

Stateline Family YMCA – Ironworks Growing Tree Camp 2020

Child Information

Child's Name _____ Male Female
Address _____ Birthdate _____
City, State, Zip _____ Age: _____
Home Phone _____ Grade Level for Fall 2019 _____

Parent/Guardian Information

Parent/Guardian #1	Parent/Guardian #2
Last Name: _____	Last Name: _____
First Name: _____	First Name: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Employer: _____	Employer: _____
Email: _____	Email: _____

Emergency Contacts (Two contacts other than parent/guardian)

Emergency Contact #1	Emergency Contact #2
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone #: _____	Phone #: _____

Medical and Behavior Questions to help us provide the best care possible

Has your child been diagnosed or treated for the following:
 Asthma Allergies Special Dietary Needs
 Diabetes Seizures Allergies to Insect Stings
 ADD/ADHD Other _____

Please provide details for any of the above checked boxes:

Physician's Name: _____
Phone Number: _____
Hospital Preference: _____

Parent Statement of Understanding

I understand that my child must be physically signed in/out by authorized adults Yes No
I understand that the YMCA is not responsible for lost, stolen or damaged personal articles Yes No
I understand that my weekly balance is due by the Wednesday prior to the week my child will attend Yes No
I give permission to the Stateline Family YMCA to:
Seek medical treatment for my child, in my absence, in the event of an emergency Yes No
Use photos or videos taken of my child for any and all promotional purposes Yes No
To transport my child as necessary for all activities. Bussing, swimming, field trips Yes No
Allow my child to go on short walks with the group under Y Staff Supervision Yes No
Allow my child to participate in field trips Yes No
To apply sunscreen/bug repellent that I supplied to my child Yes No
Allow my child to participate in swimming activities Yes No
Parent/ Guardian Signature: _____ Date: _____

YMCA Camp Registration

Camper's Name _____

Name of school your child attends: _____

Preferred T-Shirt Size: CS CM CL

Weeks and Dates	Camp Theme	Days Attending	Payments are due in full the Wednesday prior to the camp week your child will be attending. <u>5-Day Rate</u> Y Member \$153/Week General Public \$177/Week <u>3-Day Rate</u> Y Member \$106/Week General Public \$125/Week <u>2-Day Rate</u> Y Member \$77/Week General Public \$90/Week <u>Please Note</u> Field trips are subject to change A non-refundable deposit is required at time of registration \$25/week
June 8-12	Crayon Explosion Adventure	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
June 15-19	Time Machine Adventures	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
June 22-26	Camper vs Counselor	<input type="checkbox"/> Full Week *5 Day Fee is Pro-Rated <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
June 29- July 3	Shipwrecked	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
July 6-10	Lab Rats	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> F	
July 13-17	Farm Days	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
July 20-24	Going for the Gold	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
July 27-31	Into the Unknown (Disney)	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
August 3-7	The Great Outdoors	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
August 10-14	Animal Safari Adventures	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
August 17-21	Under the Big Top	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	
August 24-28	Year in a Week	<input type="checkbox"/> Full Week <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F	

Additional Authorized People
 Allowed to pick-up my child other than Parent/Guardian(s) listed above

Name _____

Relationship _____

Phone # _____

Name _____

Relationship _____

Phone # _____

Name _____

Relationship _____

Phone # _____



STATELINE FAMILY YMCA BANK OR CREDIT CARD DRAFT AUTHORIZATION

Name (please print)

Last

First

Middle Initial

Address

City

State

Zip Code

Please Select Draft Option Below:

[] Growing Tree Camp - Ironworks Child's Name _____

	FEE	DRAFT	FEE	DRAFT
<input type="checkbox"/> Full Week Draft	Y Member \$153	(\$128)	General Public \$177	(\$152)
<input type="checkbox"/> 3-Day Week Draft	Y Member \$106	(\$81)	General Public \$125	(\$100)
<input type="checkbox"/> 2-Day Week Draft	Y Member \$77	(\$52)	General Public \$90	(\$65)

* A non-refundable \$25 deposit is due at time of registration for each week that you would like to secure enrollment.

[] Sunshine Camp - Ironworks Child's Name _____

	FEE	DRAFT	FEE	DRAFT
<input type="checkbox"/> Weekly Draft	Y Member \$60	(\$35)	General Public \$85	(\$60)

* A non-refundable \$25 deposit is due at time of registration for each week that you would like to secure enrollment.

[] Wrap Around Camp (Todd School) Child's Name _____

	FEE	DRAFT	FEE	DRAFT
<input type="checkbox"/> Weekly Draft	Y Member \$60	(\$35)	General Public \$85	(\$60)

* A non-refundable \$25 deposit is due at time of registration for each week that you would like to secure enrollment.

PLEASE SELECT THE WEEK(S) and/or DAY(S) BELOW:

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> June 8-12
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 6/3 | <input type="checkbox"/> June 15-19
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 6/10 | <input type="checkbox"/> June 22-26
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 6/17 | <input type="checkbox"/> June 29- July 3
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 6/24 | <input type="checkbox"/> July 6-10
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 7/1 |
| <input type="checkbox"/> July 13-17
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 7/8 | <input type="checkbox"/> July 20-24
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 7/15 | <input type="checkbox"/> July 27-31
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 7/22 | <input type="checkbox"/> Aug. 3-7
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 7/29 | <input type="checkbox"/> Aug. 10-14
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 8/5 |
| <input type="checkbox"/> Aug. 17-21
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 8/12 | <input type="checkbox"/> Aug. 24-28
<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F
Draft on 8/19 | | | |

Please Select Payment Method On Backside



STATELINE FAMILY YMCA BANK OR CREDIT CARD DRAFT AUTHORIZATION

Draft Options

Checking Account

Bank Name _____

Account # _____

Bank Routing # _____

Savings Account

Bank Name _____

Account # _____

Bank Routing # _____

Credit Card

Name on Card _____

Account # _____

Card Type _____
(Discover, Mastercard or Visa)

Expiration Date _____ CID# _____

- **This authorization continues indefinitely and automatically until cancelled by the person signing this authorization. Draft cancellations require a 15 day notice.**
- Amount of draft will be determined by elected program and the fee and adjustments defined by the program policy. The draft may be adjusted based on increased fee rates or adjustments as defined by the program policy.
- Each program requires separate authorization forms.
- All drafts are non-refundable
- A fee of \$25 will be charged for all returned drafts because of non-sufficient funds, account closing or payment stopped. Two charges of this type will result in expulsion from the program.

I authorize the Stateline Family YMCA to draft the above named bank or credit card account for payment of membership or program fees. Any change in fees may constitute a change in the draft amount. I understand that the Stateline Family YMCA may initiate a preauthorization to validate the account number and bank transit number listed. I also understand that I am liable for the entire balance plus the processing fee for returned drafts.

Authorized Signature

Date

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance
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PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
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Home Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
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b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
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Home Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
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AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.

Yes No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number
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AUTHORIZATIONS

- Yes No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
- Yes No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
- Yes No I give permission for my child to participate in Transported Walking field trips and other activities during operating hours.
- Yes No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed
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CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center**. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus <i>Influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

- Yes year _____ (Vaccine is not required)
 No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³ 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³ 2 Varicella

¹If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4 **IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR**

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

- Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.

- For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

 Physician's Signature Required

- For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

- For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5 To the best of my knowledge, this form is complete and accurate.

 SIGNATURE - Parent, Guardian or Legal Custodian

 Date Signed

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)

Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

Yes No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)

Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider

Date of Examination

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number
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SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.		
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.		

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

<input type="checkbox"/> No specific medical condition	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gastrointestinal or feeding concerns including special diet and supplements
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy / seizure disorder	<input type="checkbox"/> Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
<input type="checkbox"/> Cerebral palsy / motor disorder		
<input type="checkbox"/> Other condition(s) requiring special care – Specify.		

- Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
- Food allergies – Specify food(s).

- Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

- a.
- b.
- c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates: _____

Stateline Family YMCA Child Care

Child's Name: _____ D.O.B.: _____

Home Address: _____ Phone: _____

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Child's Medical Information

Allergies: _____ Current Medication: _____

If needed, preferred hospital: _____

Physician & Phone: _____

Parent/Guardian Signature Authorizing Emergency Care:
_____ Date: _____

In addition to the Mother and Father listed on front of this card, the following people have permission to pick-up my child:

1. _____

2. _____

3. _____

4. _____

5. _____

Parent/Guardian Signature: _____ Date: _____

Other Information: _____

My child had permission to be photographed by the Y: Yes or No

My child's photo may be used on the Y's Facebook Page and other marketing materials: Yes or No