the YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

eliminating racism
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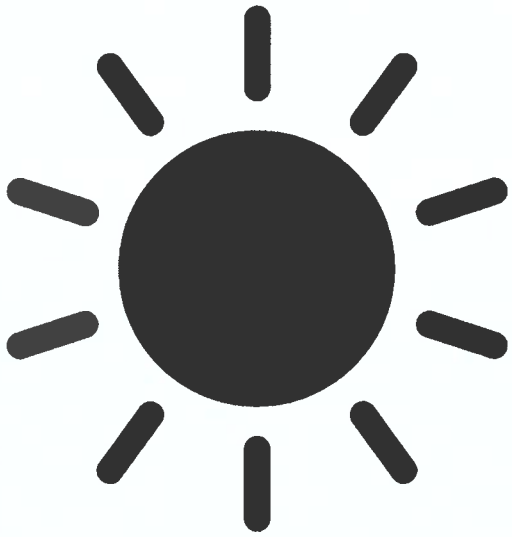
ywca

# BEST SUMMER EVER



## Little Campers

## MARSHALLTOWN YMCA-YWCA

Enclosed are the necessary materials to fully register your child for Little Campers. All forms must be fully completed and returned prior to attendance. **Children must have a physical completed within in the last year and proof of up to date immunizations in order to attend.**

Please contact Ashley Woodruff with questions at 752-8658 or ashley.woodruff@ymca-ywca.org.

### REGISTRATION CHECKLIST:

- $35 Supplies Fee
- Registration Form
- Emergency Consent Forms
- Permission Agreements
- Attendance/Payment Agreement
- Child Health Exam Form *Must be completed by a physician
- Immunization Form

# LITTLE CAMPERS REGISTRATION FORM

Child's Name _____ Date of Birth _____

Any nicknames/other names called _____

## FAMILY BACKGOUND

Please list all adults and children living in the home

| Name | Relationship | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list any special family circumstances that would be helpful for the center to know

_____

_____

## SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child ever attended preschool/daycare? _____ Where? _____

Has your child ever been cared for by anyone other than parents? _____

Does your child experience separation anxiety? _____

Does your child have any fears? _____

What is your child's favorite activity? _____

What is the primary language spoken in the home? _____ Any other languages used? _____

## PHYSICAL ROUTINES

Does your child have any special needs or abilities? _____

Does your child nap? _____What time/length is nap? _____

Does your child have any indoor/outdoor play restrictions? _____

What does your child say when he/she has to use the bathroom? _____

## BEHAVIOR

What types of discipline/management of behavior do you use with your child? _____

_____

Any additional information about your child? _____

_____

## PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment.

Child's Full Name | Date of Birth

I, _____, parent or guardian of the child named above, give my permission to providers: Marshalltown YMCA YWCA staff, to secure and authorize such emergency medical care and treatment as my child might require while under the provider's supervision. I authorize the provider to administer emergency care or treatment as required, until emergency medical assistance arrives. I agree to pay all costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent. I understand every effort will be made to notify me first and immediately in case of emergency. **I understand both pages of this form must be filled out complete with my signature indicating authorization.**

### 1. Parent/Guardians with Whom the Child Resides

- Name | Relationship to Child

Address | Home Phone | Cell Phone

Employer | Email Address

Work Phone | Work Hours

- Name | Relationship to Child

Address | Home Phone | Cell Phone

Employer | Email Address

Work Phone | Work Hours

### 2. Persons To Be Contacted in Case of Emergency and Authorized to Pick Up Your Child

*In the event parent/guardians are unavailable. Additional contacts may be added on the back.

- Name | Relationship to Child

Address | Home Phone | Cell Phone

Employer | Email Address

Work Phone | Work Hours

- Name | Relationship to Child

Address | Home Phone | Cell Phone

Employer | Email Address

Work Phone | Work Hours

- Name | Relationship to Child

Address | Home Phone | Cell Phone

Employer | Email Address

Work Phone | Work Hours

*Additional Persons may be added for Pick Up on the next page

## 3. Medical Information

Physician

Address

Phone #

Dentist

Address

Phone #

Preferred Hospital

Address

Phone #

Insurance Co

Policy ID #

Dates of Coverage

## 4. Medical History

Date of Most Recent Tetanus Shot

Known Allergies

Current Medications

## 5. Additional Persons Authorized to Pick Up Your Child

Name

Relationship to Child

Phone #

Work Phone

Name

Relationship to Child

Phone #

Work Phone

Name

Relationship to Child

Phone #

Work Phone

## 6. 6. Any persons NOT Authorized to Pick Up Your Child

*The Center requires a copy of a court order to deny a parent the right to pick up their child.

Name

Relationship to Child

Name

Relationship to Child

I,_____, the undersigned parent/guardian, do hereby give permission for my child to leave the Marshalltown YMCA YWCA with the above named persons. It is my responsibility to notify the center if there are any changes. It is my responsibility to notify the center when someone other than myself will be picking up my child. The center requires that a copy of a photo ID is on file for each of the listed individuals. **PLEASE INCLUDE ALL PARENTS/GUARDIANS ON THIS LIST.**

**This consent will be in effect for one year beginning (date)**_____

**Parent/Guardian Signature** _____ **Date**_____

# PERMISSION AGREEMENTS

Child's Full Name _____ Date of Birth _____

## RELEASE OF INFORMATION AGREEMENT

I, the undersigned parent/guardian, do hereby grant permission for my child's picture to be used in Marshalltown YMCA YWCA publications or in event a news publication is at the facility. I further give permission for my child's name to be used in conjunction with the photograph.

Parent/Guardian Signature _____ Date _____

## TRAVEL PERMISSION AGREEMENT

I, the undersigned parent/guardian, do hereby grant permission for my child to leave the Cultural Center Building. Examples include a walking trip outside of the building for exercise, a nature walk, walk to the park or walk to the Horne-Henry Center. I understand that any other activities that would require my child to leave the center will have a specific permission slip. That slip will include the exact nature of the activity, destination, transportation being used, time period of the activity, times of departure and return to our center.

Parent/Guardian Signature _____ Date _____

## SWIMMING PERMISSION AGREEMENT

I, the undersigned parent/guardian, do hereby grant permission for my child to swim with the Marshalltown YMCA YWCA at the indoor pool on Fridays.

Parent/Guardian Signature _____ Date _____

## PARENT EMAIL AGREEMENT

I, the undersigned parent/guardian, wish to provide my email address in order to receive Camp updates.

Email address _____

Parent/Guardian Signature _____ Date _____

## PARENT HANDBOOK AGREEMENT

I, the undersigned parent/guardian, acknowledge that I have received a copy of the Little Campers Handbook. I agree to follow all policies outlined within.

Parent/Guardian Signature _____ Date _____

## SUNSCREEN PERMISSION AGREEMENT

I, the undersigned parent/guardian give permission for the Marshalltown YMCA YWCA to apply a sunscreen of SPF 50 or higher to my child's exposed skin, including but not limited to the face, tops of ears, nose, bare shoulders, arms and legs. Please choose from following options:

- ☐ Marshalltown YMCA YWCA may use the sunscreen of their choice on my child.
- ☐ I will provide sunscreen for my child.

Parent/Guardian Signature _____ Date _____

## FEE SCHEDULE AND PAYMENT OPTIONS

- Registration Fee: All participants must pay a one-time Supplies Fee of $35
- Y Member Fees: $140/Week or $28/day *Please note: There is no camp on July 4th. Week 5 fees are $112/$152.
- Y Program Participant Fees: $190/Week or $38/day
- Late Registration Fee: $10 will be added to any registration not completed one week prior to the week of camp the child is attending.

**PAYMENT OPTIONS**

A child's spot in camp will only be held for the days which are paid or scheduled for payment.

1. Pay in full at time of registration, at the Y Service Desk or online at www.ymca-ywca.org. -OR-
2. Schedule weekly payments to draft on Saturdays through direct debit of credit card or bank account.

Child's Name_____Grade (going into) _____School_____

**ATTENDANCE SCHEDULE**

**Please mark with an X the days or weeks your child will attend Camp.**

**Please provide ONE WEEK notice if you need to make permanent changes to your schedule.**

| | | 6/10-6/14 | 6/17-6/21 | 6/24-6/28 | 7/1-7/5* | 7/2-7/6* | 7/8-7/12 | 7/15-7/19 | 7/22-7/26 | 7/29-8/2 | 8/5-8/9 | 8/12-8/16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Day Camp | Fees | Wk1 | Wk 2 | Wk 3 | Wk 4 | Wk 5 | Wk 6 | Wk 7 | Wk 8 | Wk 9 | Wk 10 | Wk 11 |
| Supplies Fee | $35 | | | | | | | | | | | |
| Weekly | $140/190 | | | | | | | | | | | |
| Daily - Mon | $28/38 | | | | | | | | | | | |
| Daily - Tue | $28/38 | | | | | | | | | | | |
| Daily - Wed | $28/38 | | | | | | | | | | | |
| Daily - Thu | $28/38 | | | | | | | | | | | |
| Daily - Fri | $28/38 | | | | | | | | | | | |

Name on credit/debit card or checking/savings account_____

Circle one: Visa MasterCard Discover Expiration Date_____

Credit/Debit Card Number_____

-OR-

Circle one: Checking Account Savings Account

Routing Number_____ Account Number_____

**PLEASE ATTACH A COPY OF CREDIT/DEBIT CARD OR CHECK**

I hereby authorize the Marshalltown YMCA-YWCA to charge my credit/debit card/checking/savings account for Little Campers registrations on stated dates. I understand that it is my responsibility to contact Little Campers with changes to my child's schedule no later than 8:30 A.M. of that day to receive a refund. It is also my responsibility to notify the Marshalltown YMCA-YWCA of any changes to my bank information at least a week before the automatic payment or I will be responsible for any fees incurred. A $30 returned fee will be placed on any payment returned due to insufficient funds.

Signature: _____ Date: _____

## Infant, Toddler, Preschool Age – Child Health Form

**PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information**

| | | |
|---|---|---|
| Child's name | Child's birthdate | Child Care Facility _____<br>Telephone # _____ |
| Parent/Guardian name #1 | Parent/Guardian name #2 | |
| Child home address #1 | | Telephone # 1 |
| Child home address #2 | | Telephone #2 |
| Where parent/guardian # 1 works | Work address | Home phone #<br>Work #<br>Cellular #<br>Home email<br>Work email |
| Where parent /guardian # 2 works | Work address | Home phone #<br>Work #<br>Cellular #<br>Home email<br>Work email |

**In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care facility is unable to immediately make contact with the parent/guardian.** ☐ **YES** ☐**NO**

**During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.**

Parent/Guardian Signature: _____ Date _____

**Alternate emergency contact person's name:**_____ Phone # _____

Relationship to child: Cellular # _____

| | | |
|---|---|---|
| Child's doctor's name | Doctor telephone # 1 | Hospital choice<br>**Phone #**_____ |
| Doctor's address | After hours telephone # | Does child have health insurance?<br>☐Yes, Company _____<br>**ID #** |
| Child's dentist's name (or family's dentist name) | Dentist Telephone # 1 | Does child have dental insurance?<br>☐Yes, Company _____<br>**ID#** |
| Dentist's Address | After hours telephone # | ☐ **NO, we do not have health insurance.**<br>☐ **NO, we do not have dental insurance.** |
| Other health care specialist name<br>Type of specialty | Telephone # | ☐ **Please help us find health or dental insurance.** |

Child Name:

**PARENT/GUARDIAN COMPLETE THIS PAGE** **Child's Name:** _____

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

**Growth**
☐ I am concerned about my child's growth.

**Appetite**
☐ I am concerned about my child's eating/ feeding habits or appetite.

**Rest -**
☐ I am concerned about the amount of sleep my child needs.

**Illness/Surgery/Injury** - My child
☐ had a serious illness, injury, or surgery..

Please describe:

**Physical Activity** - My child
☐ must restrict physical activity.

Please describe:

**Development and Learning**
☐ I am concerned about my child's behavior, development, or learning.

Please describe:

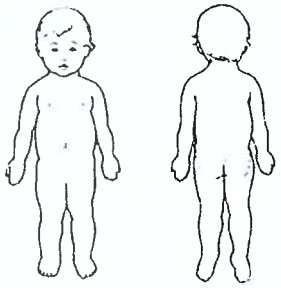
☐**Allergies**-My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

☐**Special Needs Care Plan** – My child has a special needs care plan (IEP, IFSP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.

**Body Health** - My child has problems with
☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aides or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Frequent sore throats or tonsillitis
☐ Breathing problems, asthma, cough, croup
☐ Heart, heart murmur
☐ Stomach aches, upset stomach, spitting-up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).

Parent/Guardian questions or comments for the health care provider:

## Infant, Toddler, Preschool Age – Child Health Form

**HEALTH PROFESSIONAL COMPLETE THIS PAGE**

**Child's Name:** _____

**Birthdate:** _____ **Age today:** _____

**Date of Exam:** _____

Height/Length: _____ Weight: _____

BMI– starting at age 24 mo. _____

Head Circumference- age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr: _____

Hgb or Hct- @ 12 mo: _____

Lead Risk Assessment: _____

Blood Lead Level: date _____ results _____

**Sensory Screening:**

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

**Developmental Screening/Surveillance:**
*(n = normal limits) otherwise describe*

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐ No

**Exam Results:** *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth

Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Health Care Provider comments:

**Allergies**

| |
|---|
| Environmental: |
| Medication: |
| Food: |
| Insects: |
| Other: |

**Immunization:** Please attach:

☐ Iowa Department of Public Health Certificate of Immunization

☐ Iowa Department of Public Health Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health Certificate of Immunization Exemption Religious.

☐ TB testing completed (only for high-risk child)

**Medication:** Health professional authorizes the child may receive the following medications while at the child care facility: (include *over-the-counter* and *prescribed*)

| Medication Name | Dosage |
|---|---|
| ☐ Diaper crème: | |
| ☐ Fever or Pain reliever: | |
| ☐ Sunscreen: | |
| ☐ Other | |

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

**Referrals made:**

☐ Referred to ***hawk-i*** today 1-800-257-8563

☐ Other: _____

**Health Provider Assessment Statement:**

☐ The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan _____
(please attach)

**Signature** _____
**Circle the Provider Credential Type: MD DO PA ARNP**

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year and annually.
The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015)
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

# Iowa Department of Public Health
# Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (___)_____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

| | Vaccine | Date Given | Doctor / Clinic / Source |
|---|---|---|---|
| **Diphtheria, Tetanus, Pertussis** DTaP/DTP/DT/ Td/Tdap | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Polio** IPV/OPV | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Measles, Mumps, Rubella** MMR | | | |
| | | | |
| | | | |
| ***Haemophilus influenzae* type b** Hib | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Hepatitis B** | | | |
| | | | |
| | | | |
| | | | |
| **Varicella** Chicken Pox If patient has a history of natural disease write "Immune to Varicella" | | | |
| | | | |
| | | | |
| | | | |
| **Pneumococcal** PCV/PPV | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | Vaccine | Date Given | Doctor / Clinic / Source |
|---|---|---|---|
| **Meningococcal** MCV4/MPSV4 | | | |
| | | | |
| | | | |
| **Hepatitis A** | | | |
| | | | |
| | | | |
| **Rotavirus** | | | |
| | | | |
| | | | |
| | | | |
| **Human Papilloma Virus** HPV | | | |
| | | | |
| | | | |
| | | | |
| **Other** | | | |
| | | | |
| | | | |
| | | | |

## Licensed Child Care Requirements

**4 through 5 months**
- 1 dose D/T/P
- 1 dose Polio
- 1 dose Hib
- 1 dose Pneumococcal

**6 through 11 months**
- 2 doses D/T/P
- 2 doses Polio
- 2 doses Hib
- 2 doses Pneumococcal

**12 through 18 months**
- 3 doses D/T/P
- 2 doses Polio
- 2 doses Hib or 1 dose received at ≥ 15 months of age
- 3 doses Pneumococcal if received 1 or 2 doses < 12 months of age; or 2 doses if has not received any previous doses; or received 1 dose ≥ 12 months of age

**19 through 23 months**
- 4 doses D/T/P
- 3 doses Polio
- 3 doses Hib with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 15 months of age
- 1 dose Measles/Rubella ≥ 12 months of age
- 1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease
- 4 doses Pneumococcal; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if not received any previous doses or has received no doses or has received 1 dose ≥ 12 months of age.

**24 months and older**
same requirements as the 19-23 months Except Pneumococcal. 4 doses Pneumococcal if received 3 doses < 12 months of age; or 3 doses if received 2 doses< 12 month of age; or 2 doses if received 1 dose < 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age.

## Elementary/Secondary School Requirements

**4 years of age and older**
- 5 doses Diphtheria/Tetanus/Pertussis with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥4 years of age if born after September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
- 4 doses Polio with 1 dose received ≥ 4 years of age if born after September 15, 2003; or 3 doses, with 1 dose received ≥4 years of age if born on or before September 15, 2003.
- 2 doses Measles/Rubella; the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first.
- 3 doses Hepatitis B if born on or after July 1, 1994.
- 2 doses Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has a reliable history of natural disease.

## LITTLE CAMPERS SUPPLY LIST

Please send the following items with your child each day in attendance or leave the following items at camp for the summer. Please mark all items with your child's name.

**1 Crib size sheet**

**1 Lightweight blanket**

**1 Backpack**

**1 Pair of tennis shoes and socks* if not worn daily**

**1 Extra set of clothes and underwear, accidents happen!**

***NO Pull-ups or diapers allowed.**

## THANK YOU!

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Please keep the following information for future reference!

## LITTLE CAMPERS CONTACT INFORMATION

Y Preschool Direct Line **(641)352-5072**

Marshalltown YMCA YWCA **(641)752-8658**

Brandee Brown Lead Teacher

Bat-seba Ocampo Teacher

Dulce Garcia Assistant Teacher

**(641)352-5072**

**brandee.brown@ymca-ywca.org**

Ashley Woodruff Youth/Preschool Director

**(641)752-8658**

**ashley.woodruff@ymca-ywca.org**

**REPORTING ABSENCES/LATE ARRIVALS**

Please **phone** camp staff by 8:30 a.m. if your child will be absent for the day. If no notice is given of your child's absence, you will be charged for that day. If you are registered for a day, and plan to not attend please phone staff as soon as possible. Your account will be credited or refunded if notice is given. If no notice is given, you will not be refunded. You will be charged the daily amount of $28. Staff can be reached by calling the Y at 752-8658 or 352-5072 (direct preschool line)

## THANK YOU!