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ENRICHING KIDS INSIDE & OUT

Fit Kids After School Care
MARSHALLTOWN YMCA-YWCA

Fit Kids is available to all students in grades K-6. Transportation provided for students in Marshalltown and St. Francis School Districts only

WHEN: After School, Aug 24-June 1

TIME: Monday-Friday
3:30-5:30 p.m.

LOCATION: Marshalltown YMCA-YWCA
Cultural Center
108 Washington St.
Marshalltown, IA 50158
Deb Grove Family Sports Director
deb.grove@ymca-ywca.org
www.ymca-ywca.org

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REGISTRATION PACKET FOR FIT KIDS

This packet must be completed entirely before registering for Fit Kids After School Care. Return the following items before attending the Fit Kids program.

- Completed Parental Emergency Medical Consent
- Completed School-age Assessment and Health Form
- Attached a copy of current immunization record
- Permissions form
- If scheduling payments, completed payment information and child's attendance schedule

Please contact Deb Grove, Family Sports Director
deb.grove@ymca-ywca.org / 641-752-8658

PARENTAL EMERGENCY MEDICAL CONSENT

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	RELATIONSHIP TO CHILD	
ADDRESS	EMPLOYER	
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME	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: UNITY POINT, NEAREST or Other (please specify)	
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 to better serve your child (IEP or behavior plan):

____

____

____

____

____

____

____

____

Parent's Signature___________________________________

Date ____

FEE SCHEDULE AND PAYMENT OPTIONS

Fees for Y members: $8 daily

Fees for Program Participants: $11 daily

There are two options for payment for Fit Kids. Payment can be made at the time of registration either at the service desk or online. If using this option pay in full for all of the days being registered . Registration must be done by the week before attending to avoid a $10.00 late fee. The second option is to schedule payments for the week. Please indicate below for your child's attendance schedule for this option. Payments will be scheduled weekly on Saturdays.

Child's Name________________________________ DOB____________________

School attending and grade______________________________

Attendance schedule: Monday Tuesday Wednesday Thursday Friday

Weekly (circle all that apply)

Please give at least a week notice if permanent changes need to be made to the schedule.

Payments weekly on Saturday

Name on credit/debit card or checking/savings account____

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 Fit Kids registrations on stated dates. I understand that it is my responsibility to contact Fit Kids Afterschool with changes to my child's schedule no later than 4 p.m. of the day before. 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. I understand that I am responsible for keeping my account current in order to attend the Fit Kids program. A $30 service charge will be applied to accounts for any returned payments due to nonsufficient funds, closed accounts, expired cc, over limit, or stop payment. Participants will be notified at the time of returns. Participants have 30 days to take care of any balance assessed due to returned payments. If balances aren't current after 60 days the participant will be removed from the program.

Signature: ____________________________________ Date: __________________________

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. 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 trip, transportation, time period, and arrival and departure times.

Parent/Guardian Signature_____________________________ Date_______________

Parent Email Statement

I, the undersigned parent/guardian, wish to provide my email address in order to receive Fit Kids 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 Fit Kids Handbook. I agree to follow all policies and procedures outlined within.

Parent/Guardian Signature_____________________________ Date_______________

Please text "@fitkid1" to 81010 to receive Fit Kids updates such as weather announcements and early dismissals.
Standard message rates apply

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.