	Parent/Guardian Signature	Date
1st Year Review:		
2nd Year Review:		
3rd Year Review:		

Completed form must be kept in the child's record and first page updated ANNUALLY.

YMCA 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, including: ☐ Child's proof of identity ☐ Up-to-date shot records ☐ Up-to-date physical ☐ Medication form, if applicable

PROGRAM: ☐ Before- & After-School ☐ Before-School ☐ After-School ☐ Camp ☐ Preschool ☐ School's Out Camp

CHILD'S INFORMATION:

Child's full name		Nickname	Sex	Birth date
Street address			First day of attendance	Last day of attendance
City	State	Zip	Home phone	Grade/ class level
School	Programs previously attended		Schools/programs concurrently attending	

EMERGENCY INFORMATION:

If your child takes any medication, please also fill out the ☐ Medication Authorization Form.

Allergies and intolerance to food, medications or other substances and actions to take in emergency situation
Chronic physical problems/diseases; pertinent development information; special accommodations needed; special instructions to provider

Child's physician	Physician's phone

In the event of an emergency, please number, in order of priority (1–6), which phone to contact.

Parent/guardian name 1			Cell phone	Priority
Address (enter "same" if address is the same as the child's)			Email address	
City	State	Zip	Home phone	Priority
Place of employment			Work phone	Priority

Parent/guardian name 2			Cell phone	Priority
Address (enter "same" if address is the same as the child's)			Email address	
City	State	Zip	Home phone	Priority
Place of employment			Work phone	Priority

Name, street address and phone of emergency contact if parent(s) cannot be reached
Name, street address and phone of emergency contact if parent(s) cannot be reached
Persons authorized to pick up child (appropriate custody or other court order shall be attached if a parent is not allowed to pick up the child)

SWIM PERMISSION:

☐ My child has permission to participate in swimming activities. Please check your child's ability to swim and provide a detailed statement regarding your child's swimming skills on the line below. ☐ My child cannot swim. ☐ My child can swim with assistance. ☐ My child can swim without assistance.

_____

The parent authorizes the application of hypo allergenic sunscreen/insect repellent for his or her child by YMCA staff. (Please note any adverse reaction to sunscreen/insect repellent of which you may be aware.) ☐ Yes ☐ No

Parent/guardian signature (valid for one year)_____ **Date** _____

RELEASE OF CONFIDENTIAL INFORMATION AUTHORIZATION

Permission is granted to the YMCA of South Boston/Halifax County to access my child's school records and contact school administrators and staff for purposes pertaining to growth, development and achievement of my child including, but not limited to: SOL Scores, Report Cards, Progress Reports, behavioral issues, homework assignments etc. I understand that access to this information will be used in possible grant writing and assisting the child in achieving his/her academic and social and emotional growth milestones.

☐ I will allow this. ☐ I choose not to allow this.

Signature _____ Date _____

FINANCIAL RESPONSIBILITY: Please read and check each statement below and initial at the bottom.

I am the parent/guardian of the above named child, and my financial responsibility is as follows:

☐ 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.

☐ YMCA program sessions are not prorated and I must register my child and pay for full sessions.

☐ Child Care registration fees and camp deposits are nonrefundable.

☐ If my payment is returned by my bank, I am responsible for a $25 returned payment fee in addition to the amount of the original payment, which I must pay BEFORE my child is allowed back into the program.

☐ After a second returned payment, I will have to pay cash or money order only for any future sessions/programs.

AUTOMATIC PAYMENTS FOR CHILD CARE AND CAMP

The YMCA of South Boston/Halifax County offers automatic draft for your child care and camp payments. You can stop automatic payments with a 30-day written notice. If you would like to utilize this payment option, please check your payment frequency and sign the statement below.

☐ Weekly (on Wednesdays) ☐ Bi-Monthly (1st and 15th of each month) ☐ Monthly (1st of each month) ☐ Other ( )

ELECTRONIC FUNDS (EFT) OR CREDIT CARD AUTHORIZATION

I authorize my bank to honor preauthorized Electronic Funds Transfer (or credit card institution) drawn by the YMCA of South Boston/Halifax County on my account for (membership/program/ contribution) payments as indicated below. When the bank honors the EFT (or credit card) by charging my account, such transfer shall constitute notice of payment due and my receipt for the payment. Should any preauthorized EFT (or credit card) not be honored by said bank when received by them, then it is understood that the payment is to be made by me in the amount of said payment plus posted returned draft/check fee. It is further understood that if such payment is not honored by the bank (or credit card institution), then the YMCA of South Boston/Halifax County, at its discretion, may resubmit the amount due for payment on a future date.

☐ I choose to utilize the EFT option for payment (direct debit from my ☐ Checking ☐ Savings account)

☐ I choose to utilize the credit card payment option for payment (automatic direct charge to credit card)

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

Signature _____ Date _____

STATEMENT OF AUTHORIZATION: Please read and check each statement and sign below.

☐ My child has permission to be transported by a YMCA vehicle and to participate in all YMCA program activities and related field trips.

☐ The YMCA agrees to notify me (parent/guardian) whenever the child becomes ill. I agree to pick up the child within 30 minutes of receiving the call that my child is ill. **(A temperature of over 100°F, recurring vomiting/diarrhea or a communicable disease would require exclusion from the YMCA.)**

☐ I (parent/guardian) authorize the YMCA to obtain immediate care if any emergency occurs when I (parent/guardian) cannot be located immediately. I understand that in an emergency, my child may be transported in a private vehicle.

☐ I agree to inform the YMCA child care staff/director within 24 hours or the next business day if my 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.

☐ I have been informed of my YMCA Child Care program's Emergency Preparedness Plan.

STATEMENT OF UNDERSTANDING:

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

- 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 16 years of age.** (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 consent for the use of photographs or digital images of my child in any printed/filmed material for promotions of the YMCA of South Boston/Halifax County.
- I am an adult over 18 years and wish to have my child participate in YMCA of South Boston/Halifax County 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 Boston/Halifax County, 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.

☐ I have received a copy of the YMCA Parent Handbook.

☐ I have provided a copy of my child's physical and immunization records along with this form.

☐ I have read and understand the statement above regarding the Model Release.

Signature _____ Date _____

CHILD'S NAME: _____

CHILD'S PROOF OF IDENTITY:

The **Code of Virginia** states that "Proof of identity means a certified copy of a birth certificate or other reliable proof of the child's identity and age. The following documents are acceptable forms of reliable proof. Please check which document you are submitting.

- ☐ Certified copy of birth certificate
- ☐ Birth registration card
- ☐ Notification of birth (hospital, physician or midwife record)
- ☐ Passport
- ☐ Copy of placement agreement or entrustment agreement from a child placing agency (foster care and adoption agencies)
- ☐ Record from a public school in Virginia
- ☐ Certification by a principal or his designee in the US that a certified copy of the child's birth record was previously presented
- ☐ Copy of the conferring temporary legal custody or entrustment agreement of a child to an independent foster parent
- ☐ Child identification card issued by the Virginia Department of Motor Vehicles (DMV)

For Office Use Only

Form of Identity Verification	Date of Birth	Place of Birth	Start Date	End Date
Document Number	Date Issued	Staff Signature		

YMCA OF SOUTH BOSTON/HALIFAX COUNTY

P (434) 572-8909 **W** www.ymcasouthboston.org

Mission: To put Judeo-Christian principles into practice through programs that build healthy spirit, mind and body for all.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Medication Authorization Form

For Prescription and Non-prescription (OTC) Medication

INSTRUCTIONS:

- Section A & C must be completed by the parent/guardian for ALL medication being authorized.
- Section B must be completed by a physician for any medication authorizations. This includes non-prescription medications.
- Each medication needs a separate authorization form. Multiple medications cannot be listed on one form.
- If diagnosed with asthma a inhaler with chamber and mask along with a separate action plan must accompany this document
- If a Epipen is prescribed, a separate action plan must accompany this document
- If the end date documented by the physician expires before school is out for the year, a new authorization form will be required.

SECTION A: To be completed by parent/guardian

Child's first and last name
Child's known allergies

SECTION B: To be completed by child's physician

I, _____ order the medication listed to be administered.		
Name of medication		Strength
Dosage	Times to be given	Frequency
Reason the child is taking this medication (unless confidential by law)		
Describe any additional training, procedures or competencies the child's program staff will need to know.		
This authorization is effective from: _____ (start date) until _____ (end date)		
Physician's signature		
Date:	Physician's phone number:	

SECTION C: To be completed by parent/guardian

I, _____ (parent's name) authorize _____ (program name) to administer this medication as specified in this medication form.	
Parent' signature	Date

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: _____
Last First Middle

Student's Date of Birth: _____/_____/_____ 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: |____|____|____|
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 (6th 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) ❑ 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.*):**___/___/____

Student's Name:_____Date of Birth: |____ |_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

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

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

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

Section III
Requirements

***Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)**

- ❑ 3 DTP or DTaP – at least one dose of DTaP or DTP after 4th birthday unless received 6 doses before 4th birthday
- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
- ❑ 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday
- ❑ Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
- ❑ Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
- ❑ 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ 1 Mumps – on/after 12 months of age
- ❑ 1 Rubella - on/after 12 months of age
  Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- ❑ Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
- ❑ 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

*** Additional Immunizations Required at Entry into 6th Grade**

- ❑ Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth

Student's Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: _____/_____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

TB Risk Assessment: ☐ No Risk ☐ Positive/Referred
Mantoux results: _____mm

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	☐	☐	☐	Neurological	☐	☐	☐	Skin	☐	☐	☐
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Genital	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Urinary	☐	☐	☐

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

❑ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

❑ With Corrective Lenses (check if yes)

Stereopsis	❑ Pass	❑ Fail		❑ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

❑ Pass ❑ Referred to eye doctor ❑ **Unable to test – needs rescreen**

Dental Screen

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

Recommendations to (Pre) School , Child Care, or Early Intervention Personnel

Summary of Findings (check one):
☐ **Well child; no conditions identified of concern to school program activities**
☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____

_____

_____

_____

_____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____
Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epi pen ☐ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp)**:**

Name : _____ **Signature:** _____ Date: ____/_____/_____

Practice/Clinic Name: _____ **Address**: _____

Phone: _____-_____-_____ **Fax**: _____-_____-_____ **Email:** _____