FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

All Day Child Care Program

West Cook YMCA Registration Form

Child's First Name: _____ Last Name: _____

Nickname: _____Birthday: ____/____/____ Current Age: _____

Home Address _____

City_____ State_____ Zip _____ Grade for 2020-2021: _____

Are you currently receiving Child Care Assistance Program (**CCAP**) funding for childcare services? ☐ Yes ☐ No

How did you hear about the program?
☐ WCY Website ☐ Facebook ☐ WCY Email ☐ Wednesday Journal ☐ Word of Mouth
☐ Other, please specify: _____

PLEASE CHECK THE APPROPRIATE SESSION DATES
If you would like a full week of care, please check the full week boxes below for each week offered. If you prefer only specific days, please check the specific days of each week you would prefer.

June 1-5	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.
June 8-12	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.
June 15-19	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.
June 22-26	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.
June 29-July 3	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.
July 6-10	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.
July 13-17	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.
July 20-24	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.
July 27-31	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.
Aug 3-7	☐ Full Week	☐ Mon.	☐ Tues.	☐ Weds.	☐ Thurs.	☐ Fri.

Due to performing health screenings at drop off each day, we will reach out to schedule a drop off time with you. Please indicate your typical work shift (or note if it varies) so we can schedule your drop off time:

Work Shift: ____ am _____pm ☐Varies

Child's Name _____

GENERAL INFORMATION FORM

The guardians listed on this page are allowed to pick up on a regular basis and under any condition. (Please Print)

Parent/Guardian 1: First Name_____ Last Name_____

Home Address _____ City_____ State____ Zip _____

Place of Work_____

Work Address_____ City_____ State____ Zip _____

Phone: Work _____ Home _____ Cell_____

Email_____

Parent/Guardian 2: First Name_____ Last Name_____

Home Address _____ City_____ State____ Zip _____

Place of Work_____

Work Address_____ City_____ State____ Zip _____

Phone: Work _____ Home _____ Cell_____

Email_____

Family Dynamics: (please share if you believe details would help your child while in our care)

_____

_____

Name and ages of other children in the home: _____

_____

When necessary, who should be the first contacted? _____

Please give us any other information which would help us to know your child better such as habits, developmental barriers, medical needs, behavioral concerns, fears, or any other factors that would be important to know: _____

_____

_____

Child's Name _____

APPROVAL FOR WEST COOK YMCA ACTIVITIES

Please check all the appropriate boxes that you are approving or not approving and sign and date at the bottom of the page.

Water Activity Permission Authorization:

☐ I give permission for my child to participate in swimming and other water activities offered as part of the YMCA program.

☐ I DO NOT give permission for my child to participate in water activities.

Photo/Video Permission Authorization:

☐ I give permission for my child to have their picture and/or video taken as part of the West Cook YMCA Program. I understand that the picture or video may be displayed within the facility, in the newspaper, or on other media outlets.

☐ I DO NOT give permission for my child to have their picture and/or video taken for the purpose of using within the facility, newspapers, or other media outlets.

Food Permission Authorization:

I give permission for my child to participate in the below meals. If I select to not give permission, I understand that I am responsible for providing my child with any nut free meals for throughout the program.

Breakfast	☐ Yes	☐ No (Please note we will not serve Breakfast on Mondays)
Snack	☐ Yes	☐ No
Lunch	☐ Yes	☐ No

I give authorization based on the above boxes checked:

Sign and Date

Child's Name _____

HEALTH HISTORY FORM

Child's Physician's Name _____ Phone: _____

Address, City, State, Zip _____

Child's Dentist's Name _____ Phone: _____

Address, City, State, Zip _____

Medications/Dietary Restrictions- _____

_____

If your child needs medication administered to him/her during the program, please complete the medical distribution permission form. Please list ANY additional information about your child's health history, behavior, and physical, emotional, or mental health about which the YMCA staff should be aware. All information given is confidential and will only be viewed by necessary YMCA staff.

EMERGENCY MEDICAL AUTHORIZATION

The purpose of this authorization is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under our supervision when parents or guardians cannot be reached.

☐ I hereby give my consent for the administration of any medical treatment deemed necessary by our family doctor or another licensed physician at the closest hospital facility.

☐ I DO NOT give my consent for the emergency medical treatment beyond basic first aid for my child. In the event of sudden illness or injury requiring emergency medical treatment, I hereby give the YMCA staff authority to do the following: _____

_____

I approve as checked above and know the responsibility would rely on me for any medical costs that would come up.

_____

Sign and Date

Child's Name _____

Does your child currently have a 504 Plan in place? Please describe: _____

_____

_____

_____

_____

_____

_____

Does your child currently have an IEP in place? Please describe: _____

_____

_____

_____

_____

_____

_____

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_____

I approve as checked above and know the responsibility would rely on me for any medical costs that would come up.

Sign and Date

Child's Name _____

WEST COOK YMCA PICK-UP AUTHORIZATION

All individuals who wish to pick up your child must be listed below. (Excluding parents and guardians listed on the general information sheet.) For the safety of your child, **anyone** picking up your child must have a picture I.D. Anyone without proper authorization will not be allowed to take your child.

☐ I do not wish to authorize additional individuals to pick up

Emergency contacts/ Individuals authorized to pick up child on a regular basis (apart from the guardians listed on the general information sheet):

Name_____ Relationship to child_____

Address_____ City_____ State_____ Zip_____

Daytime Phone_____ Evening Phone_____ Cell phone_____

Name_____ Relationship to child_____

Address_____ City_____ State_____ Zip_____

Daytime Phone_____ Evening Phone_____ Cell phone_____

I authorize the following additional people to pick up my child:

Name	City Located	Phone	Conditions for Releasing Child (If any)

If anyone other than those listed will be picking up your child, you must notify camp staff via e-mail. Phone authorization will not be sufficient. Reminder that all need photo I.D. needed for pick up authorization.

Child's Name _____

WEST COOK YMCA SCHOOL AGE DEVELOPMENTAL HISTORY

Please list all siblings and their ages and other members of your household: _____

_____

How would you describe your child: _____

_____

Does your child have any difficulties with speech or expressing themselves? _____

_____

How does your child respond to being in large and small groups? _____

_____

Language spoken at home: _____

Does your child have any fears: _____

Swimming and water experience: _____

Previous experience with other children: _____

Reaction to strangers: _____

How do you comfort your child? _____

What is the method of behavior management at home? _____

_____

What would you like your child to gain from this experience? _____

_____

Serious illnesses and/or hospitalizations: _____

Special physical conditions, or disabilities that may require accommodations (please be specific):

_____

Regular Medications and/or Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions or intolerances: _____

Dietary Restrictions: _____

Are there any more details or comments about your child we should know? _____

_____

Parent/Guardian Signature _____ Date_____

Child's Name _____

MEDICAL DISTRIBUTION PERMISSION FORM

(Only for students who will take medication during program or needs medicine, including an inhaler or Epi-pen, to be kept on-site.)

I give the West Cook YMCA permission to administer the following medication to my child.

- Medication must be in its **original, labeled** container. No medication will be accepted if not the original container.
- The child's name must be on the medication container.
- The date on the prescription must be current (within 1 month for antibiotics; and within 1 year for other medications).
- The medication's name, dose and frequency of administration on the label must be consistent with parental instructions.

Child's Name _____ Age _____ Gender_____

Reason for medication _____

Date to start medication _____ Date to stop_____

Days to be given ☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐As Needed Only

Prescribing Physician's Name: _____ Phone: _____

Address, City, State, Zip: _____

Prescription number_____ Name of Medication_____

Directions for administering (dosage, time of day, times per day, etc.) _____

_____

Other_____

Date	Time	Dosage	Staff Initials

Guardian's Name: _____ Signature: _____ Date: _____

Child's Name _____

WEST COOK YMCA Y-KIDS HANDBOOK AND POLICIES ACKNOWLEDGEMENT

The West Cook YMCA understands that effective communication is a key component in helping to provide you and your family with quality programs. To help serve you better, please take some time to read and understand the Emergency Childcare Program Handbook. If you have any questions or concerns, please contact us at emergencychildcare@westcookymca.org

Please print:

I, _____, parent/guardian of _____ acknowledge that I have received a copy of the West Cook YMCA's Emergency Childcare Program Handbook, and I am responsible for complying with all of the policies and procedures stated within.

I also understand that I must submit the DCFS Physical Examination Form by the first day of program.

Each day please have your child bring their water bottle, homework or eLearning assignments, and swim attire.

Parent/Guardian Signature: _____ Date: _____

Child's Name _____

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

Student's Name Last First Middle	**Birth Date** Month/Day/Year	**Sex**	**Race/Ethnicity**	**School /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 DA YR	**2** MO DA YR	**3** MO DA YR	**4** MO DA YR	**5** MO DA YR	**6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **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 result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																					**Code:**
Age/ Grade																					**P = Pass**
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**F = Fail**
Vision																					**U = Unable to test**
Hearing																					**R = Referred** **G/C = Glasses/Contacts**

IL444-4737 (R-01-12) **(COMPLETE BOTH SIDES)** **Printed by Authority of the State of Illinois**

Child's Name _____

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

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	Yes Yes	No No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth defects?	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 ☐ Braces ☐ Bridge ☐ Plate Other			
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?	Yes	No					

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

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **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 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 ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐
Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** _____
Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

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** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)