

# YWCA Central New Jersey Early Childhood Learning Center

CHILD'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

SCHOOL \_\_\_\_\_ PRESENT SCHOOL GRADE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADULTS IN HOUSEHOLD: Child lives with (check one): \_\_\_\_\_ Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Guardian

CHILDREN IN THE HOUSEHOLD: Please list name of all other children living in the home.

1. \_\_\_\_\_ AGE \_\_\_\_\_ 2. \_\_\_\_\_ AGE \_\_\_\_\_ 3. \_\_\_\_\_ AGE \_\_\_\_\_

4. \_\_\_\_\_ AGE \_\_\_\_\_ 5. \_\_\_\_\_ AGE \_\_\_\_\_ 6. \_\_\_\_\_ AGE \_\_\_\_\_

MOTHER/GUARDIAN'S NAME: \_\_\_\_\_ ADDRESS \_\_\_\_\_

HOME PHONE# \_\_\_\_\_ EMPLOYMENT NAME & ADDRESS \_\_\_\_\_

WORK PHONE# \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

FATHER/GUARDIAN'S NAME: \_\_\_\_\_ ADDRESS \_\_\_\_\_

HOME PHONE# \_\_\_\_\_ EMPLOYMENT NAME & ADDRESS \_\_\_\_\_

WORK PHONE# \_\_\_\_\_ CELL PHONE # \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATION TO CHILD \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME# \_\_\_\_\_ WORK# \_\_\_\_\_ CELL# \_\_\_\_\_

FAMILY PHYSICIAN/CLINIC \_\_\_\_\_ PHONE# \_\_\_\_\_

## **THE FOLLOWING PERSONS ARE AUTHORIZED TO PICK UP MY CHILD:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

### **PLEASE NOTE:**

Children will not be released to other individuals without written permission from the parent and/or guardian.

### **TRIP AUTHORIZATION**

I give my child permission to go on short trips to local parks, library, or other trips planned by the YWCA Children's Program.

### **EMERGENCY MEDICAL RELEASE**

To Whom It May Concern: My child is in good medical condition and able to engage in activities outlined in the YWCA Program. Should my child need emergency medical attention while attending the YWCA of Central New Jersey, I hereby give permission for him/her to receive any necessary medical treatment.

**I UNDERSTAND THAT I AM RESPONSIBLE FOR REPORTING CHANGES IN EMERGENCY NUMBERS, ADDRESS, OR PERSONS AUTHORIZED TO PICK UP MY CHILD/CHILDREN.**

\_\_\_\_\_  
**Parent/ Guardian's Signature**

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

# YWCA of CENTRAL NEW JERSEY CHILDREN'S PROGRAMS HEALTH FORM

CHILD'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_

MOTHER/GUARDIAN'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

FATHER/GUARDIAN'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

### HEALTH HISTORY (GIVE APPROXIMATE DATES)

	DATE		DATE		DATE
FREQUENT EAR INFECTIONS		HEART DISEASE/DEFECTS		CONVULSIONS	
DIABETES		BLEEDING/CLOTTING DISORDERS		MUMPS	
HYPERTENSION		MONOUCLEOSIS		MEASLES	
CHICKEN POX		GERMAN MEASLES		HAYFEVER	
IVY POISONING		INSECT STINGS		ASTHMA	

OPERATIONS OR SERIOUS ILLNESSES (DATES): \_\_\_\_\_

DISABILITIES OR CHRONIC RECURRING ILLNESSES: \_\_\_\_\_

ANY SPECIFIC ACTIVITIES TO BE ENCOURAGED OR LIMITED BY PHYSICIAN: \_\_\_\_\_

\_\_\_\_\_

DIETARY MODIFICATIONS: \_\_\_\_\_

OTHER DISEASES OR DETAILS OF ABOVE: \_\_\_\_\_

DENTIST NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DO YOU CARRY FAMILY MEDICAL/HOSPITAL INSURANCE? \_\_\_\_\_

IF SO, INDICATE CARRIER \_\_\_\_\_ POLICY # OR GROUP \_\_\_\_\_

# YWCA of CENTRAL NEW JERSEY CHILDREN'S PROGRAMS HEALTH FORM

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

THIS HEALTH HISTORY IS CORRECT AS FAR AS I KNOW AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED ACTIVITIES EXCEPT AS NOTED.

### EMERGENCY AUTHORIZATION:

I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE PROGRAM DIRECTOR TO ORDER X-RAYS, ROUTINE TESTS, AND TREATMENT FOR MY CHILD IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY. I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE PROGRAM DIRECTOR TO HOSPITALIZE MY CHILD IN ORDER TO SECURE PROPER TREATMENT, AND TO ORDER INJECTION AND/OR ANESTHESIA, AND/OR SURGERY IN MY ABSENCE FOR MY CHILD AS NAMED ABOVE, THIS FORM MAY BE PHOTOCOPIED FOR USE.

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

## THIS SECTION IS TO BE COMPLETED BY LICENSED PHYSICIAN

VACCINES	DATES OF MOST RECENT IMMUNIZATIONS
1. DAPHNIA	1.
2. PETRUSES OR WHOOPING COUGH	2.
3. TETANUS	3.
4. DIPHTHERIA	4.
5. INTERCEPT POLIO	5.
6. MEASLES	6.
7. MUMPS	7.
8. RUBELLA	8.
9. OTHER	9.

TUBERCULIN TEST GIVEN: YES / NO (circle one) \* IF YES: NEGATIVE / POSITIVE (circle one)

DATE TUBERCULIN TEST GIVEN: \_\_\_\_\_

**I have examined the above applicant. In my opinion, the applicant's condition does \_\_\_\_\_ does not \_\_\_\_\_ preclude his/her participation in an active program.**

- The applicant is under the care of a physician for the following condition(s):  
\_\_\_\_\_  
\_\_\_\_\_

- Current medications include: \_\_\_\_\_
- Explanation of any reported loss of consciousness or convulsions: \_\_\_\_\_
- Does applicant have epilepsy? Yes \_\_\_\_\_ No \_\_\_\_\_
- Does applicant have diabetes? Yes \_\_\_\_\_ No \_\_\_\_\_

### RECOMMENDATIONS AND RESTRICTIONS WHILE PARTICIPATING AT PROGRAM

- Any dietary restrictions: \_\_\_\_\_
- Any allergies (food, plants, insects, etc.): \_\_\_\_\_

**Licensed Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_