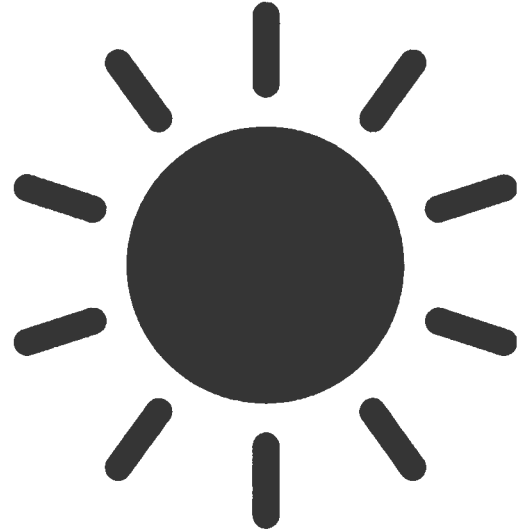




FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

eliminating racism  
empowering women  
**ywca**

# BEST SUMMER EVER



## Little Campers

### MARSHALLTOWN YMCA-YWCA

Enclosed are the necessary materials to fully register your child for Y Camp. 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 Nelson with questions at 752-8658 or [ashley.nelson@ymca-ywca.org](mailto:ashley.nelson@ymca-ywca.org).

#### REGISTRATION CHECKLIST:

\$35 Registration Fee

**\*Keep! Supply List & Contact Information Sheet**

Registration Form

Emergency Consent Forms

Permission Agreements

Attendance/Payment Agreement

Certificate of Immunization \*Must be completed by a physician

Child Health Exam \*Must be completed by a physician

Please keep for future reference!

## **YMCA–YWCA STAFF CONTACT INFORMATION**

### **Y Preschool Direct Lines**

(641)352-5072 & (641)352-5073

### **Marshalltown YMCA YWCA**

(641)752-8658

### **Brandee Brown Lead Teacher**

(641)352-5073 brandee.brown@ymca-ywca.org

### **Dulce Garcia Assistant Teacher**

(641)352-5072 dulce.garcia@ymca-ywca.org

### **Ashley Nelson Youth Director**

(641)752-8658 ashley.nelson@ymca-ywca.org

**\*Download the Remind app, use the link [remind.com/join/mtownymc](https://remind.com/join/mtownymc) or text @mtownymc to the number 81010 to receive text reminders and picture updates!**

### **REPORTING ABSENCES/LATE ARRIVALS**

Please **phone** the Y 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).

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## **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!**

\*Please put spare clothes in Ziploc bag and write child's name on bag

\*Please write child's name on tag of both sheet and blanket.

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

# 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. Additional Persons To Be Contacted in Case of Emergency and Authorized to Pick Up

\*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 #

Preferred Hospital

Address

Phone #

Dentist

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. 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 \_\_\_\_\_**

## CHILD INFORMATION

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Any nicknames/other names called \_\_\_\_\_

### FAMILY BACKGROUND

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/childcare? \_\_\_\_\_ 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? \_\_\_\_\_

## PERMISSION AGREEMENTS

Child's Full Name

Date of Birth

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### 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

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### 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 updates.

Email address

---

Parent/Guardian Signature

Date

---

### PARENT HANDBOOK AGREEMENT

I, the undersigned parent/guardian, acknowledge that I have received a copy of the Parent 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 the YMCA-YWCA is closed Monday, July 4th.
- 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 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 -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

**REQUIRED:** Mark with an X on the table below when your child will attend camp. Full time attendees should mark with an X on the weekly row. Part time attendees should mark with an X on corresponding days of the week. **\*MAY NOT BE BLANK**

		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
	Fees	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	NO CAMP
Weekly-Will attend M-F	\$140/ 190											
Daily-Monday	\$28/38					<b>*N/A CLOSED</b>						
Daily-Tuesday	\$28/38											
Daily-Wednesday	\$28/38											
Daily-Thursday	\$28/38											
Daily-Friday	\$28/38											

### PAYMENT METHOD

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 registrations on stated dates. I understand that it is my responsibility to contact the YMCA-YWCA 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 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: \_\_\_\_\_





**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.).

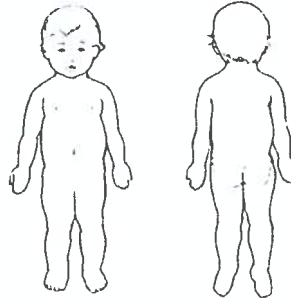
Please describe:

**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.**

Parent/Guardian questions or comments for the 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, ear-aches, 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).

## 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 _____ 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 # _____ Work # _____ Cellular # _____ Home email _____ Work email _____
Where parent /guardian # 2 works	Work address	Home phone # _____ Work # _____ Cellular # _____ Home email _____ Work email _____
<p><b>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. <input type="checkbox"/> YES <input type="checkbox"/> NO</b></p> <p><b>During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.</b>                  Parent/Guardian Signature: _____ Date _____                  Alternate emergency contact person's name: _____ Phone # _____                  Relationship to child: _____ Cellular # _____</p>		
Child's doctor's name	Doctor telephone # 1	Hospital choice _____  Phone # _____
Doctor's address	After hours telephone #	Does child have health insurance? <input type="checkbox"/> Yes, Company _____ ID # _____
Child's dentist's name (or family's dentist name)	Dentist Telephone # 1	Does child have dental insurance? <input type="checkbox"/> Yes, Company _____ ID# _____
Dentist's Address	After hours telephone #	<input type="checkbox"/> <b>NO, we do not have health insurance.</b>  <input type="checkbox"/> <b>NO, we do not have dental insurance.</b>
Other health care specialist name	Telephone #	<input type="checkbox"/> <b>Please help us find health or dental insurance.</b>
Type of specialty		

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:

Vision 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

Table with 5 rows: Environmental, Medication, Food, Insects, Other.

Immunization: Please attach:

- Immunization options: Iowa Department of Public Health Certificate of Immunization, Exemption Medical, Exemption Religious, TB testing completed.

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

Table with 2 columns: Medication Name, Dosage. Includes 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:

- Referrals: Referred to hawk-i today 1-800-257-8563, Other.

Health Provider Assessment Statement:

- Assessment statements: The child may participate in developmentally appropriate early care/learning with NO health-related restrictions, with restrictions, or has a special needs care plan.

Signature \_\_\_\_\_ Circle the Provider Credential Type: MD DO PA ARNP

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: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Address: \_\_\_\_\_

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/DTiP/DTI Td/Tdap		
Polio IPV/OPV		
Measles, Mumps, Rubella MMR		
<i>Haemophilus influenzae</i> 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/MPV4		
Hepatitis A		
Rotavirus		
Human Papilloma Virus HPV		
Other:		

### Licensed Child Care Requirements

<p><b>3 through 5 months</b>                  1 dose D/T/P                  1 dose Polio                  1 dose Hib                  1 dose Pneumococcal</p>	<p><b>12 through 18 months</b>                  3 doses D/T/P                  2 doses Polio                  2 doses Hib or 1 dose meningococcal                  1 dose Pneumococcal</p>	<p><b>19 through 23 months</b>                  4 doses D/T/P                  3 doses Polio                  3 doses Hib with the final dose in the series &gt; 12 months of age, or 1 dose received &lt; 15 months of age                  Meningococcal                  Varicella 2-12 months of age if born on or after September 15, 2003, or a reliable history of disease                  1 dose Hib                  1 dose Pneumococcal</p>
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**24 months and older**  
 some requirements at the 18-23 months (MMR, Pneumococcal, 4 doses Pneumococcal Hib, or 1 dose received < 12 months of age or 1 dose received < 15 months of age)  
 2 doses MMR with 1 dose > 12 months of age or received 1 dose > 12 months of age  
 1 dose Hib  
 1 dose Pneumococcal  
 1 dose if no doses had been received prior to 24 months of age

### Elementary/Secondary School Requirements

**3 years of age and older**  
 Diphtheria/Tetanus/Pertussis with 1 dose received > 4 years of age (born on or after September 15, 2003); or 1 dose received > 4 years of age if born on or before September 15, 2003, but before September 15, 2005, or 2 doses, with 1 dose received > 4 years of age if born on or before September 15, 2004.

**4 doses**  
 Polio with 1 dose received > 4 years of age if born after September 15, 2003; or 2 doses, with 1 dose received > 4 years of age if born on or before September 15, 2004.

**2 doses**  
 Mumps/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; born on or after July 1, 1991, or 1 dose received > 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.