

For Office Use Only  
Date Enrolled: \_\_\_\_\_



**YMCA of Paterson  
Summer Program 2021**

Print Student Name: \_\_\_\_\_  
First Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

Grade: \_\_\_\_\_ School Attending: \_\_\_\_\_

Gender:  Male  Female Race/Ethnicity \_\_\_\_\_  Unspecified

Special Needs:  Yes  No  Unspecified

Limited English Proficiency:  Yes  No  Unspecified

Free/Reduced Lunch:  Yes  No  Unspecified

**Please note you must complete the above fields for your child to be enrolled in the YMCA of Paterson Summer Program.**

**PARENT/GUARDIAN INFORMATION**

**Parent/Guardian #1**

**Parent/Guardian # 2**

\_\_\_\_\_  
First Name Last Name

\_\_\_\_\_  
First Name Last Name

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Other Phone

\_\_\_\_\_  
Other Phone

\_\_\_\_\_  
E-mail

\_\_\_\_\_  
E-mail

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

**RELEASE OF CHILD**

My child will be picked up by the close of program by me or one of the following individuals:

\_\_\_\_\_  
Name Relationship to Child Telephone

\_\_\_\_\_  
Name Relationship to Child Telephone

\*\*\*\*\* DO NOT RELEASE MY CHILD TO THE FOLLOWING PEOPLE\*\*\*\*\*

\_\_\_\_\_  
Name Relationship to Child

\_\_\_\_\_  
Name Relationship to Child

Is there a restraining order involving your child?

Yes (If yes, please speak with the Program Director)  No  Unspecified

If there is an IEP for the child or 504 accommodations plan?

Yes (If yes, please speak with the Program Director)  No  Unspecified

**EMERGENCY CONTACTS**

Please identify two persons who may be called between 7:30am-5:30pm if you are not available.

\_\_\_\_\_  
First Name Last Name

\_\_\_\_\_  
First Name Last Name

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Other Phone

\_\_\_\_\_  
Other Phone

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
City State Zip

**PARENT/GUARDIAN SIGNATURE**

I give my child permission to participate in the 2021 Summer Program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**EMERGENCY MEDICAL CARE** (To be completed by the parent or guardian.)

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. If my child requires emergency medical care and I cannot be reached, I give my consent to the YMCA of Paterson, Summer Program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.
2. This information is strictly confidential and will not be shared with anyone without my written consent or in the case of emergency medical care.
3. Following emergency medical care, my child may be released to the following people:

Name: _____	Relationship to Child: _____
Address: _____	Employer: _____
Home Phone: _____	Work Phone: _____

Name: _____	Relationship to Child: _____
Address: _____	Employer: _____
Home Phone: _____	Work Phone: _____

Name: _____	Relationship to Child: _____
Address: _____	Employer: _____
Home Phone: _____	Work Phone: _____

**4. Health/Insurance Information:**

Student's Doctor: _____	Insurance Company: _____
Phone: _____	Policy Holder's ID: _____
Allergies: _____	Religious Preference: (optional) _____
Last Tetanus: _____	Medication(s) being taken: _____
Address (Student's doctor): _____	

Additional Comments: \_\_\_\_\_

5. I understand that this consent will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this after-school program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**STUDENT HEALTH RECORD** (To be completed by the parent or guardian)

*This confidential health record will only be used to ensure the safety of the children in this program. This information will not be shared outside of this afterschool program. Feel free to continue your notes on back of this form.*

<b>Student's Name:</b>	<b>Date of Birth:</b>
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**1 . Please provide your child's medical history.**

CONDITION	YES (if yes, write approx. date)	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Corrective Device (glasses, hearing aid, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Does your child use an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGY	YES	NO
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>
Foods	<input type="checkbox"/>	<input type="checkbox"/>
Plants	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Topical ointments	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
If "yes" to any of the above, please specify allergy and describe reaction.		

**2 . List significant illnesses or surgeries. Provide the date and any instructions.**


**3 . Special situations or needs that program staff should be aware of:**

<input type="checkbox"/> Child has behavioral/emotional difficulties
<input type="checkbox"/> Child has physical disabilities
<input type="checkbox"/> Other (describe)

**4 . Special Health Care Needs**

Does your child have special health care needs that require treatment and/or medication?  YES  NO  
 If yes, describe below. If your child requires treatment and/or medication during after-school hours, complete the *Health Care Plan for a Child with Special Health Care Needs* form.

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**5 . Medication**

Does your child take medication for any condition or illness?  YES  NO if yes, describe below.  
 If your child requires medication during after-school hours, complete the *Medication Consent* form.

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**6 . Sunscreen and Topical Ointments**

Do you give permission to the after-school program to apply sunscreen or other over-the-counter topical ointments on your child?  YES  NO

**7 . Activities to be encouraged:**

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**8 . Activities your child cannot participate in:**

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**9 . My child may participate in all program activities, except those noted in number 8 above.**

Parent/Guardian Signature

Date

\*\*\*\*\*PHOTO/VIDEO/INTERVIEW CONSENT \*\*\*\*\*

I certify that I am the parent or legal guardian of \_\_\_\_\_, whose date of birth is \_\_\_\_\_. I understand that this after-school program features special events both in-school and away from school. Media representatives, newspaper and television reporters, photographers, and public-relations personnel may be present at these special events to record them. In some cases they may interview and/or photograph children who participate in these events. These photographs, videos, and interviews will only be used to promote this after-school program.

I give permission for my child to be photographed or otherwise recorded during summer program events and activities, and for any and all such photographs to be displayed by [YMCA of Paterson] in any medium (books, newsletters, web sites, social media etc.), whether now or hereafter known or developed.

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SIGNATURE OF PARENT OR GUARDIAN

DATE

If you do not wish for your child to participate in the activities described above, please review this section of this form.

I **DO NOT** give permission for my child to be photographed or otherwise recorded during after-school events and activities. As a result, my child may not be able to participate in these events and activities.

SIGNATURE OF PARENT OR GUARDIAN

DATE