/> Test performed Date Read / / Result mm					
LAB TESTS (Recommended)	Date	Results	Date	Results	
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening		
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs	
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____ Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optometrlist Yes <input type="checkbox"/> No <input type="checkbox"/>			Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal examination		
Cardiovascular/HTN			Nutritional status		
Respiratory			Mental Health		
NEEDS/MODIFICATIONS required in the school setting			DIETARY Needs/Restrictions		
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup					
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal					
EMERGENCY ACTION needed while at school due to child's health condition (e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.					
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified, please attach explanation.)					
PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>		
Physician/Advanced Practice Nurse/Physician Assistant performing examination					
Print Name		Signature		Date	
Address			Phone		

(Complete both sides)