



Name of public or private school child attends, if any:

\_\_\_\_\_

Child's Physician or Clinic's Name (Child's Primary Health Source)

\_\_\_\_\_  
Telephone Number

My child has the following special need(s):

\_\_\_\_\_

\_\_\_\_\_

The following special accommodation(s) may be required to most effectively meet my child's needs while at this center.

\_\_\_\_\_

\_\_\_\_\_

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following preexisting illness, allergies, or health concerns:

\_\_\_\_\_

\_\_\_\_\_

**My signature indicates that the information provided has not been falsified. Unless court ordered and provided to the YMCA, the YMCA will share financial, developmental or any other programmatic information with both parents and/or with both legal guardians. I have received, read and agree to abide by the program's child care and financial policies and procedures.**

**My signature also indicates that I am either the parent or legal guardian of the child applicant.**

Female Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

Male Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

Female Legal Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Male Legal Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

### **Photograph/Videotape Release**

We would like permission to photograph and/or videotape participants in our childcare programs. Photo opportunities are essential to for our corporate partners and to generate continuous community involvement. The photos will also be used for creating bulletin boards and posters around your YMCA.

Pictures are used for YMCA purposes and may be shared to the public for publication.

I give permission for photos of my child, \_\_\_\_\_, to be used by the Centennial Place Family YMCA for publicity and promotional purposes.

I do not give the Centennial Place Family YMCA permission to take any photos of my child,  
\_\_\_\_\_, to be used by for publicity and promotional purposes.

Parent/Legal Guardian) Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Authorization of Medication and Food Allergy Form

## Consent for Medication Administration and Record of Administration

I hereby request and give permission for the Centennial Place Family YMCA to administer to my child,  
\_\_\_\_\_, the following medication(s):

(Child's full name)

\_\_\_\_\_  
RX #

\_\_\_\_\_  
Medication Name

\_\_\_\_\_  
RX #

\_\_\_\_\_  
Medication Name

\_\_\_\_\_  
RX #

\_\_\_\_\_  
Medication Name

prescribed by \_\_\_\_\_  
(Name of Physician or Health Care Professional)

The above named medication should be administered as follows:

Dosage \_\_\_\_\_, \_\_\_\_\_ time(s) a day

Dates to be administered: from \_\_\_\_\_ to \_\_\_\_\_

If your child is to be administered a liquid medication you MUST provide a medicine dispenser that is calibrated to your child's dosage.

**Note:** A medication log will be completed by YMCA staff describing dose, date & time given, refuse, spillage or reaction, if any.

### Food Allergies

Food Likes:	Food Dislikes:
List the food(s) in which your child is restricted from eating:	
Does your child have food allergies? ___ No ___ Yes	
If yes, please list the foods your child is allergic to:	
Any updated instructions regarding adding new foods or other dietary changes please list as needed	

Parent/Legal Guardian) Signature \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature \_\_\_\_\_

Date: \_\_\_\_\_

**Centennial Place Family YMCA**  
**VEHICLE EMERGENCY MEDICAL INFORMATION**

Please complete every question. The information on this form will be used to communicate with emergency personnel if your child is involved in an emergency away from the facility.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Mother's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other: \_\_\_\_\_

Father's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other: \_\_\_\_\_

Notify in case of emergency (if parents/guardians can't be reached):

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Medical facility of family \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Child's Allergies \_\_\_\_\_

Current prescribed medicine \_\_\_\_\_

Child's special medical needs/conditions \_\_\_\_\_

In the event of an emergency involving my child, and if the Centennial Place Family YMCA Childcare Program cannot get in touch with me, I hereby authorize emergency medical care. I further agree to be fully responsible for all medical expenses incurred during treatment of my child.

Parent/Legal Guardian) Signature \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date: \_\_\_\_\_