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BEST SUMMER EVER

REGISTRATION FORMS

Summer Day Camp MARSHALLTOWN YMCA-YWCA

WHEN: June 6th-August 19

TIME: Monday-Friday

7:15am-5:30pm

LOCATION: Marshalltown YMCA-YWCA
Cultural Center
108 Washington St.
Marshalltown, IA 50158
Daisy Lopez
Day Camp Coordinator
E daisy.lopez@ymca-ywca.org
W www.ymca-ywca.org
P 641-752-8658





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REGISTRATION PACKET FOR DAY CAMP

This packet must be completed entirely before you can register for Summer Day Camp. Here is a checklist to guide you in completing the packet.

- Completed Parental Emergency Medical Consent
- Completed School-age Assessment and Health Form
- Attached a copy of current immunization record
- If scheduling payments, completed payment information and your child's attendance schedule
- Permissions agreement forms
- Supplies fee paid of \$35 per child

Or contact Daisy Lopez, Day Camp Coordinator - at
641-752-8658 ext. 300 / daisy.lopez@ymca-ywca.org
FAX 641-752-3324

PARENTAL EMERGENCY MEDICAL CONSENT
This form must be presented upon admission for treatment

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

CHILD'S NAME:		BIRTH DATE:	
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES			
1. NAME		D.O.B:	RELATIONSHIP TO CHILD
ADDRESS		EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER	
2. NAME		D.O.B:	RELATIONSHIP TO CHILD
ADDRESS		EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER	
EMERGENCY CONTACT PERSON(S)			
1. NAME		RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER	
2. NAME		RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER	
3. NAME		RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER	
PERSONS AUTHORIZED TO PICK UP CHILD		ADDRESS	PHONE NUMBER
1.			
2.			
3.			

Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?

Name	Name
-------------	-------------

PHYSICIAN NAME		DENTIST NAME	
PHONE NUMBER		PHONE NUMBER	
ADDRESS		ADDRESS	
HOSPITAL PREFERENCE (Please Specify): Nearest, Unity point , Other:			
KNOWN ALLERGIES		DATE OF LAST TETANUS	
PRESENT MEDICATION			
INSURANCE COMPANY		POLICY HOLDER ID	
This consent will be in effect beginning (date)		and be updated annually by the parent/legal guardian.	

SIGNATURE OF PARENT OR GUARDIAN	DATE	SIGNATURE OF PARENT OR GUARDIAN	DATE
UPDATE	DATE	UPDATE	DATE
UPDATE	DATE	UPDATE	DATE

SCHOOL-AGE ASSESSMENT & HEALTH FORM

1. **HEALTH STATEMENT** - To be completed by parent.

Child's Full Name _____

Birth Date _____

1. Significant illnesses and surgeries child has had (give age at time):

2. Any special health-related needs of child (allergies, medications, injuries, etc.):

2. **PHYSICAL ASSESSMENT** - To be completed by parent.

1. Is there any defect of vision, hearing or speech of which the child care program should be aware, or could compensate by appropriate action?

2. Is this child subject to any conditions which limit classroom activities or physical education?

3. Is this child subject to any condition which may result in an emergency situation?

4. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation?

5. Other information you would like to share (IEP or Behavior plan):

Parent's Signature _____

Date _____

FEE SCHEDULE AND PAYMENT OPTIONS

- Registration Fee: All participants must pay a one-time Registration Fee of \$35
- Y Member Fees: \$145/Week or \$28/day (\$33 on Field Trip Days)
- Y Program Participant Fees: \$195/Week or \$38/day (\$43 on Field Trip Days)
- 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 through direct debit of credit card or bank account. Payments will deduct on Saturday.

Child’s Name _____ Grade (going into) _____ School _____

ATTENDANCE SCHEDULE

Please select the days or weeks you would like to register for. Please mark with an X.

***Please note: Please provide ONE WEEK notice if you need to make permanent changes to the schedule.**

PAYMENT Payments are scheduled weekly on Saturday.

Name on credit/debit card or checking/savings account _____

		6/6-6/10	6/13-6/17	6/20-6/24	6/27-7/1	7/5-7/8	7/11-7/15	7/18-7/22	7/25-7/29	8/1-8/5	8/8-8/12	8/15-8/19	
Day Camp	Fees	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10	Wk 11	
Registration Fee	\$35												
Weekly	\$145/195												
Daily - Mon	\$28/38					X 4th of July							
Daily - Tue	\$28/38												
Daily - Wed	\$28/38												
Daily - Thu	\$33/43												
Daily - Fri	\$28/38												

Credit/Debit Card Number _____

Visa MasterCard Discover (circle one) Expiration Date _____

Checking Account Savings Account (circle one)

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 Summer Day Camp registrations on stated dates. I understand that it is my responsibility to contact Summer Day Camp 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.

Permission Agreements

Child's 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 the 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 Statement

I, the undersigned parent/guardian, do hereby grant permission for my child to leave the YMCA Cultural Center building. This could be a walking trip to the Marshalltown Public Library, Mega 10 or Anson Parks, Horne-Henry Center, or Marshalltown Aquatic Center. This also includes the weekly field trips that are listed on the Day Camp Brochure. Departure time is 9 a.m. and return time is 4 p.m. unless otherwise specified.

Parent/Guardian Signature _____ Date _____

Swimming Permission Statement

I, the undersigned parent/guardian, do hereby grant permission for my child to swim with the Marshalltown YMCA Day Camp in the Marshalltown YMCA-YWCA swimming pools on Tuesday and Friday.

Parent/Guardian Signature _____ Date _____

Parent Email Statement

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

Email address _____

Parent/Guardian Signature _____ Date _____

Parent Handbook Receipt Statement

I, the undersigned parent/guardian, acknowledge that I have received a copy of the Day Camp Handbook. I agree to follow all policies and procedures outlined within.

Parent/Guardian Signature _____ Date _____

Parent's/Guardian's Permission To Apply Sunscreen To Child

(Name of Child) _____

As the parent or guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at Marshalltown YMCA-YWCA to apply a sunscreen product of SPF- 15 or higher to my child, as specified below, when he or she will be playing outside, especially during the months of March through October and between the daily times of 10 a.m. and 4 p.m. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

- I do not know of any allergies my child has to sunscreen.
- Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle.
- I have provided the following brand/type of sunscreen for use on my child:
- My child is allergic to some sunscreens. Please use only the following brand(s) and type(s) of sunscreen:

- For medical or other reasons, please do not apply sunscreen to the following areas of my child's body:

Parent/Guardian full name (print): _____

Parent/Guardian signature: _____

Date: _____

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	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTiP/DT/Td/Tdap			Meningococcal MCV4/MPSV4		
Polio IPV/OPV			Hepatitis A		
Measles, Mumps, Rubella MMR			Rotavirus		
Haemophilus influenzae type b Hib			Human Papilloma Virus HPV		
Hepatitis B			Other		
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"					
Pneumococcal PCV/PPV					

Licensed Child Care Requirements

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

22 through 48 months
 3 doses D/T/P
 2 doses Polio
 2 doses Hib
 3 doses Pneumococcal

49 through 23 months
 4 doses D/T/P
 3 doses Polio
 3 doses Hib
 4 doses Pneumococcal

24 months and older
 5 doses D/T/P
 4 doses Polio
 4 doses Hib
 4 doses Pneumococcal

Elementary/Secondary School Requirements

4 years of age and older
 5 doses Diphtheria/Tetanus/Pertussis with 1 dose received ≥ 4 years of age, born on or after September 15, 2001, or 4 doses, with 1 dose received ≥ 4 years of age if born on or after September 15, 2001, but before September 15, 2001; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2001.

4 doses
 Polio with 1 dose received ≥ 4 years of age if born after September 15, 2001; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2001. The first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 18 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, 2001; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but born before September 15, 2001, unless the applicant has a reliable history of natural disease.