YMCA of Greater Boston Enrollment Form

FOR OFFICE USE ONLY

Initial Start Date:
Branch: 223
Location: Young Achievers
Age at Admission:

CHILD INFORMATION

Child's Name		Nickname	
Date of Birth	Gender	Age	Grade
Home Address		Phone	

DESCRIPTION OF CHILD

Eye Color		Hair Color	Skin Color
Height	Weight	Identifying Marks	Primary Language

Are you Hispanic or Latino? (Please circle) Yes No Don't know/Unsure

Which one or more would you say is your race? (Circle all that apply) White Black/African American Asian
Native Hawaiian/Pacific Islander American Indian/Alaska Native Other (specify)_____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name		Parent/Guardian Name	
Relationship to Child	Primary Language	Relationship to Child	Primary Language
Home Address City Zip Code		Home Address City Zip Code	
Home Telephone Cell		Home Telephone Cell	
Email Address		Email Address	
Business Address City Zip Code		Business Address City Zip Code	
Occupation		Occupation	
Work Hours	Work Phone	Work Hours	Work Phone

SCHOOL INFORMATION

Child's School **Young Achievers**	School Address **20 Outlook Road**
School Office Phone **(617) 635-6804**	Dismissal Time **4:00pm**
Does your child have an I.E.P. (Individual Education Plan) or 504 Plan? _____ Yes _____ No If yes, please provide a copy to the program.	

PARENT SIGNATURE: _____ **DATE:** _____

YMCA of Greater Boston
Emergency Authorization and Consent Form

CHILD'S MEDICAL INFORMATION

INSURANCE INFORMATION		*MEDICAL HISTORY* ***Please write "NONE" if there are none.***		
Child's Name	Date of Birth	Allergies/Health Conditions	Reactions	Treatment
Medical Insurance Company	Policy Number			
Other Coverage (Include Dental)		Special Disabilities/Dietary Information/ Religious Restrictions		Current Medications: Yes No Home ____ ____ School ____ ____ Program ____ ____
Child's Physician				
Phone	Address	Behavioral Issues		

Documentation of a physical examination, immunization record, and lead screening is on file at my child's school. **Yes**____ **No**_____
Children attending a Y program or camp must provide a copy of the above documents.

MEDICAL TREATMENT CONSENT

I hereby authorize certified staff of the YMCA of Greater Boston to give First Aid and CPR to my child as needed. In the event of an emergency, I hereby authorize the program staff to have my child transported to the nearest medical facility as deemed appropriate by responding medical personnel, and secure necessary medical treatment including, but not limited to: hospitalization, injections, anesthesia and/or surgery. In the event that I cannot be reached, I hereby give permission to the physician attending to my child to secure and administer treatment as necessary. I understand that the staff will make every effort to notify me of the emergency immediately.

I understand that if my child has medications available at the program I must complete annually a medication consent form and an Individual Health Care Plan signed by me and my child's doctor.

PARENT SIGNATURE:_____ **DATE:**_____

YMCA of Greater Boston
Emergency Contacts and Pick-up Authorization

EMERGENCY CONTACTS*

Please list yourself and three additional individuals to be contacted in an emergency and non-emergency, if you cannot be reached. Please note that persons listed as "Emergency Contacts" are automatically authorized to pick up your child from the program unless otherwise noted.				
Parent/Guardian		Address	Day Phone #	Evening Phone #
Name	Relationship	Address	Day Phone #	Evening Phone #
Name	Relationship	Address	Day Phone #	Evening Phone #
Name	Relationship	Address	Day Phone #	Evening Phone #

PICK-UP AUTHORIZATION

Please list below individuals who are authorized to pick up your child from the program, but would not be contacted in case of emergency. (Example: coach, neighbor, etc.)				
Name	Relationship	Address	Day Phone #	Evening Phone #
Name	Relationship	Address	Day Phone #	Evening Phone #

**Biological parents and legal guardians listed on enrollment forms are automatically authorized to pick up your child unless the program is given a copy of a current court ordered custody agreement or restraining order. A license or other positive proof of identification must be shown at pick-up time if the person is not known by staff members as an authorized pick-up person. If you wish to change, add, or delete any of these authorizations, you must do so in writing. Please note below any special instructions regarding these individuals.*

_____

Child's Name: _____

PARENT SIGNATURE: _____ **DATE:** _____

YMCA of Greater Boston
Authorization and Consent Form

Child's Name: _____ **Date:** _____

PROMOTIONAL RELEASE

I hereby grant consent and authorize the use of photographs, slides, videotapes and film of my child participating in YMCA activities for commercial and art purposes in any medium of advertising, communication, publication or publicity that will promote YMCA programs and services, and/or recognition of participants. I understand that the YMCA is a non-profit organization.

Parent/Guardian Signature:_____

SUPPORT STAFF CONSENT

YMCA programs have support staff that consist of resource advisors, family support specialists, and social service staff. In addition, student interns and/or volunteers may work within the program. I give permission for my child to interact with these support staff.

Parent/Guardian Signature:_____

OFF-SITE ACTIVITIES

I hereby grant consent for my child to:

_____ utilize local YMCA facilities
_____ take walks in local neighborhoods and to parks within a mile radius of the center
_____ visit the following designated off-site activities/locations:

Hyde Park Community Center Playground Hyde Park Branch Library Ross Field

I understand that any other activity destinations or field trips will require my written permission.

Parent/Guardian Signature:_____

WADING/SWIMMING CONSENT

I hereby grant consent for my child to participate in wading/swimming activities in life guarded locations, including at the YMCA. My child may also engage in sprinkler play under YMCA staff supervision.
My Child is ____non swimmer ___Swims with Assistance ____Can swim on own

Parent/Guardian Signature:_____

YMCA of Greater Boston Arrival and Departure Verification Form

BEFORE SCHOOL – ARRIVAL	BEFORE SCHOOL – DEPARTURE
My child will arrive at the YMCA program by: _____ Parent/Authorized Release Drop-Off _____ Other Please Specify: _____ _____ N/A	My child will depart the YMCA program by: _____ Walking (check one) _____ Supervised _____ Unsupervised _____ N/A
Arrival Time:	Departure Time:

AFTER SCHOOL – ARRIVAL	AFTER SCHOOL – DEPARTURE
My child will arrive at the YMCA program by: _____ Public School Bus (check one) _____ Supervised walk into program _____ Unsupervised walk into program _____ YMCA Bus or Van (check one) _____ Supervised walk into program _____ Unsupervised walk into program _____YMCA Contracted bus with YMCA Supervision _____ Public Transportation- Describe: _____ __ X___ Walking (check one) __ X___ Supervised _____ Unsupervised _____ Parent/Authorized Release Drop-Off _____ Other Please Specify: _____ _____ N/A	My child will depart the YMCA program by: _____ YMCA Bus or Van (need prior approval) _____ Supervised walk into home _____ Unsupervised walk into home _____ Public Transportation- Describe: _____ _____ Walking (check one) _____ Supervised _____ Unsupervised ___X__ Parent/Authorized Release Pick-Up _____ Other Please Specify: _____ _____ N/A
Arrival Time: 4:00pm	Departure Time: 6:00PM

FULL DAY - ARRIVAL	FULL DAY - DEPARTURE
My child will arrive at the YMCA program by: YMCA Bus or Van (check one) _____ Supervised walk into program _____ Unsupervised walk into program _____ Public Transportation- Describe: _____ __X___ Parent/Authorized Release Drop-Off _____ Other- Please Specify: _____ _____ N/A	My child will depart the YMCA program by: _____ YMCA Bus or Van (need prior approval) _____ Supervised walk into home _____ Unsupervised walk into home _____ Public Transportation- Describe: _____ ___X__ Parent/Authorized Release Pick-Up _____ Other- Please Specify: _____ _____ N/A
Arrival Time: 7:30a.m.-9:30a.m.	Departure Time: 4:30p.m.-6:00p.m.

Parents are reminded to contact the program in case of absence or late arrival.

Child's Name: _____

PARENT SIGNATURE: _____ **DATE:** _____

YMCA of Greater Boston
Hand Sanitizer/Topical Ointment Permission

Child's Name: _____ **Date of Birth:** _____

I give permission for my child to use hand sanitizer. I understand that they will still be required to wash hands with soap and water before eating, after using the bathroom, and if they sneeze into their hands, and they will not be required to use hand sanitizer at the program.

I understand that by signing below, I absolve the YMCA of Greater Boston of any responsibility, should a reaction occur from said product.

PARENT SIGNATURE: _____ **DATE:** _____

I give permission for the YMCA to apply sunscreen, bug spray, and other topical lotions/ointments to my child provided by me according to application instructions. I also understand that I will need to provide the above product in its original container.

If the sunscreen or bug spray I provide to the Y runs out, I give permission for the program to apply products purchased by the YMCA that meet Department of Public Health Guidelines. **Yes**_____ **No**_____

Application Instructions: _____

PARENT SIGNATURE: _____ **DATE:** _____

I give my child **(7 or older)** _____ permission to walk unattended to the non-public restroom as necessary. (For example: a rest room located in the school age area that is not used by any other groups or persons)

I understand that it is the policy of the YMCA to escort all children to the restroom when the possibility exists that a person not connected to the before/after school program may utilize that area. (For example: a rest room located in a public school basement)

PARENT SIGNATURE: _____ **DATE:** _____

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Acknowledgment of Risk and Waiver:

I understand and acknowledge my child may participate in a variety of activities that may include; swimming, boating, outdoor games, sports, rope course, and other rigorous physical activities. I hereby release and discharge, and agree to indemnify and hold harmless the YMCA of Greater Boston and its officers, directors, members, agents, employees, volunteers, and any other persons or entities on its behalf, against all claims, demands, and causes of actions whatsoever, either in law or equity, relating to or arising from any participation, medical treatment, recommendation, transportation or administration, or any lack thereof.
_____ (Parent Initials)

Child's Name:
_____

PARENT SIGNATURE:
_____

DATE: _____

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Child's Name: Date of Birth:

Please answer the following questions regarding your child's development. The information you provide will assist us in caring for your child. Thank you.

DEVELOPMENTAL HISTORY

Does he/she have any speech impairments?
Does your child have any hearing or vision difficulties?
In the past year, how many ear infections has your child had?
Is your child right or left handed?

SOCIAL RELATIONSHIPS

How would you describe your child? (ex: shy, outgoing, talkative, etc)
Has your child experienced group care before (excluding elementary school)?
Does your child know other children in this program? Name?
How does your child typically respond to new experiences? (ex: risk taker, shy, apprehensive, etc)
Does your child enjoy any special games and/or activities? If so, what?
How does your child express his/her emotions?
Does your child have any fears? (the dark, animals, etc.)
How do you comfort your child?
How does your child comfort him/herself? (nail biting, being alone, cry, laugh, etc.)
Do you utilize any type of behavior management or discipline with your child?
Have there been any major events/changes in your family life in the past year? (moving, deaths, births, divorce, etc.)
What would you like your child to gain from this experience?

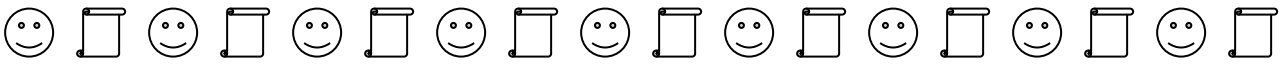
EATING HABITS **Child's Name:**

Describe your child's general attitude toward eating.
Does he/she have any favorite foods?
Does he/she refuse certain foods?

CHILD'S DAILY SCHEDULE

Please describe your child's schedule on a typical day. Include time in school or group activities, independent play, mealtimes, etc. Give approximate times for each activity/routine. Please list any additional information you would like us to know about your child.

Parent/Guardian Signature: Date:



TO BE COMPLETED BY CHILD

What do you like to do when you are not in school?
What kinds of activities would you like to do while at the YMCA?
What are you most excited about doing or learning while you're at the YMCA?

YMCA of Greater Boston
Release of Information

I hereby authorize the staff from **Young Achievers** and the staff professionals of the **YMCA of Greater Boston** to release and share information on my child, including, but not limited to attendance, report cards, IEPs, 504 Plans, progress reports and behavior charts. It is my understanding that the content of all records will remain confidential and will be used to enhance my child's academic performance and overall afterschool/summer experience. No school records may be released to any other person or agency without my full permission.

Also, I will have the option of inviting YMCA of Greater Boston Educators to attend in-school conferences and to meet with school teachers and/or staff members to discuss my child's progress per my request.

Child's Name: _____

PARENT SIGNATURE: _____ **DATE:** _____

EFT APPLICATION

Parent's Name: _____

Signature: _____Date:_____

Child's Name: _____

Cell phone # or house phone # _____ _____

Email Address: _____

☐ CREDIT CARD INFORMATION

Card Type: _____Card Issuer: _____

Account Number: _____

Name on Account: _____Expiration Date:_____/_____

Billing Address: _____

_____

Day you would like to be drafted: _____ (Weekly, Bi-Weekly, 1st or 15th)

☐ CHECKING ACCOUNT INFORMATION

Please submit a voided check

Bank Name: _____

Routing/Transit Number: _____Account Number: _____

Name of Account: _____

Billing Address: _____

_____

Day you would like to be drafted: _____ (1st or 15th of each month)

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms_____

Topical Non-Prescription (**applied to open wound/ broken skin)**_____

My child has previously taken this medication_____

My child has **no**t previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan_____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

_____

Child's Health Care Practitioner Signature _____**Date**_____

I, _____**, (parent or guardian) gives permission**
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date**_____
For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only)**

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply….

Plan was created by:
__ Parent
__ Doctor or Licensed Practitioner
__ Program's Health Care Consultant
__ School Nurse
__ Other: _Program Director

Plan is maintained by:
__ Director
__ Assistant Director
__ Child's Educator
__ Other: _____

Name of child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signatures required)
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition: **Any staff that is trained in the 5 Rights of Medication and by a person circled below**.
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant): **Circle which one is applicable:** 1:Name of trainer_____2. YMCA 1st Aid/CPR trainer 3. Parent

Name of Licensed Health Care Practitioner (please print):_____

Licensed Health Care Practitioner authorization:_____ Date:_____

Parental/Guardian consent: _____ Date:_____

For Older Children ONLY (9+ years of age)
With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. ***Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.***

Age of child: _____ Date of birth: _____ Back-up medication received? YES NO

Parent signature: _____ Date: _____

Administrator's signature: ____ Date: ____________________________________