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

_____Completed and signed all registration papers (front and back), Including DCFS paperwork.

_____Paid $25 activity

_____Attached a copy of your child's most recent physical

_____ Attach a recent picture of your child

_____ Attach your child's birth certificate.

Child's Name_______________________________________

REGISTRATION PAPERWORK MUST BE RECEIVED AT LEAST 5 BUSINESS DAYS BEFORE THE CHILD CAN ATTEND PROGRAM.

QUINCY FAMILY YMCA

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

Before School Care:	**$25 members**	**$30 program participants**
After School Care:	**Full-time (4-5 days)** **$68 - Program Participant** **$53 - Y member**	**Part-time (2-3 days)** **$56 – Program Participant** **$43 – Y members**

20% discount for each additional sibling (YMCA members)
$25 Activity Fee (paid at registration (only once) 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. Before School Care will be held at the YMCA. Children will be transported to their schools.
4. 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.
5. Please notify the program director or site coordinator when your child will be absent.
6. 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.
7. 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 $20 for Y Members or $25 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 $16.50 for Y members and $18 for program participants.

QUINCY FAMILY YMCA
Club Y (K – 3 Grade)
BEFORE AND AFTER SCHOOL PROGRAM
2011-2012 REGISTRATION FORM

CHILD' NAME______________________________BIRTHDATE______________

ADDRESS__________________________________ ZIP ____________________

SCHOOL___________________________________GRADE_________________

MOTHER__________________________________ Birthdate ________________

ADDRESS _________________________________ ZIP ____________________

PHONE (h)_________________________WORK ___________________________

CELL PHONE______________________ E-MAIL __________________________

FATHER___________________________________ Birthdate ________________

ADDRESS_________________________________ ZIP ____________________

PHONE (h)_________________________WORK___________________________

CELL PHONE______________________ E-MAIL __________________________

BEFORE SCHOOL CARE? Y ____ N ____ DAYS ATTENDING: M T W Th F

AFTER SCHOOL CARE? Y ___ N ____ DAYS ATTENDING: M T W Th F

_____FULL-TIME (4-5 days/week)____PART-TIME (2-3 days/week)

SCHOOL'S OUT DAYS/HOLIDAYS YES_______ NO_______

Y FAMILY MEMBER? YES_______ NO_______

Have you applied for SCHOLARSHIP ____ WEST CENTRAL ____ NONE___?

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.

QUINCY FAMILY YMCA
HEALTH INFORMATION

Because we care about the health and safety of your child, we need the following information to do our job properly. As the parent or guardian, it is your responsibility to keep the Youth and Family Program Director up-to-date with any medical changes that occur after this form is submitted. We also require a medical release signed by a doctor to administer prescription medication to your child while they are participating in our program.

NAME OF CHILD ____

Please check boxes applicable for any medical condition that requires special attention and explain thoroughly.

[ ] Allergies ______________________

[ ] Diabetes [ ] Epilepsy [ ] Heart

[ ] Special Medication ______________________________

[ ] Activity Restrictions ______________________________

[ ] Emotional Problems ______________________________

[ ] Learning Disabilities ______________________________

[ ] Social Problems ______________________________

[ ] Other ______________________________

Date of last tetanus shot ______________ Immunizations current? ____ Yes ____ No

Additional explanations or details: ______________________________

____

____

Person to call if parent cannot be reached in case of emergency:

Name ______________________________ Phone ______________

Name ______________________________ Phone ______________

Contact family physician ______________________ Phone ______________

Take child to emergency physician if family physician cannot be reached. _____ Yes _____ No

____

Parent/Guardian Signature Date

QUINCY FAMILY YMCA

2011 -2012 School Year

DROP OFF & PICK UP AUTHORIZATION FORM

Please have any person who will drop off or pick up your child from camp, print and sign their name below. This is for the safety and protection of your child!

CAMPER'S NAME ____

NAME – **PLEASE PRINT**	SIGNATURE	RELATIONSHIP TO CHILD

PERMISSION AUTHORIZATIONS

NAME OF CAMPER____

FIELD TRIP(S)

I give permission for the above named child to attend the field trips(s) during the week(s) he/she is enrolled in the YMCA School Age Child Care Program.

____ ________________

Parent Signature Date

DAILY ACTIVITIES

I give permission for the above named child to participate in swimming and other daily activities throughout his/her program enrollment. My child may apply the sunscreen and/or bug spray (which I have provided and labeled for him/her).

____ ________________

Parent Signature Date

*** All activities subject to change without prior notification ***

CFS 428
Rev. 4/2001

State of Illinois
Department of Children and Family Services

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**

A completely filled in form must be kept by the licensee for each child not related to the licensee. Please have this form available at all times to licensing representatives of the Department of Children and Family Services. Contact the Area Office for supplies of this form.

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

CFS 593
Rev 7/2007

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

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 5/2006

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#
Address Street City ZIP code	Parent/ Guardian		Telephone # Home	Work

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 MO	1 DA	1 YR	2 MO	2 DA	2 YR	3 MO	3 DA	3 YR	4 MO	4 DA	4 YR	5 MO	5 DA	5 YR	6 MO	6 DA	6 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)	☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐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																					Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/ Contacts
Age/Grade																					
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																					
Hearing																					

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? Child wakes during the night coughing?	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth complications/prematurity?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental 9 Braces 9 Bridge 9 Plate Other Other concerns?			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
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☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONAIRRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. **Questionairre Administered?** Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **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. ☐ No Test Needed ☐ 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☐ No☐ Objective screening Yes☐ No☐ Result_____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

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: ☐ Nurse ☐ Teacher ☐ Counselor ☐ 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 ☐ **No** ☐ 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** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature** **Date**

Address **Phone**

(Complete both sides)