

# YWCA Central New Jersey SUMMER PROGRAM 2011

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 NAME: \_\_\_\_\_ ADDRESS \_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

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

### **PLEASE NOTE:**

The Summer Program pick up hour is 6:00p.m. Children will not be released to other individuals without written permission from a parent and/or guardian. Students are not permitted to leave the program alone.

### **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.

### **YWCA HANDBOOK AND DYFS LETTER TO PARENTS RECEIPT**

**I AM IN RECEIPT OF THE YWCA CHILDREN'S PROGRAMS HANDBOOK AND DYFS LETTER TO PARENTS.**

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

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

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

**PLEASE READ THE FOLLOWING CAREFULLY. YOUR SIGNATURE BELOW  
WILL ACKNOWLEDGE ACCEPTANCE OF THESE TERMS.**

**YWCA SUMMER CAMP PROGRAM FEES**

Teachers and Administrative Staff are not able or allowed to negotiate fees or payment schedules. You must contact the Finance Office at 908-756-3500, ext. 121 to make payment arrangements.

If there are any circumstances that require your child to be absent for more than 1 week, it is very important that you call the YWCA as soon as possible. Trying to make an adjustment after the fact is very difficult, and we expect full payment unless arrangements have been made. We want to try and accommodate any unusual circumstances, but you must give us the opportunity to do so.

**LATE FEES**  
**PICK UP TIME IS 6:00 PM.**

6:05-6:20=\$15    6:21-6:36=\$25    6:37-6:52=\$35    6:53-7:00=\$45

We will attempt to locate the parent/guardian, but it is your responsibility to alert us to unusual circumstances. After 7:00pm local authorities and/or DYFS may be called to assist with locating parent/guardian.

**I HAVE READ AND UNDERSTAND THE PROCEEDING INFORMATION REGARDING THE YWCA's PAYMENT POLICIES.**

\_\_\_\_\_  
PARENT SIGNATURE

\_\_\_\_\_  
DATE

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

OFFICE USE ONLY

\_\_\_\_\_ SSBG

\_\_\_\_\_ CATH CHAR / 4C'S / DYFS

\_\_\_\_\_ FULL PAY

# YWCA 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            |      | MONONUCLEOSIS               |      | 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 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.

## 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 camp program.**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

- 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.): \_\_\_\_\_

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

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

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

YWCA CENTRAL NEW JERSEY  
232 EAST FRONT STREET  
PLAINFIELD, NJ 07060

April 1, 2011

Dear Parent:

In keeping with New Jersey's childcare center licensing requirements, we are obliged to provide you, as the parent of a child enrolled at our center, with this informational statement.

The statement highlights, among other things: your right to visit and observe our center at any time without having to secure prior permission; the center's obligation to be licensed and to comply with licensing standards; and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State's Division of Youth and Family Services (DYFS).

Please read this statement carefully and, if you have any questions, feel free to contact me at (908) 756-3500, extension 119.

Cordially,

Yolanda Fuller-McCloud  
Children's Programs Director  
(908) 756-3500 ext. 126  
YWCA Summer Camp

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Please complete and return this portion to the center: (Please print)

Name of child \_\_\_\_\_

Name of Parent(s): \_\_\_\_\_

I have read and received a copy of the Information to Parents statement prepared by the Bureau of Licensing in the Division of Youth and Family Services.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_