



**YMCA of Metropolitan Chicago Youth Programs
Mandatory Emergency Packet**

YMCA Name _____ McCormick Tribune _____

Child's Name _____ **AGE** _____

Program Child is enrolled _____ **SUMMER CAMP 2012** _____

Required Information

Completed

Registration Form _____

Emergency Information/Pick -up Form _____

Facility User/Field Trip Agreement Form _____

Medical Forms (6 months or current) _____

Medication Permission Form _____

Participant Information Form _____

Character Contract _____

Birth Certificates (DCFS licensed program only) _____

(*All paperwork is mandatory and must be completed and at the YMCA prior to the start of the program)

Director's Signature _____ Date _____

2012 Parent Signature _____ Date _____

2013 Parent Signature _____ Date _____

**YMCA of Metropolitan Chicago Youth Programs
Emergency Information/ Pick up Form**

Child's Name	Age	Birthdate
Address	City	State
		Zipcode

Parent/Guardians listed below are authorized to pick up participant and should be contacted in an emergency.

Parent/Guardian #1	Relationship	Cell Phone
Address	City	Zip Code
Name of Company where employed	Title	Work Phone

Parent/Guardian #2	Cell Phone
Address	Zip Code
Name of Company where employed	Work Phone

If either individual above can not be reached in an emergency please notify:

Emergency Contact Name	Relationship
Cell Phone	Work Phone
Home Phone	

I, _____ authorize the following people to pick up my child and be contacted in the event of an emergency from the _____ YMCA. In doing so, I relieve the YMCA of Metropolitan Chicago, its centers and employees of all responsibility for my child after he/she has been released from the program. *Attempts will be made to reach the parent/legal guardian first.*

Additional people who are authorized to pickup my child(Picture ID will be required)
(A minimum of 2 people are required to be filled out)

1.) Name _____ Relationship _____
CellPhone(_____) _____ HomePhone(_____) _____

2.) Name _____ Relationship _____
CellPhone(_____) _____ HomePhone(_____) _____

3.) Name _____ Relationship _____
CellPhone(_____) _____ HomePhone(_____) _____

4.) Name _____ Relationship _____
CellPhone(_____) _____ HomePhone(_____) _____

5.) Name _____ Relationship _____
CellPhone(_____) _____ HomePhone(_____) _____

6.) Name _____ Relationship _____
CellPhone(_____) _____ HomePhone(_____) _____

Unauthorized Pick-Up: People who CANNOT pick up your child from a YMCA youth program:

Name:	Relationship:
1.) _____	_____
2.) _____	_____
3.) _____	_____



YMCA of Metropolitan Chicago Youth Programs
IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

Insurance Information

Is the participant covered by family/medical/hospital insurance YES NO
If yes, indicate carrier or plan name _____ Group# _____
Carrier Address _____ City _____ Zip Code _____
Name of Insured _____ Relationship to participant _____
Allergies (food, medication, insects, animals, asthma or other) _____

Management or reaction to the allergy _____

IMPORTANT: THIS BOX MUST BE COMPLETED FOR ATTENDANCE

I do hereby give permission for the YMCA of Metropolitan Chicago staff to transfer child named above off the property for the purpose of medical care or program activities as deemed appropriate by the Director and in the event that I cannot be reached in an EMERGENCY, I hereby give my permission to the physician selected by the Director, to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above.

Signature of Parent/Legal Guardian Date

YMCA of Metropolitan Chicago Medication Permission Form
To be completed by Parent/s and or Guardians

- Information you provide will be deemed confidential by the YMCA of Metropolitan Chicago and will be shared only with YMCA staff involved in the program.
- Only prescription drugs that are in their original container and are accompanied with specific written directions from a licensed physician will be dispensed to campers by authorized personnel. (This includes epipens and inhalers)
- Non-Prescription drugs will only be dispensed under the signed instruction of the parent/guardian and Physician. Non-Prescription drugs must be in their original container.

Child's Name _____

Physician's Name _____ Physician's Phone # _____

Physician's Diagnosis _____

Type of Medication _____

Refrigerate YES NO

Prescription No. _____ Dosage _____

Time(s) Medication is taken at home, or indicate "as needed": _____

Time(s) Medication is taken at YMCA or indicate "as needed" : _____

Specific dates child will be taking medication at YMCA: _____

List any side effects from this medication: _____

Special Instructions: _____

The YMCA staff is hereby authorized to administer the above stated medication as required by the child's physician and which is described on this document.

Signature of Parent/Legal Guardian Date



YMCA of Metropolitan Chicago Youth Programs

Confidential Participant Information Form

(To be completed by participant's parent/guardian)

Please help us assist your child with their camp experience by letting us know a little bit about them before they arrive. This information helps us understand their unique needs and personality.

All of the information you provide here is for your child's teachers and will be held in confidence.

Participant's Name _____ Nickname _____ Birthdate _____ Age at Camp _____
Number/Age of Brothers: _____ Sisters: _____
Child lives with: (circle one) Mother Only Father Only Both Guardian-Specify: _____
Does your child have any problems with homesickness/transitions? Yes No
Please explain: _____
My child makes friends: EASILY FAIRLY EASILY HAS DIFFICULTY
Comments: _____
Sensitive about name, weight, height, etc? _____

Allergic to or have strong dislikes for certain foods? _____

Have there been any recent traumatic experiences of which the counselor/Camp Director should be aware of? _____

Does your child require any special accommodations? Physical? Behavioral? (_____ YMCA is not able to provide one-to-one attended care. Participants must be able to operate in a group with at least 8-10 other children and 1 counselor. Please contact the Director if you have any questions or concerns).
Are there any serious fears that your child may have? (Specify) _____

Describe the child's social skills with his/her peers at school. Does your child make friends easily? _____

If your child "shuts down" at home, what are some techniques you use to help them open back up? _____

When a change of behavior is needed, what works best for you at home? (i.e. time out, activity restriction, etc.) _____

Swimming Ability: (Circle one) Non-Swimmer Fair Swimmer Good Swimmer

Does the child have a fear of water? Yes No

Concerns: _____

Child's Favorites: Foods: _____ Animals: _____
Colors: _____ Books: _____
Hobbies: _____ Sports: _____

Please complete with your child.

What are the top three (3) expectations your child has for his/her session at (YMCA)?

- (1) _____
- (2) _____
- (3) _____

Please list three (3) goals you have for your child at (YMCA) :

- (1) _____
- (2) _____
- (3) _____

Please list any other information you feel will help us better serve your child, and to make their experience the highlight of their Y experience. _____

Parent/Guardian's Signature _____
Parent/Guardian's Printed Name: _____



YMCA OF METROPOLITAN CHICAGO
FACILITY USER/FIELD TRIP AGREEMENT

Date

Name _____ Address _____

City _____ State _____ Zip Code _____

Age _____ Sex _____ Home Phone _____ Work Phone _____

E-mail _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name _____ Phone Number _____ Relationship _____

I agree to follow all rules and regulations of the YMCA of Metropolitan Chicago ("YMCA") while in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, and understand and agree that I may be expelled at any time, with no refund of any monies paid, for failure to abide by such rules and regulations.

IN CONSIDERATION OF BEING PERMITTED TO UTILIZE THE FACILITIES, SERVICES AND PROGRAMS OF THE YMCA FOR ANY PURPOSE, INCLUDING BUT NOT LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT OR PARTICIPATION IN ANY PROGRAM AFFILIATED WITH THE YMCA WITHOUT RESPECT AS TO LOCATION, I HEREBY AGREE TO THE FOLLOWING:

1. I UNDERSTAND THAT ACTIVITIES AT THE FACILITY OR ELSEWHERE, INCLUDING USE OF EQUIPMENT AND PARTICIPATION IN PROGRAMS, CAN INVOLVE MOVEMENT, STRAIN AND OTHER ELEMENTS THAT CREATE RISK OF SERIOUS INJURY OR DEATH. I ALSO UNDERSTAND THAT PROGRAM ACTIVITIES INCLUDE FIELD TRIPS TO LOCATIONS OUTSIDE THE YMCA PREMISES, AS DESCRIBED IN DETAIL IN THE PROGRAM MATERIALS, AND THAT PUBLIC OR PRIVATE TRANSPORTATION MAY BE UTILIZED TO TRANSPORT PARTICIPANTS TO AND FROM THESE FIELD TRIP LOCATIONS. I HEREBY ASSUME FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE OR LOSS, regardless of severity, that I or my minor child/ward may sustain from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, or while being transported to and from field trip locations outside the YMCA premises, except for any injury, damage or loss that is caused solely by the YMCA's gross negligence.

2. I, FOR MYSELF, ANY PERSONAL REPRESENTATIVES, ASSIGNS, HEIRS AND NEXT OF KIN, HEREBY FULLY RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE the YMCA of Metropolitan Chicago, its operating centers, their respective officers, directors, Board of Managers, Trustees, members, volunteers, employees or agents (the "Releasees") and each of them from any and all claims for injuries, damages or loss that I or my minor child/ward may have or which may accrue to me or my minor child/ward from my and/or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, or while being transported to and from field trip locations outside the YMCA premises, except for any injury, damage or loss that is caused solely by the YMCA's gross negligence.

3. I HEREBY AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS the Releasees and each of them from any loss, liability, damage or cost they may incur from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, or while being transported to and from field trip locations outside the YMCA premises, except for any loss, liability, damage or cost that is caused solely by the YMCA's gross negligence.

I further expressly agree that the foregoing ASSUMPTION OF RISK, RELEASE, WAIVER AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of Illinois and if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

THIS AGREEMENT APPLIES TO ALL PAST, PRESENT AND FUTURE VISITS AND USES BY ME TO ANY YMCA FACILITY OR PROPERTY.

I HAVE READ AND VOLUNTARILY SIGNED THIS ASSUMPTION OF RISK, RELEASE, WAIVER AND INDEMNITY AGREEMENT, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE AGREEMENT. THIS AGREEMENT CONTAINS A WAIVER AND RELEASE.

SIGNATURE _____
(Participant's signature)

DATE _____

SIGNATURE _____
(in the case of a minor only: Parent's or Guardian's signature)

DATE _____



State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011



Student's Name			Birth Date	Sex	Race/Ethnicity	School/Grade Level/ID#
Last	First	Middle	Month/Day/Year			
Address			Parent/Guardian	Telephone #	Home	Work
Street			City		Zip Code	

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.

Vaccine / Dose	1			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap, Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		
MMR Combined Measles Mumps, Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps			COMMENTS:								
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease Signature Title Date

3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella

Lab Results Date MO DA YR (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN													
Date													Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade													
	R	L	R	L	R	L	R	L	R	L	R	L	
Vision													
Hearing													

Last First Middle	Birth Date <small>Month/Day/ Year</small>	Sex	School	Grade Level/ ID
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during night coughing?	Yes	No	Hospitalizations?	Yes	No
Birth defects?	Yes	No	When? What for?		
Developmental delay?	Yes	No	Surgery? (List all.)	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	When? What for?		
Diabetes?	Yes	No	Serious injury or illness?	Yes	No
Head injury/Concussion/Passed out?	Yes	No	TB skin test positive (past/present)?	Yes*	No
Seizures? What are they like?	Yes	No	TB disease (past or present)?	Yes*	No
Heart problem/Shortness of breath?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Heart murmur/High blood pressure?	Yes	No	Alcohol/Drug use?	Yes	No
Dizziness or chest pain with exercise?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental <input type="checkbox"/> Braces <input type="checkbox"/> •Bridge <input type="checkbox"/> •Plate Other		
Ear/Hearing problems?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	Yes	No	Parent/Guardian		Date
			Signature		

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI B/P

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes No And any two of the following: **Family History** Yes No
Ethnic Minority Yes No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes No **At Risk** Yes No

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.

Questionnaire Administered? Yes No **Blood Test Indicated?** Yes No **Blood Test Date** _____ (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed Test performed
Skin Test: Date Read / / Result: Positive Negative mm _____
Blood Test: Date Reported / / Result: Positive Negative Value _____

LAB TESTS (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)
Urinalysis				Developmental Screening Tool

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Antagonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting **DIETARY** Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes No If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** (for one year) Yes No Limited

Print Name (MD,DO, APN, PA) Signature Date

Address Phone

(Complete Both Sides)