YMCA OF THE IOWA MISSISSIPPI VALLEY

MAQUOKETA AREA FAMILY YMCA
School Age Summer Camp Programs
Registration Packet

This registration packet completed with immunization records required before weekly registration available.

This registration packet must be completed for all Summer Camp participants.

Child's Name:	**CHILD's School:**
Address:	**Grade Completed:**
City:	**State:** / **Zip:**
Primary Guardian's Name:	**Email:**
Primary Ph#:	**Alternative Ph#:**
Primary Guardian's Name: / **Primary Ph#:** / **Alternat** / **Secondary Guardian's Name:** / **Secondary Guar**	**Email:**
Primary Ph#:	**Alternative Ph#:**
Birth date: / **Age:**	Sex ☐ ☐ M F

Age: Sex ☐M ☐F

In Case of Emergency and Authorized Pick Up

se of emergency if parents are unavailable and are authorized to pick the child up.

Relationship: Phone:
Relationship: Phone:
Relationship: Phone:

In Case of Emergency and Authorized Pick Up

Persons to contact in case of emergency if parents are unavailable and are authorized to pick the child up.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

If there are any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child(ren) while in care at the center, please list the names of the person(s). If there is a custody or restraining order in place, we will need a copy of the document for the file.

If there are any custody or restraining

COMPLETE ONLY IF ATTENDING NON ABE LINCOLN SITES:

orders for person(s) who may attempt to pick up or have contact with the child(ren) while in care at the center, please list the names of the person(s). If there is a custody or restraining order in place, we will need a copy of the document for the file.

COMPLETE ONLY IF ATTENDING NON ABE LINCOLN SITES:

The following information is required by the Child and Adult Care Food Program the Y participates in.

My child's usual days and times of attendance will be:

Monday	Tuesday	Wednesday	Thursday	Friday
Arriving at	Arriving at	Arriving at	Arriving at	Arriving at
Leaving at	Leaving at	Leaving at	Leaving at	Leaving at

My child's anticipated meal participation will be: ☐ Breakfast ☐ Lunch ☐ PM Snack

Ethnicity/Racial Identity of Child (Answering this question is voluntary)

Hispanic or Latino	Non-Hispanic or Latino	American Indian	Alaskan Native	Asian	White	Black or African American	Pacific Islander or Native Hawaiian
☐	☐	☐	☐	☐	☐	☐	☐

SUBMIT COMPLETED REGISTRATION PACKET: Email to jcoakley@maqymca.org or fax to YMCA @ 563.652.6330 or drop off at Maquoketa Area Family YMCA

Parental Emergency Medical Consent

This form must be presented upon admission for treatment

Name:_Birth Date:_Age:

Parents/Guardians/Custodians with whom the child resides:

Name: ________________________________ Relationship to Child:_ Address:

____________________________________ Employer: City:_State:_Zip:_________

Department:_________________Work Hours: Home:_Cell:_Work:______________________

Name: __________________________________ Relationship to Child: Address: ________________________________

Employer: City:_State:_Zip:_Department:________________Work Hours: Home:_Cell:_Work:______________________

This form allows parents and guardians to authorize the provision of emergency treatment for the above named child in the event that the child becomes ill or injured while under program authority when parents/guardians cannot be reached. In the event reasonable attempts to contact me at the above listed numbers are not successful, I hereby give consent for the administration of any treatment deemed necessary by:

Physician and Dentist Information

Physician Name:___________________________Dentist Name:_________________________________Address:_

Address:______________________________________City:_State:_City:_State: Phone:

_________________________________ Phone: __________________________________

In the event that the designated practitioners are not available, then by another licensed physician or dentist and the transfer of the child to (SPECIFIC HOSPITAL OF PREFERENCE).

Date of Last Tetanus: __ Known Allergies: Present Medications:

Insurance Company: ID:

This consent will be in effect for one year beginning

Signature of Parent or Guardian: Date: Signature of Parent or Guardian: Date:

Child Name : ___________________________

Waiver of Liability

I understand that I am able and am speaking on behalf of myself and other individuals listed on this application. In consideration of my/our participation in the YMCA of the Iowa Mississippi Valley program(s) I/we do hereby agree to hold free from any and all liability the YMCA and it's respective officers, employees, and members and do hereby for myself/ourselves, my/our heirs, executors, and administrators, waive, release, and forever discharge any and all rights and claims for damages that I/we may hereafter accrue to me/us arising from, or connected with myself/ourselves to be physically sound having medical approval to participate in the childcare program of the YMCA.

Transportation and Activity Authorizations

I give permission for my child to participate in trips, tours, walks, and special events under the supervision of YMCA staff. Notifications of any activity will be given in advance of said activity. Please note that all Y activity classes that a child has signed up for will be considered a field trip from the center. The Y staff involved in teaching the class is/ are not considered a member of the childcare staff. I further understand the childcare staff will be responsible for preparing each child for lessons including assisting with changing clothes if the class requires special clothing (swim suits, gymnastic outfits, etc.). Children will be supervised at all times and no child will be allowed to go to or from any activity class without the supervision of a staff person from the childcare department.

Parent Payment Agreement

Tuition for all programs is due in advance each Friday for the next week of service. There will not be any deductions for absence or holidays. Summer Camp Programs are paid on a weekly basis. We do not offer part time care in any of our programs. Parents are required to pay an annual registration fee of $25.00. Families will be charged a late pick up fee of $5.00 per every 15 minutes after program end time. There will be an additional fee in the event of a returned check. Weeks of absence must be reported the Wednesday prior to avoid being responsible for that week's program fees. In case of withdrawal of my child from the program, I agree to give the center a two week notice.

Photography Consent

I ☐ DO or ☐ DO NOT give consent to let my child be photographed for use by the YMCA in newspapers or other media for the purpose of advertisement or publicity.

First Aid Consent

I give my permission for staff to give first aid or apply antiseptic ointment if it is deemed necessary.

Permission to Apply Sunscreen to Child

As the parent/guardian of the above child, I recognize that too much sunlight may increase my child's risk of getting skin cancer someday. Therefore, I give my permission for personnel at the **YMCA of the**

Iowa Mississippi Valley to apply a sunscreen product of SPF-15 or higher to my child, as specified below, when he/she will be playing outside during the months of March through October and between the daily times of 10 a.m. and 4 p.m.. I understand that sunscreen may be applied to exposed skin, including but not limited to the face, tops of the ears, nose, and bare shoulders, arms, and legs. I have checked all applicable information regarding the type and use of sunscreen for my child:

- ☐ I do not know of any allergies my child has to sunscreen
- ☐ Staff may use the sunscreen of their choice following the directions or recommendations printed on the bottle
- ☐ I have provided the following brand/type of sunscreen for use on my child:___________________________
- ☐ My child is allergic to some sunscreens. Please only use the following brand(s) and type(s) of sunscreen: ______________________________
- ☐ For medical or other reasons, please do not apply sunscreen to the following areas of my child's body__________________________

Parent/Guardian full legal name (print): ____

Parent/Guardian signature: ____**Date:** ____________ I understand that by typing my name above, I am electronically signing.

to jcoakley@maqymca.org or fax to YMCA @

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apply to your child. My child needs to rest after school. Body Health My child has problems

with Skin, hair, fingernails or toenails. Describe skin marks, birthmarks, or scars.

School-Age Child Health Form/Parent Statement of Health

Parent/Guardian complete this page	Child name: ______________________________________

Physical Activity- ~~My child~~ Play with friends-

~~My childPlays well in groups with other~~

~~children.~~Will play only with one or two other

children. Prefers to play alone.

Please use anXin the box to statements

Fights with other children.

: ____________

Date of last dental appointment:

______________ School and Learning- My

child Is doing well at school.

Growth Is having difficulty in some

classes.Does not want to go to

school. Frequently misses or is late for

school.

I am concerned about child's growth.

Appetite I am concerned about child's eating habits.Rest

Illness/Surgery/Injury

My child had a serious illness, surgery, or in Allergy - My child has allergies (Medicine, food,

jury.

Please describe:

Must restrict physical activity or needs special equipment to be active. Please describe:

I am concerned about my child's play activity with other children.

Frequent sore throats or tonsillitis~~Breathing problems, asthma, cough~~ ~~Heart problems or hea murmur~~

that

Stomach aches or upset stomach ~~Trouble using toilet or wetting accidents~~

Hard stools, constipation, diarrhea, watery

stools ~~Bones, muscles, movement, pain when moving~~

Show us

where these skin marks are located using the

drawing

below.

Medication[1]- My child takes medication.

Eyes/vision, glasses or contact lenses

Ears/hearing, hearing assistive aides or device,

earache, tubes in ears

Nose problems, nosebleeds

Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth

Mobility, child uses assistive equipment

I am concerned about how my child is doing in school. Please describe: dust, mold, pollen, insects, animals, etc.). List allergies: Special Needs Care Plan My child has a special needs care plan (IEP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.	Nervous system, headaches, seizures, or nerv ous habits (like twitches or tics) Females difficult monthly periods Other special needs. Please describe: Medication Name Time Given Reason for giving medication Child has Epipen, inhaler, or other emergency medication. Yes No
Parent Signature: Date:(required)	

[1] Parents: Please review the child care program policies about the use of medication at child care.
HCCI July 2016

YMCA of the Iowa Mississippi Valley
Summer Camp Programs
Code of Conduct

The code of conduct for the YMCA of the Iowa Mississippi Valley Summer Camp Programs defines expectations for all participants to ensure that all participants are safe and to reduce disciplinary problems. A disciplinary problem is defined as one in which a child is hampering the smooth flow of the program by either requiring constant one on one attention; is inflicting physical or emotional harm on other children; is physically or verbally abusing staff or is otherwise unable to conform to the rules and guidelines of the program.

Child's Name:____

1. Check in to the YMCA Summer Camp Program upon arrival to site. 2. Do not bring personal belongings to the YMCA Summer Camp Program. 3. Remain seated and quiet during role call and announcements. Answer only for myself.
4. Follow all YMCA Summer Camp Program rules.
5. Follow all instructions given by the YMCA Summer Camp Program staff. 6. Respect all other children and the YMCA Summer Camp Program staff at all times.
7. Respect all YMCA Summer Camp Program and park or business supplies, equipment and property.
8. Help in cleaning up after myself in all activities.
9. Never leave the YMCA Summer Camp Program site or assigned group without permission from a YMCA Summer Camp Program staff member.
10. Follow the Time Out instructions of the YMCA Summer Camp Program staff

For each code of conduct violation there may be a 5 – 15 minute Time Out, up to 3 Time Outs per day. Parents will be called to pick up any participant that

receives more than 3 Time Outs.

My signature below indicates that I have read and understand the expectations of the YMCA Summer Camp Program; and that I will abide by the rules listed above.

Child's Signature:____

Date:_________________

I understand that by typing my name above, I am electronically signing.

My signature below indicates that I have read and understand the expectations for the YMCA Summer Camp Program; and I support my child abiding by these rules.

Parent's Signature: ____

Date:_________________

I understand that by typing my name above, I am electronically signing.

School-Age Child Health From/Parent Statement of Health

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Parent/Guardian please complete pages 1 and 2.

Grade _____ School Telephone # Parent/Guardian name #1 Parent/Guardian name #2 Child home

address #2 ~~Telephone # 2~~

Where parent/guardian #1 works ~~Work address~~ Telephone #

~~Where parent/guardian #2 works Work address~~ Telephone #

School-Age Child Health Form/Parent Statement of Health

Name of school

the child care facility is unable to immediately make contact with the parent/guardian. ES ~~NO~~

Child home address #1 Telephone # 1

~~_____ Phone # ____________________~~

~~Relationship to child: ____________________________~~ Cellular # ___________________D After hours telephone

~~Does your child have health~~

Work #

Cellular #

Dentist telephone #1 ~~Does your child have dental insur~~

Home email

Work email

Work #

Cellular #

~~HELP us find health or dental~~

Home email

insurance ~~Other health care/mental health specialist name~~

Work email

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: ____ Date ________________

Doctor telephone #1 Hospital of choice

D name

Phone #________________________

Child does not have doctor

insurance?YESNO

Company ________________

ance? YES NO

D name

ID#

Child does not have dentist

Company ________________

ID#

After hours telephone #

HELP us find a family doctor or dentist

Type of specialty	Telephone #	

Iowa Eligibility Application FFY 20-21

Complete one application per household. Fiscal Year 2020-2021

Part 1. Check all applicable boxes:

☐ school meals
☐ special milk (restrictions apply)
☐ children in child care center
☐ Tier I home provider (HP)
☐ Head Start/Even Start
☐ children in child care home(HP)
Provider name:

Part 2. Check if any child is Homeless, Migrant, or a Runaway and call your child's school. ☐ Run away ☐ Migrant ☐ Homeless

Part 3. FIP or Food Assistance Eligible: Enter the FIP or Food Assistance Case Number for ANY household member as listed in the Notice of Decision (10 digits, include zeros). NOTE: Medicaid, Title XIX and EBT card numbers are not acceptable. Skip part 5. **Name of household member with Case Number _________________________ List Case Number ___-___-___-___-___-___-___-___-___-___**

Part 4. Children enrolled: REQUIRED OF ALL APPLICANTS.

List name(s) of all enrolled child(ren) in your household.

Ethnicity: H=Hispanic or Latino N=Not Hispanic or Latino

Race: A = Asian B = Black or African American I = American Indian or Alaska Native W=White

If ethnicity & race are not completed, the form will be completed based on visual observation

Last Name First Name Middle Name or Initial	Check box for FOSTER child	Date of Birth	Grade	OPTIONAL		Name of School/Head Start/ Child Care Center/Home
				ETHNICITY	RACE	
1.	☐					
2.	☐					
3.	☐					
4.	☐					
5.	☐					

Part 5. Total Household Gross Income: DO NOT COMPLETE PART 5 IF YOU LISTED A FIP OR FOOD ASSISTANCE NUMBER IN PART 3. Report the gross income received by EACH household member one time in the correct column: weekly, every 2 weeks, twice a month or monthly. Gross income is the amount earned before taxes and other deductions, not take-home pay. Report all other monthly income received. Self employed persons, see the worksheet on reverse side of this application.

List the names of everyone living in your household, including the children listed in Part 4. Attach a separate page if more space is needed. For FOSTER children, include only money available for child's personal use or child's own income.			**Gross Income: Report income by how often the household member is paid.**				Other Monthly Payments or Income Received.		
Last Name First Name	Age	Check if NO Income	Gross amount earned weekly	Gross amount earned every 2 weeks	Gross amount earned twice a month	Gross amount earned monthly	Welfare, child support, alimony, adoption subsidies	Pension, retirement, social security, SSI, VA benefits	All other income
1.		▫							

2.		▫							
3.		▫							
4.		▫							
5.		▫							

Last four digits of my Social Security Number: **X XX** - **X X** - ___ ___ ___ ___ ☐ I do **not** have a Social Security Number. If Part 5 is completed, the adult signing the form must provide the last 4 digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. **For further information refer to the Privacy Act Statement in the parent letter.**

Part 6. Certification and Signature. REQUIRED OF ALL APPLICANTS.

I certify (promise) that all information on this application is true and that all income is reported if required. I understand that I will receive benefits from Federal funds based on the information I give. I understand that officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal/milk benefits, and I may be prosecuted. Email of Adult Completing Form____

_______________________________________ ____ ________________

Signature of Adult Completing Form Printed Name of Adult Completing Form Date Signed

______________________________________ _____________ ________ _____________ _____________ __________

Address of Adult Completing Form Town ZIP Code Work Phone Home Phone Cell Phone

Part 7. DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY.

Income conversion factors for annual income: weekly X 52; two weeks X 26; twice a month X 24; monthly X 12

Household Income: $ ___________ ☐ Weekly ☐ Every 2 Weeks ☐ Twice Monthly ☐ Monthly ☐ Annually Household Size _______

Application Approved: ☐ Income ☐ Foster Child (free) ☐ FIP/Food Assistance CACFP HP ONLY: ☐ Head Start DOCUMENTATION REQUIRED ☐ Homeless/Migrant/Runaway ☐ Tier 1 Area (Provider's own children) (Schools only)

Eligibility Determination: ☐ Free Meals ☐ Reduced Price Meals ☐ Free Milk ☐ Tier 1 Income (All children) Application Denied: ☐ Incomplete ☐ Over income limits ☐ Tier 1 Child (Tier 2 mixed)

____ ______________

Determining Official Signature Effective Date

Self-Employment Income Worksheet: This worksheet will help you calculate the amount to report if you farm, are self employed, or have income from other sources.

Persons who are engaged in farming or who operate other types of private businesses may experience variations in cash flow or monthly income throughout the year. These persons may use their income tax records from the preceding calendar year as a basis for applying for Tier 1 meals. The income to be reported is income derived from the business venture less operating costs incurred in the generation of that income. Deductions for personal expenses such as medical expenses and other non-business deductions are not allowed in reducing gross business income.

If you have additional income from other kinds of employment, this income must be treated as separate and apart from the income generated from your business venture. USDA **DOES NOT** recognize income the same way as IRS. USDA does not permit a loss from a business venture to off-set earnings from wages or salary. Though your business may have suffered a net operational loss, for purposes of this Application, it is not possible to have a negative income. The **least self-employed income possible is zero (no income).** For example, if you operated a business at a net loss but held another job where you received wages, your income for purposes of applying for Tier 1 meals would be the income from your wages only. The loss from the business cannot be deducted from the amount of the income earned in the other job.

A prior year loss from farming or other private business operation cannot be used to reduce the current year net income for determining free and reduced price (Tier 1) eligibility. Wages paid to a spouse or other family or household member in the operation

of a farm or private business must be shown as household income in Part 4 of this Application.

Income from private business operations is to be taken from your most recent U.S. Individual Income Tax Return – Form 1040 or 1040-SR including Schedule 1 (Additional Income and Adjustments to Income). Complete the identified lines from Form 1040 or Form 1040-SR and Schedule 1.

Capital gain or (loss): Form 1040 or 1040-SR, Line 6 $

Business income or (loss): Schedule 1 Part 1, Line 3 $

Other gains or (losses): Schedule 1 Part 1, Line 4 $

Rental real estate, royalties, partnerships, S corporations, trusts, etc.:
Schedule 1 Part 1, Line 5 $

Farm income or (loss): Schedule 1 Part 1, Line 6 $

*Total = $

*The least income possible is zero (a negative number cannot be reported).
*Enter amount in the "**All other Income**" column in Part 4 on the front of this Application.