BEST SUMMER EVER

REGISTRATION FORMS

Summer Day Camp
MARSHALLTOWN YMCA–YWCA

WHEN: June 6th–August 20
TIME: Monday–Friday
7:15am–5:30pm
LOCATION: Marshalltown YMCA–YWCA
Cultural Center
108 Washington St.
Marshalltown, IA 50158
Deb Grove
Summer Camp Director &
Family Sports Director
E deb.grove@ymca-ywca.org
W www.ymca-ywca.org
P 641–752–8658
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 Deb Grove Family Sports Director – at 641-752-8658 ext. 212 or 307 / deb.grove@ymca-ywca.org
FAX 641-752-3324
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:**

<table>
<thead>
<tr>
<th>PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES</th>
<th>RELATIONSHIP TO CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. NAME</strong></td>
<td><strong>D.O.B.</strong></td>
</tr>
<tr>
<td>Address</td>
<td>Employment</td>
</tr>
<tr>
<td>Home number</td>
<td>Cell number</td>
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<tr>
<td>Work number</td>
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<tr>
<td><strong>2. NAME</strong></td>
<td><strong>D.O.B.</strong></td>
</tr>
<tr>
<td>Address</td>
<td>Employment</td>
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<tr>
<td>Home number</td>
<td>Cell number</td>
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<tr>
<td>Work number</td>
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</table>

**EMERGENCY CONTACT PERSON(S)**

<table>
<thead>
<tr>
<th>RELATIONSHIP TO CHILD</th>
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</thead>
<tbody>
<tr>
<td><strong>1. NAME</strong></td>
</tr>
<tr>
<td>Home number</td>
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<tr>
<td>Cell number</td>
</tr>
<tr>
<td>Work number</td>
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<tr>
<td><strong>2. NAME</strong></td>
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<tr>
<td>Home number</td>
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<tr>
<td>Cell number</td>
</tr>
<tr>
<td>Work number</td>
</tr>
<tr>
<td><strong>3. NAME</strong></td>
</tr>
<tr>
<td>Home number</td>
</tr>
<tr>
<td>Cell number</td>
</tr>
<tr>
<td>Work number</td>
</tr>
</tbody>
</table>

**PERSONS AUTHORIZED TO PICK UP CHILD**

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td></td>
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<tr>
<td><strong>2.</strong></td>
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<tr>
<td><strong>3.</strong></td>
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</tbody>
</table>

*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?*

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
</table>

**PHYSICIAN NAME**

**DENTIST NAME**

<table>
<thead>
<tr>
<th>PHONE NUMBER</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADDRESS</strong></td>
<td><strong>ADDRESS</strong></td>
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</tbody>
</table>

**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**
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______________________________ |
| 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: ___________________________

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.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date Given</th>
<th>Doctor / Clinic / Source</th>
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<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis</td>
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<tr>
<td>DTaP/DT/PT/DT/Td/Tdap</td>
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<tr>
<td>Polio</td>
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<tr>
<td>IPV/OPV</td>
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<tr>
<td>Measles, Mumps, Rubella</td>
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<tr>
<td>MMR</td>
<td></td>
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<tr>
<td>Haemophilus influenzae type b</td>
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<tr>
<td>Hib</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Varicella</td>
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<tr>
<td>Chicken Pox</td>
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<tr>
<td>&quot;Influenza-like illness&quot;</td>
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<tr>
<td>Pneumococcal</td>
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<tr>
<td>PCV/PPV</td>
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</tbody>
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<tr>
<th>Vaccine</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal MCV4/PPSV4</td>
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<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td></td>
<td></td>
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<tr>
<td>Human Papilloma Virus</td>
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<tr>
<td>Other</td>
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</tbody>
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Licensed Child Care Requirements

4 through 5 months
1 dose DTP/P 2 doses FSa

6 through 12 months
3 doses DTaP 4 doses FSa
1 dose FSa

24 months and older

2 doses FSa

2 doses Td/TT

2 doses FSa

4 doses PCV

Elementary/Secondary School Requirements

4 years of age and older
8 doses DTaP/DT/PT/PRP/PRN with 1 dose received at 4 years of age or older (September 12, 2003) or 4 doses, with 1 dose received at 4 years of age if born after September 12, 2003, and before September 16, 2010, or 3 doses, with 1 dose received at 5 years of age if born on or before September 15, 2010, or 4 doses, with 1 dose received at 6 years of age if born after September 15, 2007. The second dose must have been received at least 2 months after the first dose, followed by 2 doses if born on or after July 1, 1995.
1 dose FSa
2 doses FSa

2 doses DTaP/DT/PT/PRP/PRN with 1 dose received at 4 years of age if born on or after September 15, 2007. The second dose must have been received at least 2 months after the first dose, followed by 2 doses if born on or after July 1, 1995.

2 doses FSa

For children born before September 15, 2003, unless the applicant has a reliable history of recent disease.

2 doses FSa