

GLOW YMCA

PROGRAM PARTICIPANT PROFILE – SUMMER 2010

CAMP HOUGH	FE A AGES 6-9	FE 1 AGES 6-9	FE 2 AGES 6-9	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6		
	JULY 7 TO JULY 9	JULY 11 TO JULY 13	JULY 18 TO JULY 20	JULY 11 TO JULY 16	JULY 18 TO JULY 23	JULY 25 TO JULY 30	AUG 1 TO AUG 6	AUG 8 TO AUG 13	AUG 15 TO AUG 20		
YMCA DAY PROGRAMS: GENESEE COUNTY ORLEANS COUNTY WYOMING COUNTY GENESEO REC PERRY REC OTHER:			WEEK A	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6	WEEK 7	WEEK 8
			JULY 6 TO JULY 9	JULY 12 TO JULY 16	JULY 19 TO JULY 23	JULY 26 TO JULY 30	AUG 2 TO AUG 6	AUG 9 TO AUG 13	AUG 16 TO AUG 20	AUG 23 TO AUG 27	AUG 30 TO SEPT 3

CHILD AND FAMILY INFORMATION

Child's Name:	Date of Birth:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	School/Grade in Fall:
Child's Nickname:	Child lives with:			T-Shirt Size: <input type="checkbox"/> Youth <input type="checkbox"/> Adult

EMERGENCY CONTACT INFORMATION (PLEASE INCLUDE PARENT/GUARDIAN AND PLACE IN ORDER OF PREFERENCE)

Name:	Home Phone:	Date of Birth:	Relationship:	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Pick Up Authorization
	Cell Phone:			
Name:	Home Phone:	Date of Birth:	Relationship:	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Pick Up Authorization
	Cell Phone:			
Name:	Home Phone:	Date of Birth:	Relationship:	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Pick Up Authorization
	Cell Phone:			
Name:	Home Phone:	Date of Birth:	Relationship:	<input type="checkbox"/> Emergency Contact <input type="checkbox"/> Pick Up Authorization
	Cell Phone:			

PARENT/GUARDIAN AGREEMENT

- ✓ In the event of an emergency, the YMCA will make every effort to contact me. If I cannot be reached, the YMCA is authorized to act for me according to their best judgment in an emergency requiring medical care or surgery. The physician selected may hospitalize, secure proper treatment for, order injection, anesthesia or surgery for my child. I am responsible for the cost of all medical treatment and care.
- ✓ I must notify the YMCA staff immediately of any changes on these forms.
- ✓ YMCA staff and volunteers are not allowed to baby-sit or transport children at any time.
- ✓ The YMCA is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- ✓ I have read the YMCA Summer Program Parent Guide associated with my child's program and shared the Code of Conduct with my child and agree to these policies and procedures.
- ✓ My child has my permission to participate in walking field trips with the YMCA and to ride on vehicles as arranged by the GLOW YMCA for transportation to and from YMCA Summer Programs and scheduled field trips. Specifics will be posted weekly.
- ✓ I authorize the YMCA to apply sunscreen and bug repellent to my child.
- ✓ My child has permission to swim at YMCA Summer Programs. I understand that my child's swimming ability will be assessed by the Progressive Swim Instructor prior to participating in swimming activities and will be reassessed on a regular basis to ensure swimmer safety. My child will only be able to swim in areas deemed appropriate for their swimming ability by the Progressive Swim Instructor.
- ✓ The YMCA has my permission to use photographs of my child in promotional materials such as brochures, ads, YMCA website or newspaper releases. I will not be informed of or reimbursed for such photographs.
- ✓ The undersigned agrees to hold harmless the GLOW YMCA and/or its employees/agents as a result of their child's participation in the program except in the case of those incidents which are a direct result of gross negligence by the GLOW YMCA or its employees/agents.
- ✓ This agreement shall be governed by the laws of New York State.
- ✓ By signing this form, I agree that I have read this entire form and understand my responsibilities for my child's participation and conduct in YMCA programs and activities.

MY SIGNATURE ACKNOWLEDGES MY UNDERSTANDING OF AND AGREEMENT TO THE ABOVE.

Parent/Guardian Signature:	Date:
Parent/Guardian Name Printed:	Date:
PARENT/GUARDIAN SIGNATURE UPON CAMP HOUGH PICK-UP ONLY:	Date/Time:

OFFICE USE ONLY; PLEASE INDICATE DATE RECEIVED AND INITIAL EACH ITEM.

PARTICIPANT PROFILE W/ PARENT SIGNATURE	LIABILITY WAIVER W/ PARENT SIGNATURE	HEALTH FORM W/ PHYSICIAN SIGNATURE	STANDING ORDERS W/ PHYSICIAN SIGNATURE	IMMUNIZATION RECORDS

GLOW YMCA

PARTICIPANT LIABILITY WAIVER

PARTICIPANT MEDICAL PROFILE

I RECOGNIZE THAT YMCA ACTIVITIES CAN BE STRENUOUS ENDEAVORS REQUIRING ME OR MY CHILD TO BE IN GOOD PHYSICAL CONDITION. I HEREBY CERTIFY THAT I OR MY CHILD DO NOT SUFFER FROM ANY PHYSICAL INFIRMITIES OR ILLNESSES WHICH WOULD AFFECT MY OR MY CHILD'S ABILITY TO ENGAGE IN ACTIVITIES AND THAT IF I OR MY CHILD AM NOW UNDER THE TREATMENT FOR ANY OF THE FOLLOWING I WILL CHECK THE PROPER HEADING AND DISCUSS THEM WITH A YMCA STAFF MEMBER.

PLEASE CHECK THE APPROPRIATE HEADING:

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Related Disease | <input type="checkbox"/> Back Injury | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cardiac/Pulmonary Condition | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Mental Distress | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Drug Addiction/Dependency |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Recent Injury | <input type="checkbox"/> Hearing Loss/Impairment |
| <input type="checkbox"/> Neck Injury | <input type="checkbox"/> Insect Allergies | <input type="checkbox"/> Orthopedic Problem | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

Please use this space to add detail:

I FURTHER CERTIFY THAT IF I OR MY CHILD ARE ON ANY REGULAR MEDICATION I WILL DISCUSS THIS MEDICATION WITH A YMCA STAFF MEMBER AND I OR MY CHILD HAVE NOT TAKEN OR WILL NOT TAKE ANY ALCOHOLIC BEVERAGES OR MIND ALTERING DRUGS IN THE 12 HOURS PRIOR TO MY OR MY CHILD'S PARTICIPATION.

INFLATABLE ACTIVITY WAIVER

ALTHOUGH WE STRIVE TO MAKE ALL ACTIVITIES AS SAFE AS POSSIBLE, ACTIVITIES OF THIS NATURE DO COME WITH SOME ELEMENT OF RISK. THIS WAIVER ENSURES THAT WE HAVE CONTACT INFORMATION OF YOU AND/OR YOUR CHILD AND YOU ARE AWARE OF THESE RISKS. A COMPLETED PARTICIPANT LIABILITY WAIVER IS REQUIRED TO PARTICIPATE IN ALL INFLATABLE ACTIVITIES. WE WILL KEEP ON FILE CONTACT INFORMATION FOR YOUR CHILD FOR OTHER YMCA PROGRAMS AND ACTIVITIES AT YOUR REQUEST. IN CONSIDERATION OF BEING ALLOWED TO PARTICIPATE IN ANY PARTIES OR PROGRAMS AT OR WITH THE GLOW YMCA THE UNDERSIGNED ACKNOWLEDGES, APPRECIATES AND AGREES:

1. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releases of others, and assume full responsibility for all participants listed below;
2. I willingly agree to comply with the stated and customary terms, rules, and conditions for participation. If, however, I observe any significant hazards during my participation, I will bring it to the attention of the nearest official immediately; and
3. The risk of injury from this equipment can be significant, including the potential for paralysis and even death, and while particular rules, equipment, and personal discipline reduce the risk, the risk does exist;
4. I, for myself and on behalf of my heirs, assigns, personal representative and next of kin, hereby hold harmless YMCA their officers, agents, employees, other participants, and sponsoring agencies with respect to all injury, disability, death, or loss of damage to personal or property to the fullest extent of the law;
5. By signing below for my children, and/or spouse, I also agree to the above conditions, should I decide to participate.

PHOTO RELEASE

I GRANT MY PERMISSION TO THE GLOW YMCA TO USE WITHOUT LIMITATION OR OBLIGATION, PHOTOGRAPHS, FILM FOOTAGE, TAPE RECORDINGS, OR OTHER MEDIA THAT MAY INCLUDE AN IMAGE OR VOICE OF ME OR MY CHILD AT YMCA PROGRAMS FOR PURPOSES OF PROMOTING YMCA PROGRAMS.

ACKNOWLEDGEMENT OF RISK & ASSUMPTION OF RESPONSIBILITY

I UNDERSTAND THAT DURING MY OR MY CHILD'S PARTICIPATION IN ACTIVITIES AT OR WITH THE GLOW YMCA, I OR MY CHILD MAY BE EXPOSED TO PSYCHOLOGICALLY AND PHYSICALLY STRESSFUL AND CHALLENGING SITUATIONS. I UNDERSTAND THAT ALTHOUGH THE PROGRAM HAS TAKEN PRECAUTIONS TO PROVIDE PROPER ORGANIZATION, SUPERVISION, INSTRUCTION AND EQUIPMENT FOR EACH ACTIVITY IT IS IMPOSSIBLE FOR THE PROGRAM TO GUARANTEE ABSOLUTE SAFETY. I ALSO UNDERSTAND THAT I SHARE RESPONSIBILITY FOR SAFETY AND I ASSUME THAT RESPONSIBILITY.

FURTHER I WAIVE ANY CLAIM THAT MAY ARISE AGAINST THE GLOW YMCA AND/OR ITS EMPLOYEES AS A RESULT OF MY OR MY CHILD'S PARTICIPATION IN THE YMCA PROGRAM OR ACTIVITY, EXCEPT THOSE WHICH ARE A DIRECT RESULT OF THE NEGLIGENCE BY THE GLOW YMCA OR ITS EMPLOYEES. I HAVE ACCEPTED RESPONSIBILITY FOR VERIFYING MY OR MY CHILD'S PERSONAL HEALTH AND MEDICAL HISTORY ON THE TOP OF THIS SHEET. IN SO DOING I STATE THAT I OR MY CHILD HAVE NO PHYSICAL OR PSYCHOLOGICAL PROBLEMS THAT WOULD PROHIBIT PARTICIPATION IN THIS PROGRAM. I OR MY CHILD AGREES TO COMPLY WITH ALL INSTRUCTION AND DIRECTION GIVEN BY YMCA STAFF MEMBER DURING MY OR MY CHILD'S PARTICIPATION. I UNDERSTAND THE YMCA IS NOT RESPONSIBLE FOR PERSONAL PROPERTY LOST OR STOLEN WHILE MEMBERS AND/OR PROGRAM PARTICIPANTS ARE USING YMCA FACILITIES, ON YMCA PREMESIS OR AT A YMCA FUNCTION OR ACTIVITY.

<i>Participant Name:</i>	<i>Date of Birth:</i>
<i>Parent/Guardian Signature:</i>	<i>Date:</i>



YMCA

We build strong kids,
strong families, strong communities.

GLOW YMCA

PROGRAM PARTICIPANT HEALTH FORM – TO BE COMPLETED BY PARENT/GUARDIAN

THE CHILD'S PHYSICIAN SHOULD COMPLETE BOTH SIDES OF THIS FORM. PLEASE RETURN BOTH THIS FORM AND A CURRENT COPY OF IMMUNIZATION RECORDS AT LEAST TWO-WEEKS PRIOR TO START OF YMCA SESSION. PLEASE NOTE THE NEED FOR PHYSICIAN'S SIGNATURES ON BOTH SIDES OF THIS FORM. NOT ALL YMCA SUMMER PROGRAMS ADMINISTER MEDICATION, HOWEVER, IN THE EVENT OF AN EMERGENCY WE ASK THAT FAMILIES PROVIDE US THIS INFORMATION SO THAT WE CAN BEST CARE FOR YOUR CHILD.

Child Name:	Age:	Height:	Weight:
Has your child been exposed to an infectious disease or had any major illness in the last month? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, Illness/Disease:		Symptoms:	
Is the child covered by any hospitalization/medical care policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Company:			
Card Holder:		Policy/Group #:	

Child is looking forward to YMCA Program with?	Enthusiasm	Acceptance	Caution	Anxiety
Has your child been away from home before? Explain.				
Does your child have any special talents, hobbies or special interests?				
How does your child express anger/frustration? Is there a form of discipline (time-out is usually used) that works best with your child?				
Does your child have any fears?				
Things I would like my child to accomplish at the YMCA program are:				
My child's swimming ability is: <input type="checkbox"/> Afraid of water <input type="checkbox"/> Some Lessons <input type="checkbox"/> Confident in Deep Water				
Is he/she accustomed to having a wake-up call to use the bathroom in the middle of the night?				
Have any significant events happened in your family in the last few years?				
Is there any other information you think is important for us to know about your child?				

PROGRAM PARTICIPANT HEALTH FORM, CONT. – TO BE COMPLETED BY PHYSICIAN

CAMPER HEALTH HISTORY

Please Check All That Apply.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Allergies: |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Dental: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Illness: | <input type="checkbox"/> Other: |

ADMINISTRATION OF PRESCRIPTION MEDICATIONS TO CHILD

PLEASE COMPLETE WITH PATIENT'S CURRENT/SUMMER REGIMEN FOR BOTH SCHEDULED AND PRN MEDICATIONS.

DRUG NAME	ROUTE (PLEASE INDICATE PREFERRED FORMULATION)	DOSAGE	SCHEDULE & INDICATIONS (PLEASE CIRCLE ALL THAT APPLY)	HEALTHCARE PROVIDER ORDER (PLEASE CIRCLE ONE)
PHYSICIAN SIGNATURE 1 OF 2 (see reverse side of page):				DATE:

INDIVIDUALIZED STANDING ORDERS FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION – TO BE COMPLETED BY PHYSICIAN

NOT ALL YMCA SUMMER PROGRAMS ADMINISTER MEDICATION OR HOUSE MEDICATIONS. HOWEVER, IN THE EVENT OF AN EMERGENCY WE ASK THAT FAMILIES PROVIDE US THIS INFORMATION. THE FOLLOWING MEDICATIONS MAY BE AVAILABLE AND WILL BE ADMINISTERED AT THE DISCRETION OF THE YMCA NURSE/MAT/HEALTH CARE PROVIDER AS INDICATED.

CHILD NAME:		AGE:	WEIGHT:	HEIGHT:
DRUG NAME	ROUTE (PLEASE CIRCLE PREFERRED FORMULATION)	DOSAGE	SCHEDULE & INDICATIONS (PLEASE CIRCLE ALL THAT APPLY)	HEALTHCARE PROVIDER ORDER (PLEASE CIRCLE)
SUN SCREEN LOTION/SPRAY	Topical	As per package instructions	As needed	YES NO
INSECT REPELLANT	Topical	As per package instructions	As needed	YES NO
ANTISEPTIC OINTMENT	Topical	As per package instructions	Minor wound care Other:	YES NO
ANTI-ITCH OINTMENT	Topical	As per package instructions	Rashes insect bites Other:	YES NO
ANTI-STING OINTMENT	Topical	As per package instruction	Insect bites Other:	YES NO
ANTIBIOTIC OINTMENT	Topical	As per package instruction	Minor wound care Other:	YES NO
SUNBURN RELIEF OINTMENT	Topical	As per package instructions	Sunburn Other:	YES NO
IBUPROFEN	Oral	As per package instructions	Pain; swelling; fever Other:	YES NO
ACETAMINOPHEN	Oral	As per package instructions	Pain; swelling; fever Other:	YES NO
ANTI-FUNGAL CREAM	Topical	As per package instructions	Athletes foot Other:	YES NO
ANTACID/ ANTIEMETIC	Oral	As per package instructions	Nausea; diarrhea Other:	YES NO
SWIMMER'S EAR DROPS	Topical	As per package instructions	Ear pain after swimming Other:	YES NO
EYE DROPS	Topical	As per package instructions	Eye irritation; allergies Other:	YES NO
HYDROCORTISONE 0.5%	Topical	As per package instructions	Rashes; insect bites; poison ivy Other:	YES NO
COUGH SYRUP	Oral	As per package instructions	Coughing Other:	YES NO
LAXATIVE	Oral	As per package instructions	Constipation Other:	YES NO
ANTIHISTAMINE	Oral or Topical	As per package instructions	Swelling Hives; allergic reaction nasal congestion; Other:	YES NO
ANTI-DIARRHEA	Oral	As per package instructions	Diarrhea Other:	YES NO
LICE TREATMENT	Topical	As per package instructions	Detection Other:	YES NO

Health Care Provider Name:		
Address:		
City:	State:	Zip:
License Number:	Phone:	Fax:
As requested by the patient and as mandated by New York State Department of Health, a dated and/or current copy of immunizations/shot records is attached.		
PHYSICIAN SIGNATURE 2 OF 2:		DATE: