FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA BUFFALO NIAGARA
CHILD CARE ENROLLMENT FORM

PHOTO

Name _____

School _____

Grade _____

Age _____

Site _____

Start Date _____

☐ AM Program ☐ PM Program

ALLERGIES/MEDICATION

Will your child require prescription medications while in the program? ☐ Yes* ☐ No
(* if yes please complete Individual Health Care Plan and Medication Consent Form)

Does your child have allergies? ☐ Yes* ☐ No
(* if yes please describe in detail inside and complete the Individual Health Care Plan)

BEHAVIOR MANAGEMENT POLICY

The safety and well-being of each child in our care is our number one priority. When behavior expectations are not met, YMCA staff will implement our behavior management policy to help correct the undesired behavior. Listed below are the steps utilized by our staff:

a. Verbal warning given: explain why behavior is inappropriate.
b. Refocus and redirect.
c. Verbal communication between parent and site coordinator.
d. Parent conference with site coordinator and program director, followed by a written summary of meeting. Child, parent and site coordinator sign a meeting synopsis agreeing to acceptable behavior and alternative solutions.
e. If inappropriate behavior continues, child may be suspended from program for up to one week.
f. Prolonged disruptive and inappropriate behavior will result in dismissal from the SACC program.

Extreme Behavior Issues
In extreme cases, a child's behavior may warrant immediate suspension or expulsion from the program. Such cases include the use of profane or abusive language or any aggressive behavior which threatens or causes physical harm to other participants or staff.

CHILD INFORMATION

Name _____ Nick Name _____ ☐ Male ☐ Female

Grade in Fall_____ Date of Birth _____ Phone_____

Home Address_____ City _____ State _____ Zip_____

APPLICANT INFORMATION

Name of person applying for child _____ Relationship to child _____

Address _____ City _____ State _____ Zip_____

Employer_____ Day Phone_____

Cell Phone _____ E-mail Address _____

In case of an emergency, notify: (List contact information for hours during Day Care - for example work address and phone if at work)

Parent/Guardian _____ DOB_____ Address_____

Day Phone_____ Cell Phone _____

Parent/Guardian _____ DOB_____ Address_____

Day Phone_____ Cell Phone _____

Other _____ Address _____

Day Phone_____ Cell Phone _____

Physician or Medical Svc_____ Address _____ (p)_____

Names of individuals authorized to pick up child who are NOT listed above:

Name _____ Address_____ (p)_____

Name _____ Address_____ (p)_____

Name _____ Address_____ (p)_____

Name _____ Address_____ (p)_____

HEALTH INFORMATION

The following information must be filled in by the parent/guardian. The intent of this information is to provide staff the background to provide appropriate care. Provide complete information so that we can be aware of your child's needs.

Allergies Describe reaction and management of the reaction

- Medications (e.g., penicillin) _____ _____
- Food (e.g., eggs, dairy) _____ _____
- Other (e.g., insect stings, hay fever) _____ _____

Medications

Medications require a separate form. Please contact the Child Care Program Director for more information.

Insurance

Is participant covered by family medical/hospital insurance? ☐ Yes ☐ No Carrier/plan name _____

Name of insured _____ Relationship to child _____

Policy holder SS# or insurance ID # _____ Group # _____ Carrier Address _____

Health History

Any activities that child cannot participate in or needs one-on-one assistance? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

Is your child currently being treated or followed by a medical professional for any of the following:

Asthma	☐ Yes	☐ No	Diarrhea/constipation	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Seizures/Convulsions	☐ Yes	☐ No

Please explain any "YES" answers _____

_____

_____

_____

Any additional information about the child's behavior and physical, emotional or mental health the staff should be aware of?

_____

_____

_____

Special Information – AFO's, walkers, wheelchairs, assistance with toileting, behavior issues, Diets, habits, etc.

_____

_____

_____

Publicity Photographs

May we use your child in publicity photographs? ☐ Yes ☐ No

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, give permission for _____ to discuss my child's medical
(Mother, Father, Guardian) (Health care provider)
information, diagnosis and treatment, including medications with a representative of the YMCA's School Age Child Care program.

Signature of parent or guardian _____ Date _____

Health Care Provider's phone _____ Fax _____

As the Y is for youth development, we would like to know why you chose the YMCA. (Ex: I wanted my child to improve his or her social skills. I wanted to help my child stay healthy by being more physically active. I wanted my child to improve his or her academic performance.)

_____

_____

_____

_____

AUTHORIZATIONS

Participation

I give permission for my child to participate in all activities, including field trips, climbing wall, and swimming and to be transported as authorized by the YMCA if applicable. I understand I will be notified in advance of any fieldtrips. Release from Liability Recognizing that the YMCA will do its best to ensure a safe experience, I understand that accidents may occur both from my child's participation in program activities and from transportation to and from the program. I agree to assume these risks.

Medical Treatment

I hereby give permission for my child to be given cardiopulmonary resuscitation (CPR) and first aid treatment by a qualified staff member of the YMCA. In the event I cannot be contacted, I also give permission for my child to be transported by ambulance to an emergency center for treatment. I further consent to the disclosure of health information and to the medical, surgical and hospital care treatment and procedures (including, but not limited to, administration of necessary anesthetics, tests, x-ray examinations, transfusions, injections, drugs) to be performed for my child by a licensed physician or hospital selected by the YMCA director when deemed immediately necessary or advisable by the physician to safeguard my child's health.

Insurance

It is the responsibility of every individual, their parent or legal guardian, to provide for their own accident and health coverage while participating in all YMCA activities. YMCA Buffalo Niagara does not provide any accident or health coverage for its participants.

Photo Release:

The applicant hereby gives permission for the YMCA (local, national and international) to use, without limitation or obligation, photographs or other media that may include the members' image or voice to promote or interpret YMCA programs. I give permission for the YMCA to use any pictures of my child for future promotional purposes.

BY SIGNING BELOW, I RELEASE YMCA BUFFALO NIAGARA, ITS EMPLOYEES, VOLUNTEERS, INDEPENDENT CONTRACTORS, DIRECTORS AND AGENTS FROM ALL LIABILITY BASED ON ANY DAMAGE, LOSS OR INJURY WHETHER IT IS THE RESULT OF ORDINARY NEGLIGENCE OR OTHERWISE, CAUSED TO MY CHILD OR TO ME FROM PARTICIPATION IN YMCA PROGRAMS.

Signature of Parent/person(s) legally responsible: _____ Date:_____

OFFICE USE ONLY

_____ Received Parent Handbook

_____ Program Director notified of allergies & medication

_____ Form is complete (check boxes, allergy/medications)