

**YMCA "M.A.S.H - My After School Hangout" (4-8)  
After School Registration Checklist**

\_\_\_\_\_ Completed and signed all registration papers (front and back),  
Including DCFS paperwork.

\_\_\_\_\_ Paid \$25 activity (this fee must be received before your child can  
attend the program).

\_\_\_\_\_ Attached a copy of your child's most recent physical

\_\_\_\_\_ Attach a recent picture of your child

\_\_\_\_\_ Attach your child's birth certificate.

\_\_\_\_\_ All payment arrangements, other than weekly, must be made in  
advance. This includes West Central Child Care payments and co-pays, and  
scholarships.

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 M\*A\*SH Program (4 – 8<sup>th</sup> grades)

**Full-time (4-5 days)**

**\$43 – Program Participants**

**\$33 - Y member**

**Part-time (2-3 days)**

**\$33 – Program Participants**

**\$23 – Y members**

20% discount for each additional sibling (YMCA members)

\$25 Activity Fee paid at registration (once 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 M\*A\*S\*H Program allows for swimming throughout the week. Please send a swimsuit, towel, etc. on these days.
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 \$18 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 \$14.00 for Y members, and \$16.50 for program participants.

**QUINCY FAMILY YMCA**  
**M\*A\*S\*H (4-8) My After School Hangout**  
**AFTER SCHOOL PROGRAM**  
**2011-2012 REGISTRATION FORM**

**CHILD'S 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** \_\_\_\_\_

**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 M.A.S.H. (My After School Hangout) 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 \*\*\*

**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

<b>Student's Name</b> Last	First	Middle	<b>Birth Date</b>	<b>Sex</b>	<b>Grade Level</b>	<b>ID#</b>
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<b>Address</b> 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.**

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

**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	
Vision																	
Hearing																	

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

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

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

<b>ALLERGIES</b> (Food, drug, insect, other)			<b>MEDICATION</b> (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?	Yes	No
Developmental delay?	Yes	No		Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No		TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No		Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No		Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No		Dental 9 Braces 9 Bridge 9 Plate Other		
Dizziness or chest pain with exercise?	Yes	No		Other concerns?		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Information may be shared with appropriate personnel for health and educational purposes.		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				<b>Parent/Guardian Signature</b>		
Ear/Hearing problems?	Yes	No		<b>Date</b>		
Bone/Joint problem/injury/scoliosis?						

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

<b>PHYSICAL EXAMINATION REQUIREMENTS</b>		<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> (Not required for daycare.) <b>BMI</b> >85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/>						
<b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>						
<b>LEAD RISK QUESTIONNAIRE</b> 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"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Blood Test Result</b> _____						
(If child resides in Chicago, blood test is required.)						
<b>TB SKIN TEST</b> 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 <b>Date Read</b> / / <b>Result</b> mm						
<b>LAB TESTS (Recommended)</b>		Date	Results	Date	Results	
Hemoglobin or Hematocrit				Sickle Cell (when indicated)		
Urinalysis				Developmental Screening		
<b>SYSTEM REVIEW</b>	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/Optometrst 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	
<b>NEEDS/MODIFICATIONS</b> required in the school setting				<b>DIETARY</b> Needs/Restrictions		
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup						
<b>MENTAL HEALTH/OTHER</b> 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						
<b>EMERGENCY ACTION</b> 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.)		
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>		<b>INTERSCHOLASTIC SPORTS</b> (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>		Physician/Advanced Practice Nurse/Physician Assistant performing examination		
<b>Print Name</b>		<b>Signature</b>		<b>Date</b>		
<b>Address</b>				<b>Phone</b>		

(Complete both sides)

