OST Snow Day Child Information Form

Separate form per child is required

* Please note, our Program is licensed by the Massachusetts Department of Early Education and Care and all documentation listed in this from are required for participation*

Child's Name: _____

Date of Birth: _____ Current grade: _____ Current School: _____

Physical Description: Gender _____ Eye Color: _____ Hair Color: _____

Skin Color: _____ Approximate Height: _____ Approximate Weight: _____

Snow Day Rates:

- **OST Family: $60**
- **WSYMCA Member: $90**
- **WSYMCA Non-Member: $120**

Please Choose One:

- **I am an OST Family: _____**
- **I am a WSYMCA Member: _____**
- **I am NOT a WSYMCA Member: _____**

Photo and Swim Permission

Swimming Experience:

Has your child taken lessons before? _____ At the West Suburban YMCA? _____

Does your child use bubbles/floaties? _____ If yes, how many? _____

Can your child swim without an adult supporting him/her? _____

I give my child permission to partipate in FREE swim during the program and understand s/he will be supervised by YMCA staff.

Parent Signature: _____ Date: _____

Video and Photograph: *I permit the respresenatative and employees of the West Suburban YMCA to take photographs of my child. I authorize the West Suburban YMCA, its assignees and transferees to copyright, use and publish the same in print and/or electronically. I agree that the West Suburban YMCA may not use such photographs of my child with or without his/her name and for any lawful pupose, including but not limited to such puposes as publicity, illustration, advertising and web content.*

Parent Signature: _____ Date: _____

Emergency Card: ALL Information is REQUIRED

Child's Name: _____ Date of Birth: _____

Home Phone: _____ Primary Language: _____

Home Address: _____

How to reach parents/guardians (will be called FIRST in emergency; also authorized for pick up):

Parent/Guardian 1: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Parent/Guardian 2: _____ Relationship: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email: _____

Emergency Contact Persons (list in order we should call in an emergency; also authorized to pick up):

1. Name: _____Relationship: _____

   Contact Phone Number: _____ Alternative Phone Number: _____
2. Name: _____ Relationship: _____

   Contact Phone Number: _____ Alternative Phone Number: _____
3. Name: _____ Relationship: _____

   Contact Phone Number: _____Alternative Phone Number: _____

Medical Emergency Treatment

I hereby give the West Suburban YMCA Youth and Family program staff permission to administer basic first aid and/or CPR to my child and/or take my child to Newton Wellesley or the nearest hospital for medical treatment if I cannot be reached or when delay would be dangerous to my child's health.

_____ _____

Parent/Guardian Signature Date

Pediatrician: _____ Phone Number: _____

Insurance Company: _____ Policy # _____

Special Instructions: _____

Allergies: _____

If your child has an allergy, please complete the Individual Health Care Plan and Medication Consent Form on the following page.

Parent/Guardian Signature: _____ Date: _____

Child's Name: _____Date of Birth: _____

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+ years 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 signature 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: _____

Parent/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 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's Signature: _____ Date: _____

Administrator's Signature: _____ Date: _____

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 _____

Tropical 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 _____ Date: _____

I, _____, (parent or guardian) gives
Print name
permission to authorize educator(s) to administer medication to my children as indicated above.

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