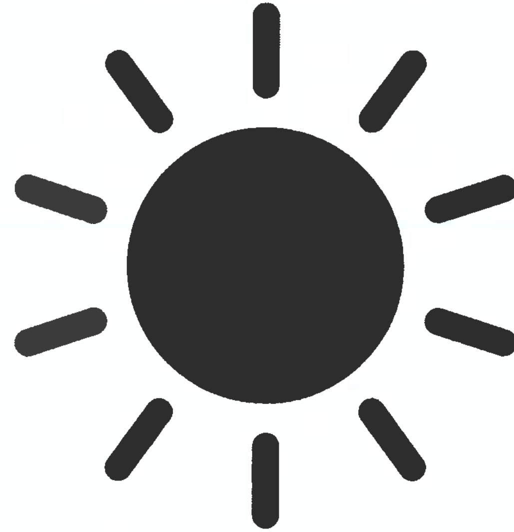
eliminating racism
empowering women
ywca

BEST SUMMER EVER



Little Campers

MARSHALLTOWN YMCA-YWCA

Enclosed are the necessary materials to fully register your child for Summer Child Care. All forms must be fully completed and returned prior to attendance. **Children must have a physical completed within in the last year and proof of up to date immunizations in order to attend.**

Please contact Ashley Nelson with questions at 752-8658 or ashley.nelson@ymca-ywca.org.

REGISTRATION CHECKLIST:

- $35 Supplies Fee
- *Keep! Supply List & Contact Information Sheet
- Registration Form
- Emergency Consent Forms
- Permission Agreements
- Attendance/Payment Agreement
- Child Health Exam *Must be completed by a physician
- Immunization *Must be completed by a physician

LITTLE CAMPERS SUPPLY LIST

Please send the following items with your child each day in attendance or leave the following items at camp for the summer. Please mark all items with your child's name.

- **1 Crib size sheet**
- **1 Lightweight blanket**
- **1 Backpack**
- **1 Pair of tennis shoes and socks* if not worn daily**
- **1 Extra set of clothes and underwear marked with child's name, accidents happen!**

***NO Pull-ups or diapers allowed.**

LITTLE CAMPERS CONTACT INFORMATION

Y Preschool Direct Lines **(641)352-5072 & (641)352-5073**

Marshalltown YMCA YWCA **(641)752-8658**

Brandee Brown Lead Teacher

Dulce Garcia Assistant Teacher

Ashley Nelson Youth Director

(641)752-8658

ashley.nelson@ymca-ywca.org

REPORTING ABSENCES/LATE ARRIVALS

Please phone camp staff by 8:30 a.m. if your child will be absent for the day. If no notice is given of your child's absence, you will be charged for that day. If you are registered for a day, and plan to not attend please phone staff as soon as possible. Your account will be credited or refunded if notice is given. If no notice is given, you will not be refunded. You will be charged the daily amount of $28. Staff can be reached by calling the Y at 752-8658 or 352-5072 (direct preschool line)

THANK YOU!

PARENTAL EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment.

Child's Full Name Date of Birth

I, ______________________________, parent or guardian of the child named above, give my permission to providers: Marshalltown YMCA YWCA staff, to secure and authorize such emergency medical care and treatment as my child might require while under the provider's supervision. I authorize the provider to administer emergency care or treatment as required, until emergency medical assistance arrives. I agree to pay all costs and fees contingent on any emergency medical care and treatment for my child as secured or authorized under this consent. I understand every effort will be made to notify me first and immediately in case of emergency. **I understand both pages of this form must be filled out complete with my signature indicating authorization.**

1. Parent/Guardians with Whom the Child Resides

- Name Relationship to Child
  Address Home Phone Cell Phone
  Employer Email Address
  Work Phone Work Hours

- Name Relationship to Child
  Address Home Phone Cell Phone
  Employer Email Address
  Work Phone Work Hours

2. Persons To Be Contacted in Case of Emergency and Authorized to Pick Up Your Child

*In the event parent/guardians are unavailable. Additional contacts may be added on the back.

- Name Relationship to Child
  Address Home Phone Cell Phone
  Employer Email Address
  Work Phone Work Hours

- Name Relationship to Child
  Address Home Phone Cell Phone
  Employer Email Address
  Work Phone Work Hours

- Name Relationship to Child
  Address Home Phone Cell Phone
  Employer Email Address
  Work Phone Work Hours

*Additional Persons may be added for Pick Up on the next page

3. Medical Information

Physician

Address

Phone #

Preferred Hospital

Address

Phone #

Dentist

Address

Phone #

Insurance Co

Policy ID #

Dates of Coverage

4. Medical History

Date of Most Recent Tetanus Shot

Known Allergies

Current Medications

5. Additional Persons Authorized to Pick Up Your Child

Name

Relationship to Child

Phone #

Work Phone

Name

Relationship to Child

Phone #

Work Phone

Name

Relationship to Child

Phone #

Work Phone

6. 6. Any persons NOT Authorized to Pick Up Your Child

*The Center requires a copy of a court order to deny a parent the right to pick up their child.

Name

Relationship to Child

Name

Relationship to Child

I,_______________________________________, the undersigned parent/guardian, do hereby give permission for my child to leave the Marshalltown YMCA YWCA with the above named persons. It is my responsibility to notify the center if there are any changes. It is my responsibility to notify the center when someone other than myself will be picking up my child. The center requires that a copy of a photo ID is on file for each of the listed individuals. **PLEASE INCLUDE ALL PARENTS/GUARDIANS ON THIS LIST.**

This consent will be in effect for one year beginning (date)_______________________________

Parent/Guardian Signature ____ **Date**______________

CHILD INFORMATION

Child's Name Date of Birth

Any nicknames/other names called ______

FAMILY BACKGOUND

Please list all adults and children living in the home

Name	Relationship	Age

Please list any special family circumstances that would be helpful for the center to know

______

______

SOCIAL AND EMOTIONAL DEVELOPMENT

Has your child ever attended preschool/daycare? ______ Where? ______

Has your child ever been cared for by anyone other than parents? ______

Does your child experience separation anxiety? ______

Does your child have any fears? ______

What is your child's favorite activity? ______

What is the primary language spoken in the home? ______ Any other languages used? ______

PHYSICAL ROUTINES

Does your child have any special needs or abilities? ______

Does your child nap? ______What time/length is nap? ______

Does your child have any indoor/outdoor play restrictions? ______

What does your child say when he/she has to use the bathroom? ______

BEHAVIOR

What types of discipline/management of behavior do you use with your child? ______

______

Any additional information about your child? ______

______

PERMISSION AGREEMENTS

Child's Full 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 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 AGREEMENT

I, the undersigned parent/guardian, do hereby grant permission for my child to leave the Cultural Center Building. Examples include a walking trip outside of the building for exercise, a nature walk, walk to the park or walk to the Horne-Henry Center. I understand that any other activities that would require my child to leave the center will have a specific permission slip. That slip will include the exact nature of the activity, destination, transportation being used, time period of the activity, times of departure and return to our center.

Parent/Guardian Signature Date

SWIMMING PERMISSION AGREEMENT

I, the undersigned parent/guardian, do hereby grant permission for my child to swim with the Marshalltown YMCA YWCA at the indoor pool on Fridays.

Parent/Guardian Signature Date

PARENT EMAIL AGREEMENT

I, the undersigned parent/guardian, wish to provide my email address in order to receive updates.

Email address

Parent/Guardian Signature Date

PARENT HANDBOOK AGREEMENT

I, the undersigned parent/guardian, acknowledge that I have received a copy of the Parent Handbook. I agree to follow all policies outlined within.

Parent/Guardian Signature Date

SUNSCREEN PERMISSION AGREEMENT

I, the undersigned parent/guardian give permission for the Marshalltown YMCA YWCA to apply a sunscreen of SPF 50 or higher to my child's exposed skin, including but not limited to the face, tops of ears, nose, bare shoulders, arms and legs. Please choose from following options:

- ☐ Marshalltown YMCA YWCA may use the sunscreen of their choice on my child.
- ☐ I will provide sunscreen for my child.

Parent/Guardian Signature Date

FEE SCHEDULE AND PAYMENT OPTIONS

- Registration Fee: All participants must pay a one-time Supplies Fee of $35
- Y Member Fees: $140/week or $28/day
- Y Program Participant Fees: $190/Week or $38/day
- Late Registration Fee: $10 will be added to any registration not completed one week prior to the week 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 -OR-
2. Schedule weekly payments to draft on Saturdays through direct debit of credit card or bank account.

Child's Name________________________Grade (going into) _______School______________

ATTENDANCE SCHEDULE

REQUIRED: Mark with X on the table below when your child will attend camp. Full time attendees should mark with an X on the weekly row. Part time attendees should mark with an X on corresponding days of the week.

		6/7-6/11	6/14-6/18	6/21-6/25	6/28-7/2	7/5-7/9	7/12-7/16	7/19-7/23	7/26-7/30	8/2-8/6	8/9-8/13	8/16-8/20
	Fees	Week1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	**NO CAMP**
Weekly-Will attend M-F	$140/ 190											
Daily-Monday	$28/38											
Daily-Tuesday	$28/38											
Daily-Wednesday	$28/38											
Daily-Thursday	$28/38											
Daily-Friday	$28/38											

***Please provide ONE WEEK notice if you need to make permanent changes to your schedule.**

Name on credit/debit card or checking/savings account______________________________

Circle one: Visa MasterCard Discover Expiration Date______________________

Credit/Debit Card Number______________________________________

-OR-

Circle one: Checking Account Savings Account

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 registrations on stated dates. I understand that it is my responsibility to contact the YMCA-YWCA 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 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.

Signature: ______________________________ Date: ________________

Infant, Toddler, Preschool Age – Child Health Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name	Child's birthdate	Child Care Facility ____________ Telephone # ____________

Parent/Guardian name #1	Parent/Guardian name #2

Child home address #1	Telephone # 1
Child home address #2	Telephone #2

Where parent/guardian # 1 works	Work address	Home phone # Work # Cellular # Home email Work email
Where parent /guardian # 2 works	Work address	Home phone # Work # Cellular # Home email Work email

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care facility is unable to immediately make contact with the parent/guardian. ☐ **YES** ☐ **NO**

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: ____________________ Date ____________

Alternate emergency contact person's name:____________________ Phone # ____________

Relationship to child: Cellular # ____________

Child's doctor's name	Doctor telephone # 1	Hospital choice **Phone #**____________
Doctor's address	After hours telephone #	Does child have health insurance? ☐Yes, Company ____________ **ID #**

Child's dentist's name (or family's dentist name)	Dentist Telephone # 1	Does child have dental insurance? ☐Yes, Company ____________ **ID#**
Dentist's Address	After hours telephone #	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.** ☐ **Please help us find health or dental insurance.**
Other health care specialist name Type of specialty	Telephone #	

Child Name:

PARENT/GUARDIAN COMPLETE THIS PAGE

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

Growth

☐ I am concerned about my child's growth.

Appetite

☐ I am concerned about my child's eating/ feeding habits or appetite.

Rest -

☐ I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child

☐ had a serious illness, injury, or surgery..

Please describe:

Physical Activity - My child

☐ must restrict physical activity.

Please describe:

Development and Learning

☐ I am concerned about my child's behavior, development, or learning.

Please describe:

☐**Allergies**-My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

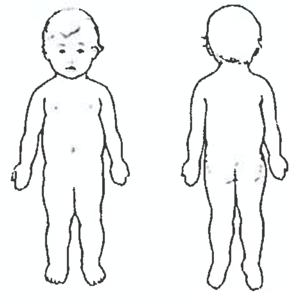
☐**Special Needs Care Plan** – My child has a special needs care plan (IEP, IFSP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.

Child's Name: ____________________

Body Health - My child has problems with

☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses

☐ Ears \ hearing, hearing aides or device, earaches, tubes in ears

☐ Nose problems, nosebleeds, runny nose

☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring

☐ Frequent sore throats or tonsillitis

☐ Breathing problems, asthma, cough, croup

☐ Heart, heart murmur

☐ Stomach aches, upset stomach, spitting-up

☐ Using toilet, toilet training, urinating

☐ Bones, muscles, movement, pain when moving, uses assistive equipment.

☐ Nervous system, headaches, seizures, or nervous habits (like twitches)

☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).

Parent/Guardian questions or comments for the health care provider:

Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE

Child's Name: ______________________________

Birthdate: _____________ **Age today:** ________

Date of Exam: _____________

Height/Length: ____________ Weight:____________

BMI– starting at age 24 mo. ____________

Head Circumference- age 2 yr. and under: ___________

Blood Pressure-start @ age 3 yr:____________

Hgb or Hct- @ 12 mo: ___________

Lead Risk Assessment:________________

Blood Lead Level: date________ results ___________

Sensory Screening:

Vison Assessment: ______________________________

Vision Acuity: Right eye ________ Left eye _________

Hearing Assessment: Right ear ______ Left ear ________

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐ No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth

Date of Dental exam ___________

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Health Care Provider comments:

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: Please attach:

☐ Iowa Department of Public Health Certificate of Immunization

☐ Iowa Department of Public Health Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health Certificate of Immunization Exemption Religious.

☐ TB testing completed (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at the child care facility: (include over-the-counter and prescribed)

Medication Name	Dosage
☐ Diaper crème:	
☐ Fever or Pain reliever:	
☐ Sunscreen:	
☐ Other	

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

☐ Referred to ***hawk-i*** today 1-800-257-8563

☐ Other: ______________________________

Health Provider Assessment Statement:

☐The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan ________________________
(please attach)

Signature ______________________________

Circle the Provider Credential Type: MD DO PA ARNP

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year and annually.
The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Iowa Department of Public Health
Certificate of Immunization

Name Last: ______________________ First: ____________ Middle: ____________ Date of Birth: ____________

Parent/Guardian: ______________ Address: ______________________________ Phone: (____)____________

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.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

Licensed Child Care Requirements

4 through 5 months
- 1 dose D/T/P
- 1 dose Polio
- 1 dose Hib
- 1 dose Pneumococcal

6 through 11 months
- 2 doses D/T/P
- 2 doses Polio
- 2 doses Hib
- 2 doses Pneumococcal

12 through 18 months
- 3 doses D/T/P
- 2 doses Polio
- 2 doses Hib or 1 dose received at ≥ 15 months of age
- 3 doses Pneumococcal if received 1 or 2 doses < 12 months of age; or 2 doses if has not received any previous doses; or received 1 dose ≥ 12 months of age

19 through 23 months
- 4 doses D/T/P
- 3 doses Polio
- 3 doses Hib with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 15 months of age
- 1 dose Measles/Rubella ≥ 12 months of age
- 1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease
- 4 doses Pneumococcal; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if not received any previous doses or has received no doses or has received 1 dose ≥ 12 months of age.

24 months and older
same requirements as the 19-23 months Except Pneumococcal. 4 doses Pneumococcal if received 3 doses < 12 months of age; or 3 doses if received 2 doses< 12 month of age; or 2 doses if received 1 dose < 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age.

Elementary/Secondary School Requirements

4 years of age and older
- 5 doses Diphtheria/Tetanus/Pertussis with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥4 years of age if born after September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
- 4 doses Polio with 1 dose received ≥ 4 years of age if born after September 15, 2003; or 3 doses, with 1 dose received ≥4 years of age if born on or before September 15, 2003.
- 2 doses Measles/Rubella; the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first.
- 3 doses Hepatitis B if born on or after July 1, 1994.
- 2 doses Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has a reliable history of natural disease.