



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CHILD CARE APPLICATION

Please complete all blanks on this form. Incomplete enrollment forms cannot be accepted.

According to the minimum standards put forth by the Commonwealth of Virginia, we are unable to care for your child until all required paperwork is submitted.

CHILD'S INFORMATION:

Child's Full Name			Nickname	
Address				
City		State	Zip	Home Phone
School		Grade Entering	Age	Date of Birth
Other Schools/Programs Concurrently Attending			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

Parent and Medical Information: In the event of an emergency, please number, in order of priority (1-6), which phone to contact.

Mother's Name		Cell Phone/Pager		Priority
Address				
City	State	Zip	Home Phone	Priority
Place of Employment			Work Phone	Priority

Father's Name		Cell Phone/Pager		Priority
Address				
City	State	Zip	Home Phone	Priority
Place of Employment			Work Phone	Priority

Doctor's Name		Doctor's Phone
Medical Insurance Provider		Policy #

Emergency names, addresses and phone numbers of TWO people to be called in the event that we cannot reach either parent:

Emergency Contact Name			Cell Phone/Pager
Address			
City	State	Zip	Home Phone

Emergency Contact Name:			Cell Phone/Pager
Address			
City	State	Zip	Home Phone

Authorized Pickup:

Authorized Persons for Pickup , in addition to emergency contacts
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(continued on next page)

Additional Information:

School and Child Care Centers previously attended
Are there any special needs, medical conditions, birth marks, and/or allergies that we should be aware of?
What are the symptoms and action to be taken if any?

We'd like to email you about upcoming events:

Email address

Are you a member of the YMCA? YMCA Member Prospective Member

YMCA Family Center	Membership Number
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PARENT STATEMENT OF UNDERSTANDING

The following information is important for the safety and protection of your child. Please read this information and sign below.

- I understand that my weekly tuition is due by 6pm on the Wednesday before each week of care. Payments made after this deadline will be assessed an additional \$15.
- I understand that my receipts should be kept as a record for filing taxes. The YMCA will not provide a year-end tax statement.
- I understand that my child must be picked up by **6pm**. I will be charged \$15 for each 15-minute interval past 6pm.
- I understand that I am not to leave my child at the YMCA or program site unless a YMCA Child Care staff member or volunteer is there to receive and supervise my child.
- I understand that it is my responsibility to sign my child in upon arrival in the morning and sign my child out before leaving in the afternoon. **Sign-in/Sign-out sheets are available as you enter the program. There must be an exchange of responsibility from one adult to another, not from a child to staff. All persons signing children in/out must be at least 18 years of age. The YMCA cannot release minors to minors.** (See other pick-up provisions in Parent Handbook.)
- I understand that my child will not be allowed to leave the program with an unauthorized person. **Any person authorized to pick up my child must be listed on this form. Authorization by telephone will not be accepted.**
- I understand that YMCA staff and volunteers are not allowed to babysit or transport children at any time outside the YMCA facilities and program. **If a violation of this policy is discovered, the YMCA will take immediate disciplinary action toward staff and volunteers.**
- I understand that by state law, the YMCA is mandated to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- I am an adult over 18 years and wish to have my child participate in YMCA of South Hampton Roads Child Care programs. I understand that even when every reasonable precaution is taken, accidents can sometimes happen. Therefore, in exchange for allowing my child to participate in YMCA Child Care, I understand and expressly acknowledge that I, for myself and for anyone entitled to act on my behalf, waive and release the YMCA, sponsors, representatives and successors from all claims or liabilities of any kind arising out of my participation in activities at or sponsored by the YMCA. I further agree to indemnify and save harmless the YMCA from any claims or demands arising out of any such injuries or losses. I understand that this release includes any claims based on negligence, action or inaction of the YMCA of South Hampton Roads, its staff, directors, members and guests. I have read, understand and am voluntarily signing this authorization and release.

I have read and understand the statements above regarding YMCA policies and procedures.

Parent/Guardian Signature	Date
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I have received a copy of the YMCA Parent Handbook.

Parent/Guardian Signature	Date
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I have provided a copy of my child's physical and immunization records along with this form.

Parent/Guardian Signature	Date
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VEHICLE CONDUCT RULES

Children must follow these basic safety rules while being transported. Transportation is a privilege and should be treated that way. A parent will be notified and asked to discuss proper behavior with his/her child when the first infraction occurs. If there is a second infraction, all transportation services will be denied for a minimum of two days.

1. No fighting, swearing or abusive behavior.
2. Each child must remain seated properly with seat belts on at all times (when available on vehicle).
3. Each child can not have any part of his/her body out of the vehicle.
4. No eating or drinking in the vehicle.
5. Potentially dangerous actions will not be tolerated.

STATEMENT OF AUTHORIZATION

1. My child has permission to be transported by a YMCA vehicle and to participate in all YMCA program activities and related field trips.
2. My child has permission to participate in swimming activities. **Please provide a detailed statement regarding your child's swimming skills** (Mandatory licensing regulation 560.B) _____

3. The YMCA agrees to notify the parent/guardian whenever the child becomes ill. The parent/guardian agrees to pick up the child within 30 minutes of receiving the call that your child is ill. **(A temperature of over 100°F, recurring vomiting/diarrhea or a communicable disease would require exclusion from the YMCA.)**
4. The parent/guardian authorizes the YMCA to obtain immediate care if any emergency occurs when she/he cannot be located immediately. I understand that in an emergency, my child may be transported in a private vehicle.
5. The parent authorizes the application of sunscreen for his or her child by YMCA staff. (Please note any adverse reaction to sunscreen of which you may be aware.)
6. The parent authorizes the application of insect repellent for his or her child by YMCA staff. (Please note any adverse reaction to insect repellent of which you may be aware.)
7. The parent agrees to inform the YMCA Child Care staff/director within 24 hours or the next business day if their child or any other immediate household member has developed any reportable communicable disease, as defined by the State Board of Health, except for life-threatening diseases which must be reported immediately.
8. I have been informed of my YMCA Child Care program's Emergency Preparedness Plan.

By signing below, you are authorizing all of the above.

Parent/Guardian Signature	Date
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MODEL RELEASE

If you do **NOT** consent for the use of photographs or digital images of your child in any printed/filmed material for promotions of the YMCA of South Hampton Roads, please sign here.

Parent/Guardian Signature	Date
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YMCA KIDS FOR CHARACTER PLEDGE

I pledge to be a kid for character.

- I will be worthy of trust.
- I will be respectful and responsible, doing what I must.
- I will show that I care for those around me.
- I will always do my share.
- I will believe in myself.



Child's Signature	Date
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For office use only—

Form of Identity Verification	
Place of Birth	Date of Birth
Birth Certificate Number	Date Issued
Date Child Entered Care	Date Child Withdrew from Care

Proof of child's identity and age may include a certified copy of the child's birth certificate, birth registration card, notification of birth (hospital, physician or midwife record), passport, copy of the placement agreement or other proof of the child's identity from a child placement agency, record from a public school in Virginia or certification by a principal or his designee of a public school in the U.S. that a certified copy of the child's birth record was previously presented. Viewing the child's proof of identity is not necessary when the child attends a public school in Virginia and the YMCA assumes responsibility for the child directly from the school (i.e. after-school program) or the YMCA transfers responsibility of the child directly to the school (i.e. before-school program). While programs are not required to keep the proof of the child's identity, documentation of viewing this information must be maintained for each child.

Payment Information

Date
Total paid
Receipt #
Received by (staff name)

Semi-annual, written or verbal communication on your child's development, behavior will be provided to you on _____ and _____.
 Parent Nights scheduled on _____ and _____.

Notes:



Written Medication Consent Form

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #22 (omit #17) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment or insect repellent.
- The child’s health care provider MUST complete #1 through #17 for Long-Term medications or when dosage directions state “consult a physician.” The parent completes #18 through #22.

1. Child’s first and last name:	2. Date of birth:	3. Child’s known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:
7A. Frequency to be administered: _____ <i>OR</i>		
7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____		
8A. Possible side effects: <input type="checkbox"/> Parent must supply package insert (or pharmacy printout) for complete list of possible side effects <i>AND/OR</i>		
8B. Additional side effects: _____		
9A. Additional special instructions (include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child’s age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____ <i>OR</i>		
9B. <input type="checkbox"/> Not applicable		
10. Reason the child is taking the medication (unless confidential by law):		
11. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally? <input type="checkbox"/> No <input type="checkbox"/> Yes If checked yes, complete #32 - #33 on the back of this form.		
12. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered? <input type="checkbox"/> No <input type="checkbox"/> Yes If checked yes, complete #32 - #33 on the back of this form.		
13. Date consent form completed:	14. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid):	
15. Prescriber’s name (please print):	16. Prescriber’s telephone number:	
17. Licensed authorized prescriber’s signature: Required for Long-Term medication or when dosage directions state “consult a physician.”		



Written Medication Consent Form

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#18 - #22)

18. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) <input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> No Write the specific time(s) the child day program is to administer the medication (i.e.: 12 pm): _____	
19. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____. (child's name)	
20. Parent or legal guardian's name (please print):	21. Date authorized:
22. Parent or legal guardian's signature:	

CHILD OR DAY PROGRAM TO COMPLETE THIS SECTION (#23 - #29)

23. Provider/Facility name:	24. Facility telephone number:	25. (leave blank)
26. I have verified that #1 - #23 and if applicable, #33 - #36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.		
27. Authorized child care provider's name (please print):		28. Date received from parent:
29. Authorized child care provider's signature:		

ONLY COMPLETE THIS SECTION (#30 - #31) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #14

30. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____. (date) Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.
31. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#32 - #35)

32. Describe any additional training, procedures or competencies the child day program staff will need to care for this child. _____ _____ _____
33. Licensed Authorized Prescriber's Signature:
34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order. DATE: _____ By completing this section the child day program will follow the written instruction on this form and <i>not</i> follow the pharmacy label until the new prescription has been filled.
35. Licensed Authorized Prescriber's Signature:

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization**

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____
 Student's Name: _____
 Student's Date of Birth: _____/_____/_____ Last First Middle
 Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____
 Student's Address: _____ City: _____ State: _____ Zip: _____
 Name of Mother or Legal Guardian: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____
 Name of Father or Legal Guardian: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____
 Emergency Contact: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, oxygen support, hearing aid, etc.):

List all prescription, over-the-counter, and herbal medications your child takes regularly:

Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: None FAMIS Plus (Medicaid) FAMIS Private/Commercial/Employer sponsored

I, _____ (do ___) (do not ___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____

Signature of person completing this form: _____ Date: ____/____/____

Signature of Interpreter: _____ Date: ____/____/____

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM**

Part II - Certification of Immunization

Section I

**To be completed by a physician, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.**

(A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.)

Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ Date of Birth:

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Last

First

Middle

Mo. Day Yr.

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6 th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <2 years of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Minimum requirements are listed in Section III).

Signature of Medical Provider or Health Department Official: _____ **Date (Mo., Day, Yr.):** ___ / ___ / ___

