FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

BEDELL FAMILY YMCA Y-KIDS CLUB

Before and after school care for PreK-5th grade kids!

Who: Pre K-5th grade children who want to have fun with their friends in a licensed quality program while parents or guardians are working.

When: Before and after school, Monday-Friday
5:30AM-8:15AM & 3:15PM-6:00PM
Scheduled No School Days-Please see the YMCA Kids Day Out Program.

Where: Spirit Lake Middle School Lunch Room & YMCA

Why: Y Kids Club is a safe, fun and well supervised program which includes crafts, quiet games, stories, physical activities, and much more!

To register fill out the attached forms for each child and return to the YMCA or Spirit Lake Elementary School. For questions please contact Kyle Johnson at 712-330-0212 or email kyle.johnson@okobojiymca.com
***Transportation paid in part by Dickinson County Endowment Fund**

Cost:

Cost	Y Member	Non-Member
Am Part Time	$7/1 day	$13/1 day
Am Part Time	$14/2 days	$20/2 days
Am Full Time	$21/3-5 days	$27/3-5 days
Pm Part Time	$7/1 day	$13/1 day
Pm Part Time	$14/2 days	$20/2 days
Pm Full Time	$21/3-5 days	$29/3-5 days
Both AM&PM	$38	$50

CHILD INFORMATION / EMERGENCY TREATMENT FORM

Child's Name:_____ Date of Birth:_____ YMCA Member: Y or N

Parent(s) / Guardian(s) with Whom the Child Resides:

Name: _____Relationship to Child: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____
Email Address:_____

Name: _____Relationship to Child: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____
Email Address:_____

Person(s) to Contact in Case of Emergency if Parent(s) are Unavailable. These people are also authorized to pick the child up from the program.

Name: _____ Relationship to Child: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____

Name: _____ Relationship to Child: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____

Medical Information:

Physician Name: _____ Dentist Name: _____
Street Address: _____ Street Address: _____
City, State, Zip: _____ City, State, Zip: _____
Phone Number: _____ Phone Number: _____
Date of Last Tetanus: _____

Known Allergies/Medical conditions:_____
Present Medications: _____
Insurance Company: _____ Policy Holder ID #: _____

I hereby give permission for my child _____to be given emergency treatment (first aid and CPR) by a qualified staff member while participating in programming conducted by the Bedell Family YMCA. I also give my permission for my child to be transported by ambulance, aid car / vehicle to an emergency center for treatment, if I cannot be reached.
Preferred Hospital: _____ Hospital Phone:_____

In the event that I, or the person(s) listed below cannot be contacted, I further consent to the medical, surgical, and hospital care, treatment and procedures to be performed for my child by a licensed physical, dentist, or hospital when deemed immediately necessary or advisable by the physical or dentist to safeguard my child's health. In case of emergency, and if emergency transportation is needed, I agree to pay all costs of transportation and health care.
This consent will be in effect beginning (date) _____ and be annually updated by the parent / guardian.

Signature of the Parent / Guardian: _____ Date: _____

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BEDELL FAMILY YMCA PARENT & GUARDIAN CONSENT/FIELD TRIP & PHOTO RELEASE

I hereby certify that my child is in good health and capable of safe participation, and can participate in the **Y Kids Club & Field Trips.** ***P/G Initials ____***

I understand and acknowledge that the activity in which my child is about to participate in has inherent risks. I agree that my child's voluntary participation in this YMCA activity shall be undertaken at his/her sole risk, and that the YMCA, its directors, employees, and volunteers shall not be liable for any claims, injuries, damages, losses, illness, diseases, death, actions or causes of action whatsoever, to my child and his/her property, arising out of or connected to participation in this program. ***P/G Initials ____***

In the event that I or emergency contact listed below cannot be reached in an emergency, I give my consent for YMCA staff to act in my behalf in granting permission for my child to receive emergency treatment. I will be responsible for the payment of any and all medical services rendered. **P/G Initials ____**

Participants with special needs or challenges will be accepted provided that reasonable accommodations can be made for their participation in the program and/or their participation does not require an inordinate amount of staff time. I understand that if my child or I requires an unusual amount of one to one attention, whether due to special needs or behavior, my child may be denied or removed from the program without refund. **P/G Initials ____**

Photo Release

I **DO**___ (or) I **DO NOT**___ hereby irrevocably release consent and allow the Bedell Family YMCA and it's agent to use my child's photograph/likeness/voice, as it pertains to my participation with the YMCA, in any manner for promotional efforts without expectation for any reimbursement in connections with its use. **P/G Initial ____**

The information I provided above is accurate and complete and I understand that it is my responsibility to provide any changes/updates to the YMCA. **P/G Initial ____**

Participant Name _____ Birth Date _____ Grade _____ M or F

Participant Address_____
Street *City* *State* *Zip*

*Parent/Guardian Name*_____

Home Phone _____ Other Phone(s) _____

I have carefully read and initialed each of the above parental/guardian consent sections. I fully understand that by signing this form I have given my consent on all sections contained within.

_____ _____
Signature of Legal Parent/Guardian **Date**

MEDICATION SHEET

THIS AUTHORIZATION IS VALID FOR UP TO A MAXIMUM OF 30 DAYS

Child's Name _____ Date: _____

Physician's Name _____ Physcian's Phone No. _____

Name of Medication(s) _____

Reason for Medication(s) _____

Please give the above medication (s) as directed below:

Amount to be given _____ At what times given _____

Doses given per day _____ Specified days to be given at the center _____

Method of administration _____

I (we) the undersigned, give the daycare authorization to administer the prescription/nonprescription medication in the amount and method stated above.

_____ _____

Parent (s) or Guardian signature Date

DATE	MEDICATION	AMOUNT	TIME GIVEN	INITIAL OF STAFF

All nonprescription and prescription medications require a written parental authorization. Each prescription shall be clearly labeled with the child's name, physician's name, name of medication, dosage and time medication is to be given. Non-prescription medications shall be in the original container and labeled with the child's name. For long-term medication, do not send more than one month's supply.

NOTE: Place your initials in the box showing the medicine was given. Use an "A" when a child is absent. Use an "O" when medication is *not given* for any reason. Document the reason the medication was not given and document that the parent was informed.

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:

(Child Care Business) _____

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: _____

MONTHLY MEDICINE RECORD

Child's Name ______________________________________

Month/Year ______________

Medicine	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	Time																															
Sunscreen																																
Sunscreen																																
Sunscreen																																

Month/Year ______________

Medicine	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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	Time																															
Sunscreen																																
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A = Absent O = Other (Please explain for each instance)

SCHOOL-AGE ASSESSMENT & HEALTH FORM
& IMMUNIZATION DECLARATION

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**

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:

_____

_____

_____

_____

_____

FOR CENTERS SERVING SCHOOL-AGE CHILDREN OPERATING IN THE SAME SCHOOL FACILITY IN WHICH THE CHILD ATTENDS SCHOOL:

My signature below certifies that immunization information concerning my child has been provided and is available in the school file.

Parent's Signature_____ Date _____