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2025-2026 School Age Paperwork Checklist

Please return all items by Friday, August 15, 2025 to keep your child's registration in good standing.

- ❑ Copy of Birth Certificate or Passport
- ❑ Emergency Consent and Release *(Must have at least 2 emergency contacts outside of the home)*
- ❑ Photo Release
- ❑ Developmental History
- ❑ Medical Form – must be updated as follows:
  - Every 2 years – 6 years and older

  (This must be submitted on the DHS Certificate of Child Health Examination Form included in your packet)
- ❑ COVID-19 Waiver
- ❑ Late Pick-Up Policy
- ❑ Acknowledgment of On-Site Services
- ❑ Annual CACFP Enrollment Form
- ❑ Household Eligibility Form *(Optional if not applying for Scholarship)*
- ❑ DCFS Summary of Licensing Standards *(Please detach and return only the last page)*
- ❑ Automatic Bank Draft Form *(monthly automated draft for tuition)*
- ❑ Individualized Services & Support Form
- ❑ Allergy Action Plan from Physician *(If your child has an allergy that requires medicine)*
- ❑ Medical Authority Modified Meal Request *(For substitutions due to medical reasons)*

Illinois State licensing standards require that each child's file must be complete before the child may attend Children's Center programming. Thank you for your cooperation.

We'll have all the forms available and the files ready to be re-signed (if applicable) but you can also find our forms online at http://www.mcgawymca.org/cc/support

For your convenience, we are offering the following paperwork check-in times:

Thursday, July 10th from 3:00pm - 5:30pm
Wednesday, July 16th from 3:00pm - 5:30pm
Tuesday, July 22nd from 3:00pm - 5:30pm

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McGaw YMCA Children's Center
EMERGENCY CONTACTS, CONSENT, AND RELEASE FORM

PERSONAL INFORMATION Child's Classroom_____

Child's Full Name: _____ Birth Date_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # (____) _____

In an emergency call first: Name: _____ Relationship: _____ Phone: _____

Parent/Legal Guardian #1 (Relationship to Child):	Parent/Legal Guardian #2 (Relationship to Child):
Name:	Name:
Employer:	Employer:
Dept/Position:	Dept/Position:
Work Phone:	Work Phone:
School: Hours:	School: Hours:
Cell Phone:	Cell Phone:
Email:	Email:

Other Family Members:_____

What is the primary language spoken at home? Are there any additional languages spoken?

_____

Is there a court order that limits either parent from visiting this child or from removing him/her/them from the Center? Please Note: The Children's Center cannot limit parent's access to their children without a notarized court order, which must be attached to this form and kept at the Center. ☐ YES ☐ NO

Health care/ Insurance child is under _____

Policy Holder Name _____

Child's Physician: _____ Phone # _____

Child's Dentist _____ Phone # _____

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EMERGENCY CONTACTS, CONSENT, & RELEASE

Please list names, addresses, relationship and phone numbers of any persons you would like to have on your permanent list, who have your consent for the Center to release your child from our care into their custody. (Your required contacts may be called in emergencies if the Center is not able to contact the legal guardians/ caregivers residing in the household at the numbers given previously.)

Please list the name and relationship of other adults ages 16 and older living in your household (grandparent, nanny, etc.):

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____

You must completely fill out at least TWO Emergency Contacts and Authorized Pick Ups who do not live in your household. Anyone listed must have complete contact information.

Required Contacts

1. Name _____ Relationship _____

Address _____City_____ State _____Zip_____

Cell Phone _____ Work Phone _____Birth Date_____

2. Name _____ Relationship _____

Address _____City_____ State _____Zip_____

Cell Phone _____ Work Phone _____Birth Date_____

Additional Contacts

3. Name _____ Relationship _____

Address _____City_____ State _____Zip_____

Cell Phone _____ Work Phone _____Birth Date_____

4. Name _____ Relationship _____

Address _____City_____ State _____Zip_____

Cell Phone _____ Work Phone _____Birth Date_____

I authorize the McGaw YMCA Child Care Center to release my child to the person(s) listed above to act on my behalf in an emergency in the event that I cannot be reached. These persons will show staff proper identification with matching addresses before my child will be released. It is my responsibility to keep all information current.

_____ _____

Parent/Legal Guardian Signature #1 Date

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MEDICAL CONSENT

I, the parent/legal guardian of_____give consent to have my child receive first aid by Center staff. I understand that the center staff receives training in the basics of first aid and CPR. I authorize the McGaw YMCA Child Care Center to secure emergency medical treatment for my child. I give consent for those listed as pick-up and emergency contacts to act on my behalf until I am available. I accept responsibility for any and all expenses incurred in securing emergency medical treatment for my child.

I authorize the McGaw YMCA Child Care Center, and its staff and agents, to administer medication (over the counter and prescribed) to my child as specified in the physician's written instructions or instructions on packaging. The McGaw YMCA Child Care Center has my permission to apply any topical ointment, such as diaper ointment, sunscreen, lip balm, lotion, insect repellent, etc.

Parent/Legal Guardian
Signature #2 _____ Date _____

CONSENT FORMS: Initial & sign in the spaces below to indicate your acknowledgement and acceptance of the outlined terms and conditions.

_____I authorize the McGaw YMCA Children's Center, its staff, and agents, to take my child on walking trips, excursions, and field trips. I also give permission for my child to be transported in a school bus contracted by McGaw YMCA, or as a passenger in any vehicle owned or leased by the McGaw YMCA. I am responsible for communicating with the McGaw YMCA Children's Center before the designated time if my child will not attend that day.

_____I give permission for my child to participate in physical activities such as gym and swimming. I understand that physical activities are a regular part of the program my child attends.

_____I have read the Parent Handbook and agree to abide by the policies and regulations therein including the Guidance and Discipline policies. The Parent Handbook is located online and upon request to staff.

_____I authorize the McGaw YMCA Children's Center to send electronic information through the email and cell phone provided.

_____I would like to be added to the McGaw YMCA Children's Center school directory. This directory can aid families and our PAG who wish to communicate about events happening within their class or center-wide.

Parent/Legal Guardian
Signature #3 _____ Date _____

Each year your child attends our programs; the information on this form must be reviewed for accuracy.

Signature lines provided below are designated for annual reviews of this form.

I have reviewed the information on this form and verify all information is still accurate:

_____ _____
Updated Signature Updated Date

_____ _____
Updated Signature Updated Date

_____ _____
Updated Signature Updated Date

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PHOTO AND VIDEO/AUDIO RECORDING RELEASE

I am 18 years of age or older and, if not, my Mother/Father/Legal Guardian has also signed below.

For my participation in activities to be conducted by the National Council of Young Men's Christian Associations of the United States of America (YMCA of the USA) , I hereby give my permission and consent, now and for all time, to YMCA of the USA and collaborating third parties to make, reproduce, edit, broadcast or rebroadcast any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities, for publication, display, sale or exhibition thereof in promotions, advertising, education and legitimate business uses without any compensation to, and/or claim, by me. I may, or may not be, identified in such reproductions; however, I shall not be stated by name to have endorsed any particular commercial products or commercial services.

I further agree to the following:

- Any video film, footage, sound track recordings, and photo reproductions of me and/or my narrative account of my experience during said activities, I authorize, according to this Release, shall belong to YMCA of the USA and collaborating third parties. Therefore, they will have full right of disposition of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities;
- Any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience within said activities will not be subject to any obligation of confidentiality and may be shared with and used by YMCA of the USA and collaborating third parties;
- YMCA of the USA and collaborating third parties collaborating shall not be liable for any use or disclosure to a third party of any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience; and
- YMCA of the USA and collaborating third parties shall exclusively own all known or later existing rights to worldwide and shall be entitled to the unrestricted use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience for any purpose without compensation to me.

I agree that my consent and this release are irrevocable. I hereby release and discharge YMCA of the USA and collaborating third parties from any and all claims in connection with the uses and reproductions, any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account of my experience as described herein.

_____

I am the Mother/Father/Legal Guardian of (_____).

☐ For the consideration contained herein, I hereby CONSENT to the foregoing on behalf of my minor child.

☐ For the consideration contained herein, I hereby DO NOT consent to the foregoing on behalf of my minor child. **

Signature of Mother/Father/Legal Guardian: _____

Parent/Guardian Printed Name: _____

Date: _____

** *Please be advised that teachers will continue to be required to take photos for the purposes of classroom communication and child development assessments. This release is for marketing purposes only.*

YMCA OF THE USA
101 N Wacker Drive, Chicago IL 60606
P 800 872 9622 F 312 977 9063 ymca.net

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School Age Developmental History

School's Out, Summer Day Camp, SLP, MSX

In an effort to help us know and understand your child, we ask that you complete this form. It is important that you answer all of the questions. Staff that will be working directly with your child and will be reviewing this information.

Child's Full Name _____ Nickname _____

Date of Birth_____ Age_____ Grade in the Fall _____ School in the Fall _____

Child resides with: ☐ Both parents ☐ Mother ☐ Father ☐ Other _____

Family members in household: _____

My child identifies as (optional):

☐ Female ☐ Male ☐ Nonbinary

Child's Development and Personality

What are your child's favorite activities?

Please describe your child's temperament, personality, needs, abilities, etc.

What are your child's strengths and challenges?

How does your child handle transitions from one activity/place to another? What have you found that works to ease these transitions?

Describe your child's ability to make and keep relationships/friendships with adults and children.

How does your child show emotions of anger, being scared, tense, or uncomfortable? How do you comfort them in these instances?

In general, how do you handle discipline?

Do you have any suggestions for our staff, which may help your child be successful?

Are there any home factors that might help us better support your child?

Consider changes such as recent move, births, illnesses, divorce, separation, or any unusual circumstances.

Medical History

Does your child have asthma or another chronic condition? ☐ Yes ☐ No If YES, please explain and give any pertinent information. Provide an action plan if necessary.

Does your child have any allergies or sensitivities? ☐ Yes ☐ No If YES, please explain and give any pertinent information

Does your child have any food allergies? ☐ Yes (Please have doctor fill out the FAAP form) ☐ No (No further action needed)
If exposed, what does the reaction look like?

Does your child take any medications regularly? ☐ Yes ☐ No
If YES, please list medications. To administer, we must have a signed medical consent forms and doctor's prescription. For more information, please read information regarding medications in the Parent Handbook.

Does your child wear any appliances? (glasses, contacts, mouth guard, etc.)

Does your child have sensitive skin or burn easily? Please include any special notes regarding sunscreen/bug spray application.

What do you want your child to gain from his or her experience in the School Age program?
Please check all that apply

- ☐ Make new friends
- ☐ Gain a sense of belonging
- ☐ Higher self-esteem
- ☐ Opportunity for creativity
- ☐ Good adult role models
- ☐ Become less shy
- ☐ A structured homework time
- ☐ Experience new things
- ☐ Become more outgoing
- ☐ Learn the core values of the YMCA, caring, honesty, respect & responsibility.
- ☐ Learn new skills
- ☐ Learn to swim
- ☐ Have a lot of fun
- ☐ Learn to get along better with other children
- ☐ Other_____

If you have any other information that you would like to share with us about your child, please feel free to use this space or attach additional documents.

I have reviewed the information on this form and verify all information is accurate:

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Parent/Legal Guardian Signature Updated Date

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																				
Age/ Grade																				
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																				
Hearing																				

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Student's Name (Last / First / Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during the night	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No		Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENNG (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**

Skin Test: Date Read / / **Result: Positive ☐ Negative ☐** **mm** _____
Blood Test: Date Reported / / **Result: Positive ☐ Negative ☐** **Value** _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION **Yes ☐ No ☐ Modified ☐** **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

ADULT PARTICIPANT WAIVER, RELEASE AND ACKNOWLEDGEMENT

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. McGaw YMCA has put in place preventative measures to reduce the spread of COVID-19; however, **McGaw YMCA cannot guarantee that you will not become infected with COVID-19**. Further, participation could increase your risk of contracting COVID-19.

READ CAREFULLY BEFORE SIGNING

By signing this agreement, **I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by participation; and that such exposure or infection may result in personal injury, illness, permanent disability, and death**. I understand that the risk of becoming exposed to or infected by COVID-19 at McGaw YMCA may result from the actions, omissions, or negligence of myself and others, including, but not limited to, McGaw's employees, volunteers, and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my participation at McGaw YMCA. On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless McGaw YMCA, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of McGaw YMCA, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation at McGaw YMCA.

I represent that I have adequate insurance to cover any injury or illness I may suffer or cause while participating in this activity, or else I agree to bear the costs of such injury or illness myself. I further represent that I have no medical or physical condition which could interfere with my safety in this activity, or else I am willing to assume – and bear the costs of – all risks that may be created, directly or indirectly, by any such condition.

In the event that I file a lawsuit, I agree to do so in the state where McGaw YMCA is located, and I further agree that the substantive law of that state shall apply. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

By signing this document, I agree that if I am exposed or infected by COVID-19 during my participation in this activity, then I may be found by a court of law to have waived my right to maintain a lawsuit against the parties being released on the basis of any claim for negligence.

I have had sufficient time to read this entire document and, should I choose to do so, consult with legal counsel prior to signing. Also, I understand that this activity might not be made available to me or that the cost to engage in this activity would be significantly greater if I were to choose not to sign this release, and agree that the opportunity to participate at the stated cost in return for the execution of this release is a reasonable bargain. **I have read and understood this document and I agree to be bound by its terms.**

If I have signed a separate general waiver of liability connected to my participation at McGaw YMCA I agree that the terms of that waiver are wholly incorporated into this document and that the terms of this document are incorporated into the separate general waiver.

Signature_____Print Name_____

Address_____City_____State_____

Zip _____Telephone (_____)_____Date _____

PARENT OR GUARDIAN ADDITIONAL AGREEMENT
(Must be completed for participants under the age of 18)

In consideration of_____(PRINT minor(s) name(s)) being permitted to participate in this activity, I further agree to indemnify and hold harmless Releasee from any claims alleging negligence which are brought by or on behalf of minor or are in any way connected with such participation by minor.

Parent or Guardian _____ Print Name _____ Date _____

Late Pick-up Policy

Parents of participants enrolled in **Children's Center Programs** will be charged **$1.00 per minute / family** based on the **program pick-up times** listed below:

- **Full Day Program 6:00pm**
- **School's Out 6:00pm**
- **Summer Day Camp 5:30pm**

- If you know you are going to be late please notify the center so we can let your child and the teachers know. **Late fee will still be charged.**

- If a parent or authorized pick-up person does not arrive or call by 5 minutes past the designated pick-up up time, staff will assume an emergency exists and will begin to call emergency contacts for your child.

- If no emergency contact can be reached within 1-hour past designated pick-up time, staff may contact the Evanston Police Department who will pick up the child.

- **Late fees must be paid within 5 business days of the late pick up date.**

- Failure to pay late pick-up fees can be cause for the child's suspension or termination from the program.

- Continued disregard for the pick-up times can result in suspension or termination form the program.

It is very important to have updated contact information in your child's file at all times. Any child who is not picked up will be under the supervision of an assigned teacher/administrator until the parent, emergency contact, or the authorities arrive. All information about the incident will be discussed directly with the parent or guardian and never with the child.

Child's Name: _____

Parent/Legal Guardian Signature: _____ Date:_____

Update Signature: _____ Date:_____

Update Signature: _____ Date:_____

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Acknowledgement of On-Site Services

I, the undersigned parent/legal guardian of _____ acknowledge
child's name
that the vendors listed below provide food and/or services to the McGaw YMCA Children's Center.

- Food2You –
  provides catered lunches and organic milk daily
- Performance Food Service –
  provides snack and breakfast items weekly
- Aegis Pest Control Solution –
  provides indoor and outdoor preventative pest control services monthly
- 4M Building Solutions, LLC. (Formerly Anchor-World Cleaning Services)
  provides daily and nightly cleaning services

Signature lines provided below are designated for annual reviews of this form

I have reviewed the information on this form and verify all information is accurate:

Parent/Legal Guardian Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

ILLINOIS STATE BOARD OF EDUCATION
Annual Enrollment Form
Child and Adult Care Food Program

This form is required for Child Care Centers, Pre-K, Head Start, Even Start, and Licensed Outside School Hours Programs.

This form is NOT required for At-Risk After-School, License-exempt Outside School Hours, or Emergency Shelters.

Parents/Centers: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and every year thereafter.This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6. Section 5: this section is optional. CACFP sponsors must ensure households are made aware that failure to provide racial or ethnic identity information will not impact their eligibility. However USDA strongly encourages CACFP sponsors to explain the importance of this data to parents/guardians to complete this section. The center will review completed enrollment form.

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age) | **2** DAYS OF WEEK IN ATTENDANCE | **3** TIMES CHILD NORMALLY ATTENDS DURING WEEK | **4** MEALS RECEIVED

First Child

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Second Child ☐ Same Days as Above ☐ Same Times as Child Above ☐ Same Meals as Above

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Third Child ☐ Same Days as Above ☐ Same Times as Child Above ☐ Same Meals as Above

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Please answer both questions. This information is voluntary.

5 ETHNIC/RACIAL CATEGORIES—

A. Ethnic data of child(ren) — Mark only one. ☐ Hispanic or Latino ☐ Not Hispanic or Latino

B. Racial data of child(ren) — Mark one or more that apply. ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ American Indian or Alaska Native

6 SIGNATURE

I certify the information above is correct. _____ *Signature of Parent or Guardian* _____ *Date* _____ *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY

Effective Date of this enrollment form: _____

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which this form is received.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by: 1. mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; or 2. fax:(833) 256-1665 or (202) 690-7442; or, 3. email: program.intake@usda.gov

SUMMARY OF LICENSING STANDARDS FOR DAY CARE CENTERS

Introduction

The Department of Children and Family Services (DCFS) is responsible for licensing day care centers. When a day care center is licensed, it means that a DCFS licensing representative has inspected the facility and the facility was found to meet the minimum licensing requirements. A license is valid for three years. The day care center's license must be posted. It will indicate the maximum number of children allowed in the facility and the areas where children may receive care.

Licensed day care facilities are inspected annually by DCFS licensing staff. If a complaint has been received regarding a violation of the licensing standards of a day care center, a licensing representative will conduct a licensing complaint investigation to determine if the alleged violation should be substantiated or unsubstantiated. Individuals may contact the Day Care Information Line to learn of substantiated violations.

Day Care Information Line 1-877-746-0829

This statewide toll-free information line provides information to the public on the past history and record, including substantiated violations, of licensed day care homes, day care centers, and group day care homes. This number operates Monday through Friday from 8:30 a.m. to 5:00 p.m.

Summary of Licensing Standards for Day Care Centers

The following is a summary of the licensing standards for day care centers. It has been prepared for you so that you may monitor the care provided to your child. This is a summary and does not include all of the licensing standards for a day care center. State licensing standards are *minimum* standards. If you observe a violation of any of these standards, you are encouraged to discuss your concerns with the day care center operator. In most cases, parents and day care operators are able to resolve the parents' concerns and issues. If you believe the day care operator is not responding to your concerns and may not be meeting state licensing standards, you may make a complaint to the local DCFS Licensing Office or by calling the Child Abuse Hotline at 1-800-252-2873 and stating that you want to make a licensing complaint. A DCFS licensing representative will investigate

your complaint and report the results back to you. The day care center is required to provide a copy of its own written policies regarding the operation of the facility to each staff person and to parents of enrolled children.

Staffing

- The day care center must have a qualified child care director on site at all times. The director must be at least 21 years old, have completed two years of college or have equivalent experience and credentials.
- Early childhood teachers must be at least 19 years old, have two years of college or have equivalent experience and credentials.
- School-age workers must be at least 19 years of age and at least five years older than the oldest child in their care. They must have completed one year of college or have the equivalent experience and credentials.
- Early childhood assistants and school-age assistants must have a high school diploma or the equivalent and must work under direct supervision of an early childhood teacher or a school-age worker.
- Student and youth aides must be at least 14 years of age, at least five years older than the oldest child in their care, and must work under direct supervision of an early childhood teacher or a school-age worker.
- Student and youth aides are not generally counted for purposes of maintaining staff/child ratios.
- The director and all child care staff must have 15 hours of in-service training annually.
- All staff must have current medical reports on file and are subject to background checks for any record of criminal conviction or child abuse and neglect.
- A person certified in first aid, including CPR and the Heimlich maneuver, must be present at all times.

Group Size and Staff Requirements:

AGE OF CHILDREN	STAFF/CHILD RATIO	MAXIMUM GROUP SIZE
Infants (6 weeks through 14 months)	1 to 4	12
Toddlers (15 through 23 months)	1 to 5	15
Two years	1 to 8	16
Three years	1 to 10	20
Four years	1 to 10	20
Five years (preschool)	1 to 20	20
School-age: Kindergartners present	1 to 20	30

- Exception: One early childhood teacher and an assistant may supervise a group of up to 30 children if all of the children are at least five years of age.
- Whenever children of different ages are combined, the staff/child ratio and maximum group size must be based on the age of the youngest child in the group.

General Program Requirements

- Parents must be allowed to visit the center without an appointment any time during normal hours of operation.
- Staff must demonstrate respect for each child enrolled regardless of gender, ability, cultural, ethic or religious differences.
- There must be a balance of active and quiet activity. Daily indoor and outdoor activities are to be provided for children to make use of both large and small muscles.
- In pre-school programs where children receive care for less than three hours per day, outdoor activity is not required.
- Children may not be left unattended at any time.

Infants and Toddlers

- Infants and toddlers must be in separate space away from older children.
- A refrigerator and sink must be easily accessible.
- Toys and indoor equipment must be cleaned and disinfected daily. Safe, durable equipment and play materials must be provided.
- Either the day care center or the parent may provide food for infants not consuming table food. Feeding times and amounts consumed must be documented in writing.
- No food other than formula, milk, breast milk or water may be placed in a bottle for infant feeding. Microwaves are not to be used for bottle warming.
- Children who cannot turn over alone must be placed on their backs.
- The facility must have a clearly defined diaper changing area with the procedures for changing diapers clearly posted. A hand-washing sink must be accessible for hand washing.
- Staff changing diapers must wash their hands and the child's hands with soap and running water after diapering.
- Information about feeding, elimination and other important information must be recorded in writing and made available to parents when the child is picked up at the end of the day.
- Only new cribs manufactured on or after June 28, 2011 must be in place

School-Age Children

- The facility must have a designated area for school-age children so they do not interfere with the care of younger children.
- Clear definitions of responsibility and procedures are to be established among parent, day care center and school when children move to and from school.
- A variety of developmentally appropriate activities and materials must be available for children. Opportunities must be provided to do homework, if requested.

Evening, Night and Weekend Care

- Family-like groups of mixed ages are allowed.
- Staff must be awake at all times and in the sleeping area whenever children are sleeping.
- Each child must have an individual cot, bed or crib.
- An evening meal and a bedtime snack must be served.
- Breakfast must be served to all children who have been at the facility throughout the night and are present between 6:30 a.m. and 8:30 a.m.

Enrollment and Discharge

- Parents must be provided the names, business address and telephone number of persons legally responsible for the program.
- Parents must be provided, in writing, information on the program, fees, arrival and departure policies explaining to the parents and guardians what actions the caregiver will take if children are not pick up at the agreed upon time, and the guidance and discipline policies.
- Parents must complete an enrollment application, which includes, for first time enrolment, providing a certified copy of their child's birth certificate (which will be copied by the center and returned to the parent), emergency numbers, and persons authorized to pick up their child.
- A child may only be released to a parent or other responsible person designated by the parent.
- Daily arrival and departure logs must be kept by the center.

Guidance and Discipline

- Parents must be given a copy of the guidance and discipline policy.
- The following are prohibited:
    - corporal punishment
    - threatened or actual withdrawal of food, rest or use of the bathroom
    - abusive or profane language
    - public or private humiliation
    - emotional abuse, including shaming, rejecting, terrorizing or isolating a child

- "Time-out" is to be limited to one minute per year of age. "Time-out" may not be used for children less than two years of age.

Transportation

- The driver must be 21 years of age and hold a driver's license that has been continuously valid for three years.
- Children must not be allowed to stand or sit on the floor of the vehicle. Age appropriate safety restraints must be used when transporting children in vehicles other than school buses.
- The driver must make sure that a responsible person is present to take charge of a child when delivered to his or her destination.

Health Requirements for Children

- A medical report indicating that the child has been appropriately immunized must be on file for each child. Parents are encouraged to be informed about childhood immunizations by going to the following Web site: http://www.state.il.us/dcfs/daycare/Childhood_Immunizations.shtml. A tuberculin skin test is to be included in the initial exam unless waived by a physician.
- The medical report is valid for two years for infants and preschool children. Exams for school-age children are required consistent with the requirements of the public schools.
- The center will comply with the Illinois Department of Public Health's Hearing and Vision Screening Codes and the Illinois Child Vision and Hearing Test Act.
- Children aged one to six years must have either a lead risk assessment or a lead screening.
- Water must be freely available to all children.
- Children's hands must be washed with soap and water upon arrival at the center, before and after meals or using the toilet, after wiping or blowing their noses, after outdoor play and after coming into contact with any soiled objects.

- Prescription and non-prescription medication may be accepted only in its original container. The center must maintain a record of the dates, times administered, dosages, prescription number (if applicable) and the name of the person administering the medication.
- Medication must be kept in locked cabinets or other containers that are inaccessible to children.

Nutrition and Meals

- Menus must be posted.
- Meals and snacks must meet nutritional guidelines.
- Children in care two to five hours must be served a snack. Children in care five to 10 hours must be served a meal and two snacks or two meals and one snack. Children in care more than 10 hours must be served two meals and two snacks or one meal and three snacks.

Napping and Sleeping

- Children under six years of age who remain five or more hours must have the opportunity to rest or nap.
- Infants must sleep in safe, sturdy, freestanding cribs or portable cribs.
- Toddlers may use either stacking cots or full-size cribs.
- A cot or bed must be provided for each toddler or preschool child in attendance five or more hours. Each cot, bed or crib must be labeled with the name of the child.

Physical Space

- Infants and toddlers must be housed and cared for at ground level unless special approval has been granted from the Department.
- Indoor space must provide a safe, comfortable environment for the children. Floors and floor coverings must be washable and free from drafts and dampness.
- Toilets and lavatories must be readily accessible to the children.

- Hot and cold running water must be provided.
- Hazardous items must be inaccessible to children.
- Parents must be notified before pesticides are applied, unless in an emergency
- Exits must be unlocked and clear of equipment and debris.
- Drills for fire and tornado must be conducted. A floor plan must be posted in every room indicating the areas providing the most safety in the case of a tornado and the primary and secondary exit routes in case of fire.
- Smoking or the use of tobacco products in any form is prohibited in the child care center or in the presence of children while on the playground or on trips away from the center.
- Play materials must be durable and free from hazardous characteristics.
- The facility may not use or have on the premises any unsafe children's product as described in the Children's Product Safety Act. Lists of unsafe children's products and recalls from 1989 to now are available at: www.idph.state.il.us/webapp/SRSApp/pages/index.jsp.
- The facility must be cleaned daily and kept in sanitary condition at all times.
- First-aid kits must be maintained and readily available for use.

Outdoor Play Area

- Play space must be fenced or otherwise enclosed or protected from traffic and other hazards. There must be a shaded area in summer to protect children from excessive sun exposure.
- All areas of the outdoor play space must be visible to staff at all times.
- Equipment must be free of sharp points or corners, splinters, protruding nails or bolts, loose or rusty parts, the potential for entrapment and/or other hazards.
- Protective surfaces must be provided under equipment from which a child might fall

- All swimming pools must be fenced or otherwise inaccessible to children.
- During hours of operation and at all times that children are present there must be a means for parents of enrolled children to have direct telephone contact with a center staff person.

This summary has been developed to assist parents in monitoring the care provided by the day care center.

For a complete copy of the Licensing Standards, write or call

Department of Children and Family Services
Office of Child and Family Policy
406 East Monroe Street
Springfield, Illinois 62701
Telephone (217) 524-1983

Licensing Standards for Day Care Centers may also be accessed through the DCFS website: www.state.il.us/dcfs and following the links to Part 407, Licensing Standards for Day Care Centers. You may also contact your nearest DCFS office.

Printed by Authority of the State of Illinois
DCFS #89 – August 2012 – 30,000 Copies
CFS 1050-52 – Rev. 8/2012

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE Food Allergy Research & Education

PLACE PICTURE HERE

Name: _____ D.O.B.: _____

Allergic 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.

☐ **Special Situation/Circumstance - If this box is checked, the child has an extremely severe allergy to the following food(s) _____.**

Even if the child has MILD symptoms after eating (ingesting) this food(s), Give Epinephrine immediately.

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

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **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 BODY SYSTEM**, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM A **SINGLE BODY SYSTEM** (E.G. SKIN, GI, ETC.), FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. 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

HEALTHCARE PROVIDER AUTHORIZATION SIGNATURE DATE

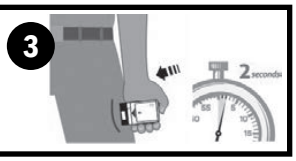
Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

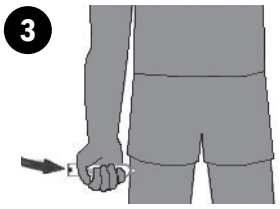
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q® from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q® against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



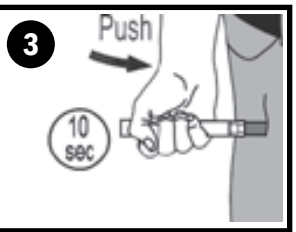
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

1. (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN
2. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
3. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



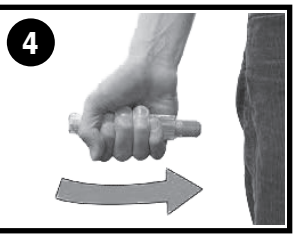
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI™ by finger grips only and slowly insert the needle into the thigh. SYMJEPI™ can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Epinephrine first, then **call 911**. Monitor the patient and call their emergency contacts right away.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

MEDICAL AUTHORITY MODIFIED MEAL REQUEST FORM

For Use in the USDA School Nutrition Programs, Child and Adult Care Food Program, & Summer Food Service Program

This form may be used to request a meal modification for a child with a physical or mental impairment that restricts their diet. Portions of this form must be completed by a State Licensed Healthcare Professional, which refers to an individual authorized to write medical prescriptions under Illinois law.

SECTION 1: CHILD INFORMATION

Child's Name: _____ Date of Birth: _____

Facility Name: _____ Age/Grade: _____

SECTION 2: MEAL MODIFICATION INFORMATION

TO BE COMPLETED BY A STATE LICENSED HEALTHCARE PROFESSIONAL

1. Provide a description of the child's physical or mental impairment and how it restricts their diet and/or access to meal programs.

2. Are there any food items and/or ingredients that must be avoided? ☐ Yes ☐ No

   If yes, please list the food items and/or ingredients to be avoided.

   List alternatives that may be provided for any items or ingredients above.

3. List any additional modifications and/or services needed to accommodate the child's impairment or disability.

SECTION 3: SIGNATURES

Parent/Guardian Name: _____ Relationship: _____

Phone: _____ Email: _____

Parent/Guardian Signature: _____ Date: _____

Medical Authority Name (First & Last) _____

Medical Authority Signature _____ Date _____

SEND COMPLETED FORMS TO

Eileen Canafax
McGaw YMCA - Children's Center
eileenc@mcgawymca.org

SPONSOR/SCHOOL FOOD AUTHORITY USE ONLY

Date Received: _____ Received By: _____

Date(s) of Follow-Up Communication* _____

**Attach documentation of pertinent information received from any follow-up communication to this form.*

Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form online, or obtain the form from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **Mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or

2. **Fax:**
   (833) 256-1665 or (202) 690-7442; or

3. **Email:**
   program.intake@usda.gov

PREFERENCE MODIFIED MEAL REQUEST FORM

For Use in the USDA School Nutrition Programs, Child and Adult Care Food Program, & Summer Food Service Program

This form may be used to request a meal modification for a child with a preference (i.e., not a physical or mental impairment) that restricts their diet. Please note, federal regulations provide meal program Sponsors with the option to accommodate food preferences.

SECTION 1: CHILD INFORMATION

Child's Name: _____ Date of Birth: _____

Facility Name: _____ Age/Grade: _____

SECTION 2: MEAL MODIFICATION INFORMATION

1. Provide a description of how the child's diet is restricted.

2. Are there any food items and/or ingredients that must be avoided? ☐ Yes ☐ No

   If yes, please list the food items and/or ingredients to be avoided.

   List alternatives that may be provided for any items or ingredients above.

3. List any additional modifications needed to accommodate the child's preference.

SECTION 3: SIGNATURES

Parent/Guardian Name: _____ Relationship: _____

Phone: _____ Email: _____

Parent/Guardian Signature: _____ Date: _____

SEND COMPLETED FORMS TO

Eileen Canafax
McGaw YMCA - Children's Center
eileenc@mcgawymca.org

SPONSOR/SCHOOL FOOD AUTHORITY USE ONLY

Date Received: _____ Received By: _____

Date(s) of Follow-Up Communication* _____

**Attach documentation of pertinent information received from any follow-up communication to this form.*

Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form online, or obtain the form from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **Mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or

2. **Fax:**
   (833) 256-1665 or (202) 690-7442; or

3. **Email:**
   program.intake@usda.gov

☐ Children's Center only ☐ Membership and Children's Center

McGaw YMCA Children's Center
Checking Account/Credit Card Draft Agreement

This agreement authorizes the McGaw YMCA to charge your bank account or credit card monthly fees. A voided check or copy of credit card must be attached to this form.

Please note: A monthly child care receipt will be mailed to your address on file.

Child's Name: _____ Child's Class: _____

Program Start Date: _____ Draft Start Date: _____

Parent/Guardian Name: _____ Address:

_____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

The McGaw YMCA is a 501(c)(3) charitable organization. Please consider a tax-deductible contribution to support child care for families who cannot afford to pay full price and check the appropriate box below. Contributions will be processed each month at the same time as your tuition.

☐ $5/month (supports one class section for a child)
☐ $15/month (supports a youth membership)
☐ $30/month (supports two youth membership)
☐ $50/month (supports membership for a single-parent family)
☐ Other monthly amount: _____
☐ One-time donation of: _____

FOR CHECKING ACCOUNT DRAFTS
We cannot accept debit cards for bank drafts. To draft from your checking account, please provide a voided check.

Name on account: _____

Routing Number: _____ Account Number: _____

FOR CREDIT CARD DRAFTS
We accept Mastercard, Visa, and Discover.

Name on card: _____ ☐ Visa ☐ MasterCard ☐ Discover ☐ Am Ex

Card Number: _____ Exp. Date: _____ CVV: _____

I authorize the McGaw YMCA to debit the balance of my childcare account from the above listed account on or around the 1st of the month or 15th of the prior month. I understand that bank holidays may delay the draft.

I understand that it is the responsibility of the drafted party to maintain sufficient funds to cover all drafts as well as to inform the McGaw YMCA of any changes in account information. If drafts are refused for any reason, a $25 fee will be charged and payment by cash or money order must reach the YMCA's registration office with 48 hours of notification. Failure to make this payment will result in a discontinuation of childcare services.

I agree to the terms and conditions of the withdrawal of funds from my checking account or credit card as outlined above and in my membership agreement where applicable. I authorize the McGaw YMCA to draft my checking account or credit card for childcare fees. I understand that this draft will continue until the end of the program or 30 Days after the receipt of my cancellation in writing.

Draftee's Signature: _____ **Date:** _____

For office use only:
Received: Staff: _____ Date: _____ **Input:** Staff: _____ Date: _____ **Updated:** Staff: _____ Date: _____

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Individualized Services and Support Form

Date: _____
Child's Name: _____ Classroom/Program: _____
Parent/Family Name: _____
Phone Number: _____ Best Time to Call: _____
Email Address: _____

Please Check and Describe all that Apply.

Medical

❑ Allergies (Please list any known allergies for this child)
_____
❑ Medications (Please list names of any medications that have been prescribed for this child and dates to administer/expiration dates)
_____
_____
❑ Medical Conditions (Please list any medical conditions that this child may need support with)
_____

Services

Has this child had an IFSP/IEP/504 Plan in the past or currently? ❑ Yes ❑ No
Does this child receive one-on-one support (In school or privately)? ❑ Yes ❑ No
Has your child been diagnosed with a disability? ❑ Yes ❑ No
If yes, please describe: _____

Please select any of the services that this child is currently receiving (Check all that apply):
❑ Speech Therapy ❑ Occupational Therapy ❑ Physical Therapy ❑ Social Work Services
❑ Behavioral/Counseling Services ❑ Feeding Therapy ❑ Adapted Physical Education (APE)
❑ Other _____

Please share any additional information about your child's individualized care needs if this applies:

Family Support

Please select presenting issues or needs (Check any that may apply):

❑ Educational ❑Parenting/Co-Parenting ❑Employment ❑Healthcare ❑Legal

❑Housing ❑Domestic Violence ❑Mental Health/Therapy ❑Financial ❑Other

Please attach any relevant documentation with this form (IEPs, 504 Plans, Service Reports/Plans, etc.). Family Support Staff may contact you for service coordination if applicable.