



# AFTER-SCHOOL 2011-2012 REGISTRATION FORM

**FRONT DESK USE ONLY:**

REC'D: \_\_\_/\_\_\_/\_\_\_

 REGISTERED IN DAXKO BILLING INFO STORE PAYMENTS SCHEDULED

UNIT NUMBER \_\_\_\_\_

**FORMS RECEIVED:** MEDICAL INFORMATION PARENT CONSENT TRANSPORTATION**PLEASE PRINT ALL INFORMATION**DATE: \_\_\_\_\_  After-School Program  Leaders-in-Training

CHILD ONE LAST: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

 MALE  FEMALE DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ School of Enrollment \_\_\_\_\_ Grade \_\_\_\_\_

CHILD TWO LAST: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

 MALE  FEMALE DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ School of Enrollment \_\_\_\_\_ Grade \_\_\_\_\_**ENROLLMENT INFORMATION**  Session 1: September 12- November 4  Session 2: November 7- January 6, 2012  
 Session 3: January 9- March 9  Session 4: March 12-May 11  Session 5 May 14- June 16 (\*5 weeks) 5 days  3 days (please circle days needed) MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAYFEE/WEEK: 3 DAY – Member \$54; Siblings \$51 / Non-Member \$63; Siblings \$60 (8 Weeks; Holiday weeks prorated)  
5 DAY – Member \$90; Siblings \$85 / Non-Member \$105; Siblings \$100 (8 Weeks; Holiday weeks prorated)**PRIMARY GUARDIAN INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**SECONDARY GUARDIAN INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_  CHECK IF SAME

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**ETHNICITY: (Optional - this information is tracked for funding purposes only)** Black American  Hispanic  Asian or Pacific Islander  American Indian  Brazilian  Other \_\_\_\_\_**EMERGENCY CONTACT(S) (Please list parent/guardian names and other contacts):**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

**\*Please note weeks with Holidays and School Calendar half-days will be prorated. School Vacation camps and half-day programs require separate registration.**

CHILD'S NAME: \_\_\_\_\_

**THE FOLLOWING INDIVIDUALS ARE ALLOWED TO PICK UP MY CHILD:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

**DO NOT ALLOW THE FOLLOWING INDIVIDUALS PICK UP MY CHILD:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATION: \_\_\_\_\_

\_\_\_\_\_

Please provide copies of any custody agreements, court orders, and restraining orders pertaining to the child to the Director.

**ADDITIONAL INFORMATION:**

CHILDRENS PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CHILD ONE ALLERGIES/SPECIAL DIETS? \_\_\_\_\_

Individual Health Plan for child with a chronic health condition? If yes, please attach.

SPECIAL LIMITATIONS OR CONCERNS? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CHILD TWO ALLERGIES/SPECIAL DIETS? \_\_\_\_\_

Individual Health Plan for child with a chronic health condition? If yes, please attach.

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? If yes, please attach.

SPECIAL LIMITATIONS OR CONCERNS? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the YMCA and all branches thereof, its directors, officers, employees, and agents (hereinafter referred to as "releasees") the releasees and each of them from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about the YMCA premises or in any way observing or using any facilities or equipment of the YMCA or participating in any program affiliated with the YMCA whether caused by the negligence of the releasees or otherwise.*

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

**For questions regarding this form, please contact  
Apyrl Anastacio, School Age Program Director, at [aanastacio@ymcamv.org](mailto:aanastacio@ymcamv.org), or (508) 696 7171 ext. 105**

**Please return completed registration form by mail to:  
YMCA of Martha's Vineyard, attention: After School  
111R Edgartown Vineyard Haven Rd., Vineyard Haven, MA 02568  
Fax: (508) 696 6806. Forms can also be brought to the Member Service Desk**



# YMCA 2011 AFTER-SCHOOL MEDICAL INFORMATION FORM

## THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN

**PLEASE NOTE:** You must complete the following medical history form **AND attach your child's immunization record.** Updated medical records are required by state mandate. Your child will not be admitted into After-School Program unless all required information is on file. **Please request extra copy if registering more than one child in After-School Program.**

NAME OF CHILD \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME OF PARENT(S)/GUARDIAN(S) \_\_\_\_\_

PRIMARY MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: ( ) - \_\_\_\_\_ \*\* E-MAIL: \_\_\_\_\_

CELL: ( ) - \_\_\_\_\_ WORK: ( ) - \_\_\_\_\_

### EMERGENCY CONTACT:

NAME: \_\_\_\_\_ RELATION TO CHILD: \_\_\_\_\_

PHONE: ( ) - \_\_\_\_\_ CELL: ( ) - \_\_\_\_\_

### FOR OFFICE USE ONLY:

#### DATES ATTENDING AFTER-SCHOOL PROGRAM (check all that apply):

- Session 1: September 12 - November 4     Session 2: November 7- January 6  
 Session 3: January 9- March 9     Session 4: March 12-May 11     Session 5: May 14-June 16

### MEDICATION, ALLERGIES, PHYSICAL HANDICAPS

Please list medications that your child is taking. If your child will be taking any medications (prescription or over-the-counter) during After-School Program, you **must** complete a medication authorization form.

\_\_\_\_\_  No Medications

- My child has no allergies or  My child is allergic to:  
 Bees     Medication     Food     Other \_\_\_\_\_  
What symptoms may occur? \_\_\_\_\_

Does your child carry an Epi-Pen?  Yes  No (If yes, one **must be provided** to After-School Program.)

Does your child have a physical handicap? \_\_\_\_\_

### INSURANCE INFORMATION

Is the participant covered by family medical / hospital insurance?  Yes  No

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Social Security number of policy-holder or insurance ID number \_\_\_\_\_

### PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE:

I herby give permission to the YMCA of Martha's Vineyard medical personnel or the After-School Program director to order XRays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the After-School Program director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of After School program.

SIGNATURE OF PARENT/GUARDIAN (REQUIRED) \_\_\_\_\_ DATE \_\_\_\_\_

**THIS SIDE TO BE COMPLETED BY A MEDICAL PRACTITIONER  
ONLY IF MEDICATION IS TO BE ADMINISTERED**

**\* A CURRENT, SIGNED RECORD OF IMMUNIZATION WITH DATE OF PHYSICAL MUST BE PROVIDED**

**A physician must have completed a physical examination in the last 24 months.**

**NAME OF CHILD** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**NAME OF PARENT(S)/GUARDIAN(S)** \_\_\_\_\_

-----  
**DATE OF EXAM:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**GENERAL INFORMATION:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Heart \_\_\_\_\_

**\*Please attach current certificate of Immunization**

**MEDICAL INFORMATION PERTINENT TO ROUTINE CARE AND EMERGENCIES:**

May participate in all After-School Program activities       May participate except for: \_\_\_\_\_

Is this individual taking prescription medication?  NO  YES (please list all prescriptions): \_\_\_\_\_

Does the individual have allergies?  NO  YES Explain: \_\_\_\_\_

Is the individual on a special diet?  NO  YES Explain: \_\_\_\_\_

Does the individual have special needs?  NO  YES Explain: \_\_\_\_\_

Has the child ever had, or does he/she now suffer from (please check all that apply and provide explanation if needed):

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Asthma (inhaler Y/N) | <input type="checkbox"/> Allergy requiring EPI-Pen    | <input type="checkbox"/> ADD/ADHD         | <input type="checkbox"/> Autism                   |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Seizures         | <input type="checkbox"/> High/ Low Blood Pressure |
| <input type="checkbox"/> Physical Handicaps   | <input type="checkbox"/> Recent/ Recovering Fractures | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Other                    |

-----  
**\* This form must be completed by physician before any medications, including over-the-counter, can be administered.**

-----  
**MEDICAL CARE PROVIDER INFORMATION**

Print name \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in an active After-School Program.

\_\_\_\_\_  
**SIGNATURE OF PHYSICIAN, APRN OR PA (REQUIRED)**

\_\_\_\_\_  
**DATE**

**YMCA of Martha's Vineyard After-School Program  
PARENT/GAURDIAN CONSENT FORM**

NAME OF CHILD \_\_\_\_\_

Please sign this form to acknowledge that you have read the Family Handbook and agree to the policies and procedures outlined below. Signature of parent/guardian is required for your child to enter After School program.

**Medical Consent**

As the parent/guardian, I hereby give consent to the YMCA of Martha's Vineyard After-School program to provide emergency medical treatment for the above named child in the event that I cannot be reached. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of the child.

Recognizing that the YMCA will do its best to ensure a safe experience, I understand that certain dangers or accidents may occur. I hereby release the YMCA of Martha's Vineyard from any and all responsibility and liability of any nature, including claims of injury, illness, death, loss or damage, resulting from my child's participation in any program activities.

**Participation Agreement** *(Please go over these items with your child):*

1. Participant agrees to abide by rules and regulations set by the program for the health, safety and welfare of the participants.
2. All medications will be brought directly to the site staff in accordance with the Plan for Administration of Medication and will be accompanied by a medical consent form.
3. The YMCA is not responsible for lost, damaged or stolen personal belongings.
4. Continued inappropriate behavior, including but not limited to threatening, bullying, not following directions, teasing, sexual harassment/intimidation, fights, or improper behavior in vehicles, may result in immediate dismissal from the program with no refund.
5. Children will not be accepted at the center if they are ill. This includes, but is not limited to fever of 100°F or higher, stomach virus, or any contagious symptoms; rashes, sore throat, vomiting, etc. Should the child become ill during the day, the parent or designated emergency contact person(s) will be notified to pick up the child.
7. Children will be dropped off and picked up at the designated times. If extended care is needed, registration is required so that adequate staff can be provided. If the child is not enrolled in extended care, late pick-up penalties will apply.
8. The YMCA of Martha's Vineyard After-School Program has the right to refuse a child to the program if all required documentation has not been provided (i.e., immunization record, signed medical form, signed Parent/Guardian Consent form).

**By Signing Below, I Agree That:**

- ✓ I have read and understand the parent/guardian consent and Family Handbook.
- ✓ I authorize my child to participate in routine transportation, field trips, special activities away from the facility, and water-related activities occurring in water that is more than two (2) feet deep.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature of Parent / Guardian**

\_\_\_\_\_  
**Date**