ATTLEBORO NORTON YMCA · SCHOOL VACATION PROGRAM

Registration Form 2024 – 2025 School Year

Camper's Name: _____ Gender: ___Male ___Female

Street: _____

City / Town: _____ State: _____ Zip: _____

Home Phone: _____ Birth Date: _____ Age: _____ Grade in Fall: _____

Which days will your child attend the school vacation program each week?

☐MON ☐TUE ☐WED ☐THU ☐FRI

PARENT & EMERGENCY CONTACT INFORMATION **(All of the information below is required for Authorized Pickup verification.)**

Parent 1 Name _____ Date of Birth _____ Authorized to Pick Up? __Yes __No
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Relationship to Child _____

Parent 2 Name _____ Date of Birth _____ Authorized to Pick Up? __Yes __No
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Relationship to Child _____

Emergency Contact Name _____ Date of Birth _____ Authorized to Pick Up? __Yes __No
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Relationship to Child _____

Additional Pick-Ups (optional) Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Relationship to Child _____

Additional Pick-Ups (optional) Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____
Relationship to Child _____

YOUR CHILD'S HEALTH HISTORY: (Check – giving approximate dates)

Frequent Ear Infections	_____	Hay Fever	_____	Chicken Pox	_____
Heart Defect/Disease	_____	Ivy Poisoning, etc.	_____	Measles	_____
Convulsion	_____	Insect Sting Allergy	_____	German Measles	_____
Diabetes	_____	Penicillin Allergy	_____	Mumps	_____
Bleeding/Clotting	_____	Other drug Allergies	_____	Asthma	_____

Food Allergies – Please list allergies, child's reactions, and any related prescriptions or treatments:

_____

Operations or serious injuries (dates): _____

_____

Chronic or recurring illness: _____

_____

Other diseases or details of above: _____

_____

Name of dentist/orthodontist: _____Phone: _____

Name of physician: _____ Phone: _____

Insurance carrier: _____ Policy/Group #: _____

Any specific activities to be restricted? _____

Will your child require any medications while in the program?

(If yes, please complete the Individual Health Care forms that must be signed by your child's physician and returned prior to your child's first day in the program.)

☐ **Yes** ☐ **No**

Transportation Plan and Authorization

AFTER CARE TRANSPORTATION PLAN

My child will ARRIVE at YMCA via

_____Parent Drop Off

_____Other

My child will DEPART YMCA

at an approximate time of _____ via

_____Parent Pick Up

_____Supervised Walk

_____Public/Private Van

_____Contract/Van

_____Private Transportation Arranged by Parent

_____Other

Parent/Guardian Signature: _____ Date: _____

AGREEMENTS & WAIVERS

Health Policies Agreement: I agree to all health policies as outlined in the Attleboro Norton YMCA 's Child Develop Centers Family Handbook, including (but not limited) to the wearing of face coverings when required. I also agree to communicate any symptoms of or potential exposure to COVID-19. I understand that if I fail to comply with any of the Health Policies, my child's enrollment in the program may be terminated.

First Aid & Medical Consent Waiver: I authorize staff at the Attleboro Norton YMCA who are certified in Basic First Aid and CPR to administer first aid and emergency care when appropriate and as needed. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the staff at the Attleboro Norton YMCA to transport my child to _____Hospital (or the nearest hospital) and to secure any necessary medical treatment for my child.

Field Trip Permission Form: I permit my child to leave the Attleboro Norton YMCA on authorized trips under the supervision of the YMCA staff.

Parent/Guardian Signature:_____Date: _____

Permission to Photograph and/or Videotape

I give permission for my child to be photographed and or videotaped during the hours he/she attends the program for non-profit purposes and for use in the YMCA's marketing materials.

_____ _____

Parent/Guardian Signature Date

Swim

I give permission for my child to participate in recreational swim at the YMCA.

_____ _____

Parent/Guardian Signature Date

ATTLEBORO YMCA CHILD PROTECTION GUIDELINES

The Attleboro YMCA wants to ensure a safe, positive environment that promotes growth and well-being of all children. The purpose of this document is to outline our policies in regards to staff hiring, our expectations of parents, and measures we have implemented to prevent child abuse.

YMCA Employee Training & Policies

- All prospective employees and program volunteers are background checked through the EEC website and at least two references are checked.
- All staff and volunteers will participate in an orientation program that reviews our Child Protection Policies.
- Attleboro YMCA staff are mandated reporters. If they suspect a child has been abused, they will immediately notify their supervisor and complete a written report. This report will immediately be reviewed by their supervisor Director. A decision will then be made to report the incident to law authorities and the Department of Children & Family Services.
- In the event a reported child abuse incident involves an employee or volunteer, the Director will suspend the employee or volunteer. Reinstatement will occur only after all allegations have been cleared to the satisfaction of the Director and the investigating agency(ies).
- Staff will never be alone with a child in a place where they cannot be observed.
- **Staff are not allow to babysit for children they meet at the Y or through Y programs. They are not allowed to transport children in their personal vehicles.**

Parents' Rights & Responsibilities

- If a parent/guardian has any concerns about their child's safety or suspects any form of abuse, they should immediately notify the Director.
- Parents should understand that staff are mandated reporters and are required by law to report any suspected cases of child abuse.
- Parents should pick up their children on time and notify the Y if they are running late. If there is no communication from a parent and emergency contacts cannot be reached at the end of the program time, the Y will contact the local police and DCF after one hour.
- If a person arrives to pick up a child and appears to be under the influence of drugs or alcohol, the staff may contact the police.
- If there are any changes in custody or who is allowed to pick up a child, parents should notify the Director.

I have read the policies above and understand the staff policies set in place to keep my child safe. I understand my responsibilities as a parent in the effort to prevent child abuse and to protect all children in Y childcare and programs.

_____ _____

Parent/Guardian Signature Date

This form is only required if your child requires medications while at the program or has any of the conditions listed below.

MEDICATION & HEALTH CARE PLAN FORMS

If your child will require any medication during the program day or has any on-going medical conditions, such as asthma, allergies, or diabetes, please fill out the following forms as necessary.

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 **not** 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)**

This form is only required if your child requires medications while at the program or has any ongoing medical conditions.

Child's Photo

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
__ Older school age child (9+ yrs. of age)
__ Other: _____

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:
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):

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: _____

This form is only required if your child has food allergies.

Food Allergy Action Plan

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

Place Child's Picture Here

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:**		To be determined by physician authorizing treatment
▪ If a food allergen has been ingested, but *no symptoms*:		☐ EpiPen	☐ Antihistamine	
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen	☐ Antihistamine	
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ EpiPen	☐ Antihistamine	
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen	☐ Antihistamine	
▪ Throat †	Tightening of throat, hoarseness, hacking cough	☐ EpiPen	☐ Antihistamine	
▪ Lung †	Shortness of breath, repetitive coughing, wheezing	☐ EpiPen	☐ Antihistamine	
▪ Heart †	Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen	☐ Antihistamine	
▪ Other †	_____	☐ EpiPen	☐ Antihistamine	
▪ If reaction is progressing (several of the above areas affected), give		☐ EpiPen	☐ Antihistamine	

The severity of symptoms can quickly change. † Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____) . State that an allergic reaction has been treated, and additional epinephrine may be needed)

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____
c. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

This form is only required if your child has asthma.

Asthma Action Plan

AMERICAN LUNG ASSOCIATION®

General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/Health Care Provider _____ Phone numbers _____
- Physician Signature _____ Date _____

Severity Classification

- ○ Mild Intermittent ○ Moderate Persistent
- ○ Mild Persistent ○ Severe Persistent

Triggers

- ○ Colds ○ Smoke ○ Weather
- ○ Exercise ○ Dust ○ Air pollution
- ○ Animals ○ Food
- ○ Other _____

Exercise

1. Pre-medication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Control Medications

Medicine	How Much to Take	When To Take It

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Peak Flow Meter

Between 50 to 80% of personal best or

_____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- ○ Take quick-relief medication every 4 hours for 1 to 2 days
- ○ Change your long-term control medicines by _____
- ○ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- ○ Take quick-relief treatment again
- ○ Change your long-term control medicines by _____
- ○ Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Peak Flow Meter

Between 0 to 50% of personal best or

_____ to _____

Go to the hospital or call for an ambulance if

- ○ Still in the red zone after 15 minutes
- ○ If you have not been able to reach your physician/health care provider for help
- ○ _____

Call an ambulance immediately if the following danger signs are present

- ○ Trouble walking/talking due to shortness of breath
- ○ Lips or fingernails are blue