



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CHILD INFORMATION FORM YMCA CHILD CARE CENTER

CHILD'S INFORMATION One form per child

Is the Child a YMCA Member? No Yes Member Number _____ Past Participant? Yes No

Staff will fill in

Name _____ Age _____ DOB ____/____/____ Male Female
First Middle Last At start of program

Address _____
City State Zip

Phone _____

PARENT/GUARDIAN INFORMATION Attach a court order if any restrictions

Parent/Guardian 1 _____ DOB ____/____/____

Address _____
City State Zip

Email _____

Primary Phone _____ Home Work Cell

Secondary Phone _____ Home Work Cell

Where are you when your child is in our care? _____ Address _____

Parent/Guardian 2 _____ DOB ____/____/____

Address _____
City State Zip

Email _____

Primary Phone _____ Home Work Cell

Secondary Phone _____ Home Work Cell

Where are you when your child is in our care? _____ Address _____

PEOPLE OTHER THAN PARENTS/GUARDIANS AUTHORIZED TO PICK UP CHILD

Name _____ Phone _____ Relationship to Child _____

Address _____ Location during day care hours _____

Name _____ Phone _____ Relationship to Child _____

Address _____ Location during day care hours _____

Name _____ Phone _____ Relationship to Child _____

Address _____ Location during day care hours _____

EMERGENCY CONTACT INFORMATION Other than Parents

Name _____ Phone _____ Relationship to Child _____

Address _____ Location during day care hours _____

APPROXIMATE DROP-OFF & PICK-UP TIMES

	Monday	Tuesday	Wednesday	Thursday	Friday
Drop Off Time	_____	_____	_____	_____	_____
Pick Up Time	_____	_____	_____	_____	_____

IMMUNIZATION HISTORY

Provide updated child immunization records. Contact your doctor or local health department to obtain records. Records must be provided prior to attending.

Immunization records are attached. They are current and accurate to the best of my knowledge.

HEALTH HISTORY & MEDICAL INFORMATION

Is your child currently taking any medications? Yes No

If yes, what kind and why? _____

If medication needs to be administered during your child's attendance, you must complete an Authorized to Administer Medication Form.

Should we be aware of any illnesses, medications, physical limitations, allergies, behavior concerns, special needs, etc.?
 None Yes

Please check any special medical condition that your child may have.

- | | | | | | |
|--|-------------------------------------|---|---|---------------------------------|------------------------------------|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Asperger's | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cognitive |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Motor Disorder | <input type="checkbox"/> LD | <input type="checkbox"/> OCD |
| <input type="checkbox"/> Other (Please list) _____ | | | | | |

Please list any allergies

Food _____

Dietary Restrictions _____

Seasonal _____

Other/Please list below _____

Describe triggers, symptoms, and steps we should follow, when to call parents, when to consider emergency care for your child. Identify staff that you have given training, etc. Attach a separate sheet if needed.

Physician's Name _____ Phone _____

Address _____

The Health Examination Report form is signed by my physician, children under the age of 2 years will require a new form every six months, and every two years for children 2 years and older.

PARENT/GUARDIAN AUTHORIZATION

Sunscreen/Insect Repellent Authorization

- | | | |
|--|---------------|----------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child | Brand Name | Strength |
| <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to self-apply sunscreen | Child Generic | 50+ |

I AUTHORIZE THE FOLLOWING

- I approve this application and certify that the applicant is capable of such an experience.
- I agree to pay the registration fee and all weekly enrollment fees.
- The YMCA Child Care Center fees are not refundable.
- I understand that no refunds are given if a child leaves early due to illness, disruptive behavior as determined by the YMCA Child Care Center Director, or for any other reason.
- **I grant permission for the applicant to participate in all planned activities and walking field trips.**
- In case of accident or illness, the YMCA Child Care Center is authorized to secure emergency medical treatment. Prudent attempts will be made to contact the parents immediately.
- The YMCA Child Care Center is not responsible for lost, stolen, or damaged personal articles.
- I authorize the YMCA of Greater Waukesha County to have and use photographs, slides, and video of the person named in this application as may be needed for its public relations programs.
- I hereby assume all risks of injury arising out of my presence on the premises of the YMCA of Greater Waukesha County, my use of its equipment or facilities and my participation in its activities, whether on its premises or at another location, and for myself and my heirs and assigns hereby waive, release, and agree to hold free from all claims and damages the YMCA of Greater Waukesha County and its officers, directors, members, employees, or agents. I understand the risks and dangers involved in participating in the programs and activities of the YMCA, am physically capable of participating in such programs, and agree not to participate in activities that may injure myself or others.
- I understand that there are no pets on location.
- I have received a copy of the handbook.

Parent/Guardian Signature _____ Date _____