



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Greene Summer Camp Registration Checklist

1. ____ Registration Form
2. ____ Parent Statement
3. ____ Summer Day Camp Agreement
4. ____ Credit Card / Bank Draft Form
5. ____ Field Trip Permission Form
6. ____ Commonwealth of VA School Entrance Health Form, including:
 - Certificate of Immunization
 - Physical Exam
7. ____ Sunscreen Form
8. ____ Medication Form (if necessary)
9. ____ F.A.R.E. Form (if necessary)
10. ____ Handbook Signature
11. ____ ** Copy of Child's Birth Certificate**

First day attended: _____

Last day attended: _____

Notes:

PIEDMONT FAMILY YMCA

151 McIntire Park Drive
Charlottesville, VA 22902
434-974-9622
PiedmontYMCA.org

Piedmont Family YMCA Summer Day Camp 2020 Registration Form



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Camp attending _____ Child's name (last/first): _____ Rising grade: _____

Birth date: _____ Age: _____ Gender: Male Female Unspecified T-shirt size: _____

Ethnic Origin:

Black or African American White Asian or Pacific Islander
 Hispanic or Latino American Indian or Alaska Native Other: _____

Allergies/(type) _____ None

ADD/ADHD _____ None

Special Circumstances **(see back page and provide additional information if necessary)** None

Check which parent to contact for immediate response:

Guardian 1 (first/last): _____ Employer _____
Home address _____ City _____ Zip _____
Mobile # _____ Home # _____ Work # _____ ext: _____ Email address: _____

Guardian 2 (first/last): _____ Employer _____
Home address _____ City _____ Zip _____
Mobile # _____ Home # _____ Work # _____ ext: _____ Email address: _____

EMERGENCY INFORMATION

In case of an emergency, please contact the following first: Guardian 1 Guardian 2

Child's doctor _____ Doctor's # _____

Hospital preference _____ Insurance company _____ Policy # _____

If guardian cannot be reached, call. PHONE NUMBER CANNOT MATCH PRIMARY CONTACT INFO:

Name (first/last) _____ Relationship to child _____
Mobile # _____ Home # _____ Work # _____ ext: _____

Name (first/last) _____ Relationship to child _____
Mobile # _____ Home # _____ Work # _____ ext: _____

Name (first/last) _____ Relationship to child _____
Mobile # _____ Home # _____ Work # _____ ext: _____

In addition to the listed emergency contacts, I authorize the Branch to allow the following individual(s) to pick up my child (Must be 18 years or older)

Persons NOT authorized to visit or pick up my child **(COURT DOCUMENTATION IS REQUIRED AND MUST BE ON FILE.)**

Please create a security "code word." Staff members will ask for the code during rides-out/pick up. Please share your child's code word only with persons authorized to pick up. **CODE WORD:** _____

PARENT STATEMENT OF UNDERSTANDING

The following information is important for the safety and protection of your child. Please read the information, sign this form and return it along with the rest of this registration packet to the Piedmont Family YMCA – **Attn: Brooks Summer Day Camp or BrooksSummerDayCamp@PiedmontYMCA.org**. Your signature below indicates that you have received a copy of the YMCA Summer Day Camp Program Parent Handbook.

- I understand that YMCA staff and volunteers are not allowed to care for or transport children at any time outside of the YMCA program.
- I understand that I am not to leave my child at the Summer Day Camp Program or program site unless a Program staff or volunteer is there to receive and supervise my child.
- I understand that my child will not be allowed to leave the program on his/her own or with an unauthorized person. Any person authorized to pick-up my child must either be listed with the YMCA or other arrangements must be made by calling the Program Director.
- I understand that should a person arrive to pick up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff will be required to contact the police.
- I understand that the YMCA is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.
- I understand that I am responsible for the \$50.00 non-refundable Annual Registration Fee and weekly Summer Camp payments. Weekly payments will be drafted by the Summer Day Camp Program on Wednesday's prior to session attending. There will be no refunds if my child does not attend. There will be a \$35 fee for all returned checks or charges. A two-week notice is required for any child that is voluntarily withdrawn from the program.
- I understand that there will be a charge of \$1.00 for every minute that my child remains in care waiting to be picked up after the end of the program. If I or another authorized person has not been contacted within 30 after the end of the program, Social Services and/or the Police Department will be notified.
- I understand that my child's participation in this program is a privilege that can be revoked if my child fails to exhibit proper respect for program staff or volunteers.
- I understand that a lunch, two snacks and water bottle are to be brought to camp each day. All items must be labeled with first/last name and date per licensing standards.

Parent/Guardian Signature: _____ Date: _____

2020 Summer Day Camp AGREEMENT

(Please read and initial each statement)

- The YMCA shall notify the parent/guardian whenever the child becomes ill and the parent/guardian will arrange to have the child picked up as soon as possible if so requested by the YMCA. _____

- I will inform the Summer Day Camp Director within 24 hours or next business day after my child or any member of the immediate household has developed any reportable communicable disease, as defined by the State Board of Health, except for life threatening diseases which must be report immediately. _____

- I authorize the YMCA Staff to obtain immediate medical care if any emergency occurs when the parent/guardian cannot be located immediately. I understand that if I have an objection to the provision of such care on religious or other grounds this objection must be made in writing to the YMCA. _____

- I agree to provide the YMCA with all requested health information (a physical and immunization records). I understand that all registration materials must be completed **within 2 weeks** of registration or my spot in camp will be removed and the process will be restarted.

- I give permission for my child to be included in the YMCA Summer Day Camp photos and videos. I understand that these photos and videos may be used for promotional use and social media. _____

- I understand that I am responsible for the \$50 Annual Registration Fee and weekly camp payment for weeks reserved. Weekly payments will be drafted by the Summer Camp Program on Wednesday's one week before each week session you have registered for. Summer Day Camp payments will be paid for the weeks registered regardless of my child's attendance. There will be no refunds if my child does not attend. _____

- I agree that in the event of illness, vacation, or other absences, I will notify the Summer Camp program by 9:30AM that day. Regardless of illness and/or other activities, I am responsible for my child's tuition payment. Credit is given for medical emergencies, sudden illness, and death in the immediate family with documentation. _____

- I understand that if my child has any special needs or circumstances, I will provide documentation to help staff better serve my child's needs. An action plan to ensure success in the program may be needed if discipline or behavior becomes an issue. _____

I have read, understand, and agree to abide by the YMCA Summer Day Camp policies.

Parent/Guardian: _____ Date: _____

Administrator of Center: _____ Date: _____

First Day of Attendance: _____ Last Day of Attendance: _____

The Piedmont Family YMCA is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

Date Completed Registration Received: __/__/__

CREDIT CARD/BANK DRAFT AUTHORIZATION

Drafts/Charges will occur on Wednesday one week prior to the session of Summer Day Camp.

I authorize the YMCA to charge my credit card/bank account for payments. If at any time there is to be a charge, deletion, or cancellation of my child's enrollment, it is to be submitted in writing to the YMCA two weeks prior to the date of my credit card charge/bank draft in order to cancel the charge/draft.

Should any charge/draft not be honored by my credit card company/bank when received by them, it is understood that the payment is to be made by me in the amount of the refused payment, plus a \$35 service charge.

CREDIT CARD

NAME ON CARD: _____

CARD ISSUER: _____

CREDIT CARD NUMBER: _____

EXP. DATE: _____

BILLING ADDRESS: _____

PRINT NAME: _____

SIGNATURE: _____

BANK DRAFT

BANK NAME: _____

ACCOUNT NUMBER: _____

ROUTING NUMBER: _____



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Piedmont Family YMCA Summer Day Camp Field Trip PERMISSION FORM

Child's Name _____

I do hereby give permission for my child to attend weekly field trips each Wednesday of sessions 1-10.

I understand and that my daughter/son will be driven to and from the activity by a responsible YMCA staff, volunteer, or school system bus driver. I do hereby agree to hold free from any and all liability the YMCA and its respective officers, employees, volunteers, and members, and do hereby for myself, my heirs, executors and administrators, waive and release and forever discharge any and all rights and claims for damages which I may have hereafter accrued to me arising out of or in connection with my child's participation in any of the activities of the YMCA.

In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the YMCA staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above.

Each Wednesday, my child shall arrive at camp no later than 8:30am to ensure we are able to leave for scheduled trips on time. No care is provided for campers who do not attend field trips or do not arrive at camp on time.

Parent/Guardian's printed name

Parent/Guardian's signature

Home Phone number

Date

Other phone numbers to contact parent/guardian (please identify): _____

COMMONWEALTH OF VIRGINIA SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____
 Student's Name: _____
 Student's Date of Birth: Last First Middle
 / / State or Country of Birth: Main Language Spoken: _____
 Student's Address: _____ City: _____ State: _____ Zip: _____
 Name of Mother or Legal Guardian: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____
 Name of Father or Legal Guardian: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____
 Emergency Contact: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, oxygen support, hearing aid, etc.):

List all prescription, over-the-counter, and herbal medications your child takes regularly:

Check here if you want to discuss confidential information with the school nurse or other school authority. | Yes | No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: None FAMIS Plus (Medicaid) _____ FAMIS _____ Private/Commercial/Employer sponsored

I, _____ (do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: _____ Date: _____ / _____ / _____

Signature of person completing this form: _____ Date: _____ / _____ / _____

Signature of Interpreter: _____ Date: _____ / _____ / _____ MCH 213

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM**

Part II - Certification of Immunization

Section I

**To be completed by a physician, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.**

(A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.)

Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:					Date of Birth:		
<i>Last</i>	<i>First</i>	<i>Middle</i>			<i>Mo.</i>	<i>Day</i>	<i>Yr.</i>
IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN						
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5		
*Tdap booster (6 th grade entry)	1						
*Poliomyelitis (IPV, OPV)	1	2	3	4			
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4			
*Pneumococcal (PCV conjugate) *only for children <2 years of age	1	2	3	4			
Measles, Mumps, Rubella (MMR vaccine)	1	2					
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:				
*Rubella	1		Serological Confirmation of Rubella Immunity:				
*Mumps	1	2					
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used	1	2	3				
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:				
Hepatitis A Vaccine	1	2					
Meningococcal Vaccine	1						
Human Papillomavirus Vaccine	1	2	3				
Other	1	2	3	4	5		
Other	1	2	3	4	5		
I certify that this child is ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's <i>Regulations for the Immunization of School Children</i> (Minimum requirements are listed in Section III)							
Signature of Medical Provider or Health Department Official: _____				Date (Mo., Day, Yr.): ____ / ____ / ____			

Section II
Conditional Enrollment and Exemptions

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

DTP/DTaP/Tdap:[]; DT/Td:[]; OPV/IPV:[]; Hib:[]; Pneum:[]; Measles:[]; Rubella:[]; Mumps:[]; HBV:[]; Varicella:[]

This contraindication is permanent: [], or temporary [] and expected to preclude immunizations until: Date (Mo., Day, Yr.): [] [] [] .

Signature of Medical Provider or Health Department Official: _____ **Date (Mo., Day, Yr.):** [] [] []

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official: _____ **Date (Mo., Day, Yr.):** [] [] []

Section III
Requirements

***Minimum Immunization Requirements for Entry into School and Day Care (requirements are subject to change)**

- 3 DTP or DTaP – at least one dose of DTaP or DTP after 4th birthday unless received 6 doses before 4th birthday
 - Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine
 - 3 Polio – at least one dose after 4th birthday unless received 4 doses of all OPV or all IPV prior to 4th birthday
 - Hib – 2-3 doses in infancy; 1 booster between 12-15 months; 1 dose between 15-60 months if unvaccinated, for children up to 60 months of age only
 - Pneumococcal – 2-4 doses, depending on age at 1st dose for children up to 2 years of age only
 - 2 Measles – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
 - 1 Mumps – on/after 12 months of age
 - 1 Rubella - on/after 12 months of age
- Note: Measles, Mumps, Rubella requirements also met with 2 MMR – 1st dose on/after 12 months of age; 2nd dose prior to entering kindergarten
- Hep B – 3 doses required (2 doses if Merck adult formulation given between 11 – 15 years of age; check the indicated box in Section I if this formulation was used)
 - 1 Varicella – to susceptible children born on/after January 1, 1997; dose on/after 12 months of age

*** Additional Immunizations Required at Entry into 6th Grade**

- Tdap – booster required for entry into 6th grade if at least 5 years since last tetanus-containing vaccine

For current requirements consult the Division of Immunization web site at
<http://www.vdh.virginia.gov/epidemiology/immunization>

Certification of Immunization 04/07

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth

Student's Name: _____ Date of Birth: ____/____/____ Sex: M F

Health Assessment	Date of Assessment: ____/____/____ Weight: _____ lbs. Height: _____ ft. _____ in. Body Mass Index (BMI): _____ BP _____ Age / gender appropriate history completed Anticipatory guidance provided TB Risk Assessment: <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred Mantoux results: _____ mm	Physical Examination										
		1 = Within normal treatment			2 = Abnormal finding			3 = Referred for evaluation or treatment				
		HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuro logic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ski	<input type="checkbox"/>	<input type="checkbox"/>
	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPSDT Screens Required for Head Start – include specific results and date: Blood Lead: _____ Hct/Hgb _____												

Developmental Screen	Assessed for:	Assessment Method:	Within normal	Concern identified:	Referred for Evaluation
	Emotional/Social				
	Problem Solving				
	Language/Communication				
	Fine Motor Skills				
	Gross Motor Skills				

Hearing Screen	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: ___Left ___Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
	L				
	<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer				

Vision Screen	<input type="checkbox"/> With Corrective Lenses (check if yes)					Dental Screen	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care	
	Stereopsis	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail					<input type="checkbox"/> Not tested
	Distance	Both	R	L	Test used:			
		20/	20/	20/				
	<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen							

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel	Summary of Findings (check one):	
	<input type="checkbox"/> Well child; no conditions identified of concern to school program activities	
	<input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____	

	___ Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ ___ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction Response required: <input type="checkbox"/> none <input type="checkbox"/> epi pen <input type="checkbox"/> other: _____	
	___ Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)	
	___ Restricted Activity Specify: _____	
___ Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____		
___ Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.		
___ Special Diet Specify: _____		
___ Special Needs Specify: _____		
Other Comments: _____		

Health Care Professional's Certification (Write legibly or stamp):		
Name : _____	Signature: _____	Date: ____/____/____
Practice/Clinic Name: _____	Address: _____	
Phone: _____	Fax: _____	Email: _____



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Sunscreen Permission Form

Child's Name _____ Grade _____

I give my permission for the staff at the YMCA Summer Day Camp Program to apply Rocky Mountain SPF 30 Kids Broad Spectrum Sunscreen to my child, as specified below, when he or she will be playing outside.

I further understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of ears, nose, bare shoulders, arms, and legs. *Children nine years of age and older may administer their own sunscreen if supervised.

The YMCA Staff cannot apply the sunscreen except in the presences of multiple staff.

I have checked all applicable information regarding the type and use of the sunscreen for my child:

Staff may apply (1/8) Rocky Mountain SPF 30 Kids Broad Spectrum Sunscreen to my child as described above.

I do not give the staff permission to apply Rocky Mountain SPF 30 Kids Broad Spectrum Sunscreen to my child. I will furnish sunscreen for my child (required to fill out medication authorization form).

Please note any adverse reactions:

Parent's or Guardian's Full Name (Please Print): _____

Parent's or Guardian's Signature: _____ Date: _____

Office Use: Date Received: _____ _____ Staff Initials: _____ _____

Medication Authorization Form

For Prescription and Non-prescription Medications

VDSS Division of Licensing Programs Model Form



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

INSTRUCTIONS:

- **Section A** must be completed by the parent/guardian for **ALL** medication authorizations.
- **Section A and Section B** must be completed for any **long-term medication authorizations** (those lasting longer than 10 working days).

Section A: To be completed by parent/guardian

Medication authorization for: _____
(Child's name)

_____ has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name: _____

Dosage and times to be administered: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____
(Start date) (End date)

Parent's or Guardian's Signature: _____ Date: _____

Section B: to be completed by child's physician

I, _____ certify that it is medically necessary for the medication(s) listed
(Name of Physician)

below to be administered to: _____ for a duration that exceeds 10 work days.
(Child's name)

Medication(s): _____

Dosage and Times to be administered: _____

Special instructions (if any): _____

This authorization is effective from: _____ until: _____
(Start date) (End date)

Physician's Signature: _____ Date: _____

**FARE**

Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No**NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.****Extremely reactive to the following allergens:** _____

THEREFORE:

- If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS

**LUNG**

Shortness of breath, wheezing, repetitive cough

**HEART**

Pale or bluish skin, faintness, weak pulse, dizziness

**THROAT**

Tight or hoarse throat, trouble breathing or swallowing

**MOUTH**

Significant swelling of the tongue or lips

**SKIN**

Many hives over body, widespread redness

**GUT**

Repetitive vomiting, severe diarrhea

**OTHER**

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.



- INJECT EPINEPHRINE IMMEDIATELY.**
- Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS**NOSE**

Itchy or runny nose, sneezing

**MOUTH**

Itchy mouth

**SKIN**

A few hives, mild itch

**GUT**

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE



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Piedmont Family YMCA Summer Day Camp Parent Handbook

2020

PROGRAM PHILOSOPHY

We believe that the summertime is a valuable opportunity for children to engage in a wide range of enriching activities while developing relationships and enhancing their sense of belonging. Our program is designed to address each of these opportunities in a safe, fun, and empowering way.

PARTICIPATION

Open to rising first grade through rising fifth grade students.

HOURS

7:30am – 6:00pm

The YMCA Summer Day Camp Program operates is in operation Monday through Friday at Brooks YMCA, Crozet YMCA and Greene County.

REGISTRATION

First, parents will register online and pay the registration fee. Secondly, parents will submit required documentation either online or by dropping them off at the branch. (**You will have two weeks to submit all documentation**) Lastly, once all documents have been reviewed, a confirmation email will be sent confirming a spot.

FINANCIAL ASSISTANCE

We offer a financial assistance to families. You must allow five days for processing.

ENROLLMENT

Children are admitted to the YMCA Summer Day Camp on a first come, first served basis. Registration is available on our website at www.piedmontymca.org.

PAYMENTS

Payment will be drafted or charged each Wednesday prior to scheduled services. If a payment is declined the payment plus \$35 fee must be paid prior to the child's attendance the following week. Fees are not reduced for days of illness, early pick up, suspension, or absences due to participation in other activities. Parents are responsible for tuition fees whether a child attends the program or not.

WITHDRAWAL

A two-week written notice is required to terminate enrollment. Parents are required to pay for all weeks regardless of the child's attendance, if no written notice is received.

DISCIPLINE AND DISMISSAL

Children are entitled to a pleasant and harmonious environment at the YMCA Summer Day Camp Program. We cannot serve children who display chronically disruptive behavior. Chronically disruptive behavior is defined as verbal or physical activity which may include, but is not limited to such behavior that requires constant attention from the staff, inflicts physical or emotional harm on other children, is abusive of the staff, and/or shows a disregard of the rules. If a child cannot adjust to meet the program expectations, the child may be discharged.

If inappropriate behavior occurs, staff will communicate with children about their actions and consequences; divert their behavior; separate children from each other,

and/or separate children from specific activities.

Our staff will not use corporal punishment; will not isolate children out of sight or sound of the group; and will not deprive any child of food, water or bathroom privileges as a part of punishment. Reasonable efforts will be made to assist children in adjusting to our program. At no time during our programs are parents allowed to discipline children other than their own. If a situation arises concerning another child, please speak to a staff person and not the child.

LATE PICK UP

Parents are expected to pick up their children before closing time 6:00 p.m. There will be a late pick-up charge of \$1.00 per minute for every minute after 6:00 p.m. until the child is picked up. The charge will be drafted from your designated account on the Wednesday following the late pick up.

Children of parents who are chronically late may be terminated from our program.

NON-PICK UP

If a child has not been picked up by 6:00 p.m. the staff will attempt to call the parent(s). If parents cannot be reached, our staff will call the two emergency numbers on file. If at 6:30 p.m., the child is still at the site and parents or emergency contacts cannot be reached, the local police or Department of Social Service will be contacted.

PICKUP AND DROP

Parents will drop off the child and pick up the child at a designated location with a Y staff. You must provide a CODEWORD (which was created at registration) when picking up your child.

PARENT VISITATION

Custodial parents are welcome to visit the YMCA Summer Day Camp with prior arrangements. Upon arrival they must check in with the program Site Supervisor. For liability and supervision reasons, it is not possible for non-enrolled children visiting the program to take part in activities.

PROGRAM STAFF

The YMCA Summer Day Camp staff are supervised by the Site Supervisor and Program Director.

REPORTING OBLIGATION

As a licensed child care provider, we are required by law to report to Child Protective Services all suspected child abuse or neglect (VA Code 63.2-1509).

MEDICAL CONDITIONS

If a child has a temperature of 101 degrees or above, recurring vomiting or diarrhea, or has been diagnosed with a communicable disease, the child may not attend the program. If a child exhibits these conditions once admitted to the program, the parent will be notified to pick up the child immediately. If the parents cannot be reached, the emergency numbers will be called. The sick child will be assigned to a designated rest area while waiting for his or her parent to arrive.

If a child in our program has contracted a communicable disease, we are required to notify other parents in the program within 24 hours, but will keep the child's identity

confidential. If your child has a known medical condition for which special care and/or emergency treatment is required and/or possible, a written and signed Action Plan from your child's physician is required.

HAND WASHING AND TOILETING

Children are required to wash with soap and running water after toileting and before and after meals.

LUNCH AND SNACK

The parent is required to provide lunch, two snacks daily and water daily. Please do not put food in glass or bottles. All food must be labelled with first and last name.

SUNSCREEN AND INSECT REPELLENT

Sunscreen and insect repellent shall be applied only with written parent authorization which notes any adverse reactions. Sunscreen and insect repellent must be in the original container and labeled with the child's name. Per licensing regulations, sunscreen application must be done by staff for children under the age of nine years. Children age nine years and older may apply their own sunscreen with staff supervision. We ask that parents apply sunscreen prior to drop off. Sunscreen shall be inaccessible to children under five years of age. Insect repellent shall be inaccessible to all children in care. For sunscreen, a record shall be kept that includes the child's name, date of use, frequency of application and any adverse reactions; manufacturer's instructions for age, duration, and dosage shall be followed.

TRANSPORTATION

Staff is not allowed to transport any child in their personal vehicle.

FIELD TRIP

On field trip days, the students will be transported by the school system buses. Students need to be dropped off by 8:30am in order to attend the field trip. Students will be back on campus by dismissal (4:30). If you pick up your child during a field trip, they may not return back to the camp.

SAFETY PROCEDURE

The procedure to identify where children are at all times:

1. Frequent counts, every 15 minutes.
2. Monitor bathroom use.
3. Designate groups of children to specific staff.

The procedure to ensure that all children return to the site after a field trip:

1. Children are accounted for before the group leaves, on the bus, and upon arrival.
2. Each staff will be responsible for his/her group.
3. Close communication will be kept between all staff.

The procedure for the search of a missing child:

1. The surrounding area will be searched.
2. The notification of emergency services. (911)
3. The notification of the Child Care Director.
4. Our office contacts the parents.

The playground safety plan for all Y Summer Camp locations:

1. Our staff remains on the playground area near each group of children.
2. If an injury occurs, the nearest staff attends to the child.
3. If needed, emergency services will be notified by the staff.
4. The YMCA Child Care Director contacts the parents.
5. Our staff will accompany the child to the hospital.

MEDICAL/GENERAL EMERGENCY

Minor bumps and scratches are inevitable, but we make every effort to keep the children safe through supervision and childproofing. Minor injuries will receive appropriate first aid. In the event of an emergency injury or illness that requires immediate medical attention, we will call 911, provide first aid and/or CPR, and then contact parents or guardians. Responding emergency medical personnel will make determinations as to whether the child should be transported to the nearest hospital.

EMERGENCY SHELTERS

Each location has designated emergency shelters in place.

ACTIVE INDOOR/OUTDOOR PLAY

We designate periods of active games and play in our program. Therefore, for safety reasons, wearing closed toes shoes is required. If a child is not wearing closed-toe shoes, he or she will not be permitted to participate in active play. During playground time, staff will monitor playground equipment and that all grounds are free of debris and mulch is at adequate level per licensing regulations. Materials that will be used include: playground balls, board games, school supplies (paper, pencil, crayons, etc), STEM supplies and other school related materials and equipment.

MEDICATION

In order for the program to administer medication to a child, the parent must complete the approved medication authorization form. Authorization for short-term medication administration must be renewed every ten (10) working days or will expire. Program staff will dispose of medication that is not picked up by the parent within 14 days after authorization expires. Long-term medication administration is allowed only with written authorization from the child's physician and parent.

The medication must be in the original container, and be labeled with the child's name, name of the medication, dosage amount, and the times to be given. All medication shall be kept in a locked container, out of the reach of children, unless we receive specific written instructions from a physician to do otherwise. To avoid giving children outdated medication, the staff will document expiration dates and contact parents when a prescription is expired and dispose of medication not picked up by parents. Medication will be given by staff trained as MAT staff.

PROCEDURE TO FOLLOW IN CASE OF A DISASTER (NATURAL OR MAN-MADE)

In the event of a fire, thunderstorm, severe winter weather, tornado, earthquake, flood, bomb threat, terrorist attack, or any other natural or man-made disaster, staff and the Child Care Director will keep each other informed. The program staff will contact each parent of the child (ren) at our program, and inform them of any location changes or pick-up instructions. The Site Supervisor and staff will evaluate the environment for

safety, and determine if the children need to move to a safer location. The staff will gather the attendance record, emergency and health supplies and each child's registration file to be taken with them. The staff will complete the evacuation checklist prior to leaving the site. The site has an emergency evacuation plan and shelter available. If a disaster or emergency occurs, our Site Supervisor will contact parents and/or emergency personnel as needed. If a disaster or emergency occurs before the program begins or after the program ends, please listen to local television and radio stations for information regarding the program.

SUPERVISION

When children arrive after scheduled classes or activities, including field trips, staff shall sign them into the program, supervise them following proper ratio requirements, and attempt to or integrate them into the class or activity.

Children arriving from another program/agency shall be signed in by program staff. If a child is expected but does not arrive, staff shall contact the program/agency directly to ascertain the whereabouts of the child. Additionally, parents will be contacted. Staff shall employ active supervision to be aware of all children in their assigned grouping of children, regularly counting children and monitoring their actions.

SAMPLE DAILY SCHEDULE

Subject to change

7:30am-9:00am Rides in, Activity Rotation
9:00am-9:45am Assembly, Devotion, Games
9:45am-10:00am Snack
10:00-12:00pm Swimming/Outside Huddle Games
12pm-12:30 pm Lunch
12:30-1:00pm: Reading/Yoga
1:00pm- 3:45pm Inside Huddle games
3:45pm-4:00pm Snack
4:00pm-4:30pm: Closing Assembly
4:30-6:00pm: Dismissal / Games

LICENSING INFORMATION

The YMCA Summer Day is licensed through the Commonwealth of Virginia. Standards for licensed child care centers address certain health precautions, adequate play space, ratio of children to staff, equipment, program and record keeping. Criminal record checks and specific qualifications for staff are required. Standards require the facility to meet applicable fire, health and building codes. If you would like additional information about licensing, contact them at (540) 332-2330.

ORGANIZATIONAL CHART

Piedmont Family YMCA BOARD OF DIRECTORS

^

YMCA CEO: Jessica Maslaney

^

Executive Director: Roderick Howard

^

Brooks Camp Director: Bonita Patton

^

Greene Camp Director: Caroline Butler

Crozet Camp Director: Dave Hennessey

^

Site Supervisors: TBD

^

Lead Counselors: TBD

^

Assistant Counselor: TBD

If you have any questions or concerns, please contact Greene County at

(434) 270-7548.

*****Please sign and return the confirmation page with the required documentation.*****



**FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

I, _____ ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND
THE PIEDMONT FAMILY SUMMER DAY CAMP PARENT HANDBOOK.

Parent/Guardian signature: _____ Date: _____