WYOMING COUNTY YMCA
SUMMER REC
2016 PARTICIPANT FORMS

WYOMING COUNTY YMCA PERRY REC

PROGRAM PARTICIPANT PROFILE – SUMMER 2016

WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6
JULY 11 TO JULY 15	JULY 18 TO JULY 22	JULY 25 TO JULY 29	AUGUST 1 TO AUGUST 5	AUGUST 8 TO AUGUST 12	AUGUST 15 TO AUG 19

CHILD AND FAMILY INFORMATION

Child's Name:	Date of Birth:	Age:	Gender: ☐ Male ☐ Female	School/Grade in Fall:
Child's Nickname:	Child lives with:			T-Shirt Size: ☐ Youth ☐ Adult

Parent's Name:	Home Phone: Cell Phone:	Date of Birth:	Relationship:	☐ Emergency Contact ☐ Pick Up Authorization
Parent's Name:	Home Phone: Cell Phone:	Date of Birth:	Relationship:	☐ Emergency Contact ☐ Pick Up Authorization
Emergency Contact Name:	Home Phone: Cell Phone:	Date of Birth:	Relationship:	☐ Emergency Contact ☐ Pick Up Authorization
Emergency Contact Name:	Home Phone: Cell Phone:	Date of Birth:	Relationship:	☐ Emergency Contact ☐ Pick Up Authorization

PARENT/GUARDIAN AGREEMENT

- ✓ In the event of an emergency, the YMCA will make every effort to contact me. If I cannot be reached, the YMCA is authorized to act for me according to their best judgment in an emergency requiring medical care or surgery. The physician selected may hospitalize, secure proper treatment for, order injection, anesthesia or surgery for my child. I am responsible for the cost of all medical treatment and care.
- ✓ I must notify the YMCA staff immediately of any changes on these forms.
- ✓ YMCA staff and volunteers are not allowed to baby-sit or transport children at any time.
- ✓ The YMCA is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- ✓ I have read the YMCA Summer Program Parent Guide associated with my child's program and shared it with my child and agree to these policies and procedures. My child will be expected to follow all Camp rules and regulations. Failure to abide by the Camp rules and regulation may result in expulsion from the program.
- ✓ My child has my permission to participate in walking field trips with the YMCA and to ride on vehicles as arranged by the GLOW YMCA for transportation to and from YMCA Summer Programs and scheduled field trips. Specifics will be posted weekly.
- ✓ I authorize the YMCA to apply sunscreen and bug repellant to my child.
- ✓ My child has permission to swim at YMCA Summer Programs. I understand that my child's swimming ability will be assessed by the Progressive Swim Instructor prior to participating in swimming activities and will be reassessed on a regular basis to ensure swimmer safety. My child will only be able to swim in areas deemed appropriate for their swimming ability by the Progressive Swim Instructor.
- ✓ The YMCA has my permission to use photographs of my child in promotional materials such as brochures, ads, YMCA website or newspaper releases. I will not be informed of or reimbursed for such photographs.
- ✓ The undersigned agrees to hold harmless the GLOW YMCA and/or its employees/agents as a result of their child's participation in the program except in the case of those incidents which are a direct result of gross negligence by the GLOW YMCA or its employees/agents.
- ✓ By signing this form, I agree that I have read this entire form and understand my responsibilities for my child's participation and conduct in YMCA programs and activities.

MY SIGNATURE ACKNOWLEDGES MY UNDERSTANDING OF AND AGREEMENT TO THE ABOVE.

Parent/Guardian Name:	*Parent/Guardian Signature:*	*Date:*

IN ADDITION TO THIS FORM, THIS PACKET CONTAINS THE FOLLOWING FORMS THAT MUST BE COMPLETED AND TURNED IN BY SATURDAY JUNE 27TH.

PARTICIPANT LIABILITY WAIVER – READ AND SIGNED BY PARENT/GUARDIAN – INCLUDED IN THIS PACKET

PARTICIPANT HEALTH FORM – FILLED OUT BY PARENT/GUARDIAN AND SIGNED BY PHYSICIAN – INCLUDED IN THIS PACKET

INDIVIDUAL STANDING ORDER FORM – FILLED OUT AND SIGNED BY PHYSICIAN – INCLUDED IN THIS PACKET

IMMUNIZATION RECORDS – COPY PROVIDED AT CHECK-IN – PROVIDED BY PHYSICIAN

WYOMING COUNTY YMCA PERRY REC

PARTICIPANT HEALTH FORM – TO BE COMPLETED BY PARENT/GUARDIAN

THE CHILD'S PHYSICIAN SHOULD COMPLETE BOTH SIDES OF THIS FORM. PLEASE NOTE THE NEED FOR PHYSICIAN'S SIGNATURES ON BOTH SIDES OF THIS FORM.

NOT ALL YMCA SUMMER PROGRAMS ADMINISTER MEDICATION, HOWEVER, IN THE EVENT OF AN EMERGENCY WE ASK THAT FAMILIES PROVIDE US THIS INFORMATION SO THAT WE CAN BEST CARE FOR YOUR CHILD.

Child Name:	Age:	Height:	Weight:
Has your child been exposed to an infectious disease or had any major illness in the last month? ☐ No ☐ Yes			
If yes, Illness/Disease:		Symptoms:	
Is the child covered by any hospitalization/medical care policy? ☐ Yes ☐ No			
Insurance Company:			
Card Holder:		Policy/Group #:	

Child is looking forward to YMCA Program with? Enthusiasm Acceptance Caution Anxiety
Has your child been away from home before? Explain.
Does your child have any special talents, hobbies or special interests?
How does your child express anger/frustration? Is there a form of discipline (time-out is usually used) that works best with your child?
Does your child have any fears?
Things I would like my child to accomplish at the YMCA program are:
My child's swimming ability is: ☐ Afraid of water ☐ Some Lessons ☐ Confident in Deep Water
Is he/she accustomed to having a wake-up call to use the bathroom in the middle of the night?
Have any significant events happened in your family in the last few years?
Is there any other information you think is important for us to know about your child?

PROGRAM PARTICIPANT HEALTH FORM, CONT. – TO BE COMPLETED BY PHYSICIAN

CAMPER HEALTH HISTORY

Please Check All That Apply.

☐ Asthma ☐ Heart Defect/Disease ☐ Frequent Ear Infections ☐ **Allergies:**
☐ Convulsions ☐ Bleeding/Clotting Disorder ☐ Neurological Disorders ☐ Dental:
☐ Diabetes ☐ Hearing Problems ☐ ADD/ADHD ☐ Other:
☐ Emotional Disorder ☐ Vision Problems ☐ Illness: ☐ Other:

ADMINISTRATION OF PRESCRIPTION MEDICATIONS TO CHILD

PLEASE COMPLETE WITH PATIENT'S **CURRENT/SUMMER** REGIMEN FOR BOTH SCHEDULED AND PRN MEDICATIONS.

DRUG NAME	ROUTE (PLEASE INDICATE PREFERRED FORMULATION)	DOSAGE	SCHEDULE & INDICATIONS (PLEASE CIRCLE ALL THAT APPLY)	HEALTHCARE PROVIDER ORDER (PLEASE CIRCLE ONE)
PHYSICIAN SIGNATURE 1 OF 2 (see reverse side of page):				**DATE:**

Individualized Standing Orders for Administration of Over-The-Counter Medication – To Be Completed by Physician

Not all YMCA Summer Programs administer medication or house medications. However, in the event of an emergency we ask that families provide us this information. The following medications may be available and will be administered at the discretion of the YMCA nurse/MAT/health care provider as indicated.

Child Name:		**Age:**	**Weight:**	**Height:**
Drug Name	**Route (please circle preferred formulation)**	**Dosage**	**Schedule & Indications (please circle all that apply)**	**Healthcare Provider Order (please circle)**
Sun Screen Lotion/Spray	Topical	As per package instructions	As needed	**Yes No**
Insect Repellant	Topical	As per package instructions	As needed	**Yes No**
Antiseptic Ointment	Topical	As per package instructions	Minor wound care Other:	**Yes No**
Anti-itch Ointment	Topical	As per package instructions	Rashes insect bites Other:	**Yes No**
Anti-Sting Ointment	Topical	As per package instruction	Insect bites Other:	**Yes No**
Antibiotic Ointment	Topical	As per package instruction	Minor wound care Other:	**Yes No**
Sunburn Relief Ointment	Topical	As per package instructions	Sunburn Other:	**Yes No**
Ibuprofen	Oral	As per package instructions	Pain; swelling; fever Other:	**Yes No**
Acetaminophen	Oral	As per package instructions	Pain; swelling; fever Other:	**Yes No**
Anti-fungal Cream	Topical	As per package instructions	Athletes foot Other:	**Yes No**
Antacid/ Antiemetic	Oral	As per package instructions	Nausea; diarrhea Other:	**Yes No**
Swimmer's Ear Drops	Topical	As per package instructions	Ear pain after swimming Other:	**Yes No**
Eye Drops	Topical	As per package instructions	Eye irritation; allergies Other:	**Yes No**
Hydrocortisone 0.5%	Topical	As per package instructions	Rashes; insect bites; poison ivy Other:	**Yes No**
Cough Syrup	Oral	As per package instructions	Coughing Other:	**Yes No**
Laxative	Oral	As per package instructions	Constipation Other:	**Yes No**
Antihistamine	Oral or Topical	As per package instructions	Swelling Hives; allergic reaction; nasal congestion; Other:	**Yes No**
Anti-diarrhea	Oral	As per package instructions	Diarrhea Other:	**Yes No**
Lice Treatment	Topical	As per package instructions	Detection Other:	**Yes No**

Health Care Provider Name:		
Address:		
City:	State:	Zip:
License Number:	Phone:	Fax:
As requested by the patient and as mandated by New York State Department of Health, a dated and/or current copy of immunizations/shot records is attached. _____ Physician Initials		
Physician Signature 2 of 2:		**Date:**