FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Summer Day Camp 2025
Required Paperwork Checklist

Items below need to be completed and all forms are available at:
https://www.mcgawymca.org/camps/summer/
Please return all items by **April 30th** to keep your child's registration in good standing.

- ❑ Copy of Birth Certificate
- ❑ Emergency Consent and Release *(must have at least 2 emergency contacts outside of the home)*
- ❑ Copy of Most Recent Physical
- ❑ Developmental History
- ❑ Photo Release
- ❑ Draft Form
- ❑ COVID-19 Waiver
- ❑ Late Pick-Up Policy
- ❑ Camp Handbook Acknowledgment *(Policy Handbook available at front desk or online)*
- ❑ Email/Text Communication form
- ❑ On-Site Services Form
- ❑ Individualized Services & Support form *(As needed)*
- ❑ Medical Consent Form - Prescription/Non-Prescription (*As needed)*
- ❑ Food Allergy Action Plan *(if your child has an allergy that requires medicine)*

Each child's files must be complete before the child may attend camp. Thank you for your cooperation.

We will be offering paperwork check-ins to ensure this process is an easy one. We'll have all the forms available and the files ready to be re-signed. Just a reminder that all of our camp paperwork is also available online at the McGaw YMCA Children's Center website and you may submit it at any time.

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

Thursday, April 3 from 3:30pm–5:30pm
Monday, April 7 from 3:30pm–5:30pm
Tuesday, April 15 from 3:30pm–5:30pm
Friday, April 23 from 3:30pm–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 # (____) _____

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

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

Parent/Guardian #1 (Relationship to Child):	Parent/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:_____

Is there a court order that limits either parent from visiting this child or from removing him/her 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. These people may also be called in emergencies, if the Center is not able to contact the legal guardians or caregivers or adults, residing in the household at the numbers given previously:

Please list the name and relationship of other adults 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 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 _____ 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 in your child's classroom.

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

Parent/Legal Guardian
Signature _____ Today's 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:

_____ _____
Parent/Legal Guardian Signature Updated Date

_____ _____
Parent/Legal Guardian Signature Updated 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 SCREENING **(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)

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School Age Developmental History

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 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):

☐ Male ☐ Female ☐ Other

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 create and sustain relationships with adults and children.

How does your child show emotions of anger, being scared, tense, or uncomfortable? How do you comfort him/her 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.

Does he/she have any allergies or sensitivities? ☐ Yes ☐ No If YES, please explain and give any pertinent information

Does your child have any food allergies? ☐ Yes ☐ No 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 fair skin or burn easily? Please include any special notes regarding sunscreen/bug spray application.

Experiences

What water or swimming experiences does your child have? For example: beach, pool, lake, water park

Please check your child's swimming ability:

☐ NON-SWIMMER (my child cannot swim)
☐ SOME SWIMMING ABILITIES (my child can swim, but is not advanced)
☐ ADVANCED SWIMMER (my child is a proficient swimmer)

How comfortable is your child in the water?

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

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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: _____

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

❑ 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. 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: _____

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 names) being permitted to participate in this activity, I further agree to indemnify and hold harmless Releases 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, School's Out – 6:00pm**
- **Summer Day Camp – 5:30pm**
- **Summer Learning Program (SLP) – 4:30pm**
- **MetaMedia Summer Experience (MSX) – 12:30pm**

- 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(ren)'s Name(s): _____

Parent/Guardian Signature: _____ Date: _____

Update Signature: _____Date: _____

Update Signature: _____ Date: _____

McGaw YMCA Children's Center
Parent Signature Page

I have received and read the 2025 McGaw YMCA Children's Center Summer Day Camp Parent Handbook and agree to the policies and procedures set forth within. **You can find the electronic version of the Camp Handbook on our website at https://www.mcgawymca.org/camps/summer/

Child's name (please print) _____

Parent's name (please print) _____

Signature _____

Date _____

Please return with camp enrollment paperwork prior to the start of camp.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

TEXT & EMAIL COMMUNICATION

Summer 2025

We will do our best to provide you and your family up to date and accurate communications through our text & email distribution systems. In order to provide this information please make sure that we have your accurate email in our system. The contact information you provide will also be used by administration to get in touch with you if necessary.

PLEASE PRINT CLEARLY:

Child's Name: _____ Class: _____

Child's Name:_____ Class: _____

Child's Name:_____ Class: _____

Parent/Guardian #1: _____

Email Address: _____

Cell/Text: _____ Cell Phone Carrier: _____

Parent/Guardian #2:_____

Email Address: _____

Cell/Text: _____ Cell Phone Carrier: _____

Please EMAIL communications to:

- ☐ Parent #1
- ☐ Parent #2

Please TEXT communications to:

- ☐ Parent #1
- ☐ Parent #2

The MAIN CONTACT in our computer system for my family should be:

- ◯ Parent #1
- ◯ Parent #2

Please make sure to keep all of your information accurate with the Site Coordinator.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Acknowledgement of On-Site Services

I, the undersigned parent of _____ acknowledge that
child's name
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 Foods –
  provides snack and breakfast items weekly
- Aegis Pest Control Solution –
  provides indoor and outdoor preventative pest control services monthly
- 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 Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

MCGAW YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Individualized Services & Support Form

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

Specialized Needs

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 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:
❑ 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:
_____
_____
_____

Please attach any relevant documentation with this form (IEPs, 504 Plans, Service Reports, etc.). The Family Support Staff will contact you to meet, discuss, and develop a support plan for your child in our program if applicable.

MEDICAL CONSENT FORM – PRESCRIPTION/NON-PRESCRIPTION

Name of Child: _____ Today's Date: _____

Class Name: _____ Name of Medication: _____

Start Date: _____ End Date: _____

I, _____, give permission to _____ to administer _____ of
Name of parent/guardian Authorized staff Name of medication

_____ to my child, _____, at approximately _____ on
Dose amount Child's name Times of dosage

_____ for _____.
Dates of authorized dosage Reason for medication

Has your child received this medication before? If YES, when: _____

Has you child been given a dosage of this medication today? If yes, time of last dose _____

Additional dosage information or instructions: _____

Possible side effects to watch for with this medication: _____

Name and phone number of child's physician: _____

_____

Signature of parent/guardian: _____ Date: _____

TO BE COMPLETED BY YMCA STAFF

	Yes	No
1. Is the permission form above completed and signed by parent?	☐	☐
2. Is the medication in a safety-cap container?	☐	☐
3. Is the original prescription or store label on the medication container?	☐	☐
4. Is the name of the child given above on the container?	☐	☐
5. Is the date on the prescription current (within the month for antibiotics and within the expiration date for other types of medication)?	☐	☐
6. Is the dose, name of drug, and frequency of administration provided on the label the same as the parental instructions given above?	☐	☐

MEDICATION CAN BE ADMINISTERED ONLY IF THE ANSWERS TO ALL ABOVE QUESTIONS ARE "YES."

All questions have been checked by staff _____
Staff Signature

If some questions were not checked yes, please explain:

_____

MEDICATION ADMINISTRATION RECORD

DATE	TIME	DOSE	STAFF SIGNATURE	DOUBLE CHECKED BY

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

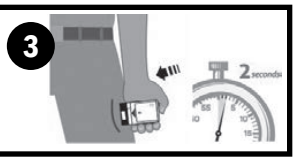
Form provided courtesy of **Food Allergy Research & Education** (FARE - FoodAllergy.org) - January 2023

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

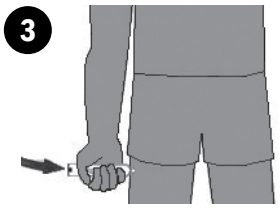
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



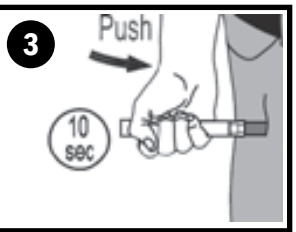
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION

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.



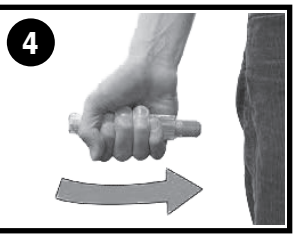
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

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