Child's Name: _____

School Attending in Fall 2023_____

Kindergarten Readiness Day Camp Registration Checklist

_____ Completed Lockport City School District Registration For Fall of 2023

_____ Kindergarten Readiness Enrollment Application

_____ Health History Form completed by parent, signed and dated

_____ Most Recent Immunization

_____ Current Physical (Not older than 1 year)

_____ Written Medication Consent (if needed for on site medications)

_____ Copy of Medical Treatment Plan (allergies, chronic health issues, asthma)

_____ Copy of Behavior Plan (if currently in place)

_____ Copy of IEP

INCOMPLETE REGISTRATIONS WILL NOT BE ELIGIBLE FOR PLACEMENT IN THE KINDERGARTEN READINESS DAY CAMP.

Eligible applicants will be notified by the YWCA as to their acceptance status.

Office use:

Date application received_____
Complete____
Incomplete___

Date Application was Completed____
Date of applicant notification_____

Lockport City School District/ YWCA of the NIAGARA FRONTIER
2023 SUMMER KINDERGARTEN READINESS DAY CAMP
ENROLLMENT APPLICATION

ATTENDING: My child will attend the following weeks:

WEEK 1 (July 10-14) _____
WEEK 2 (July 17-21) _____
WEEK 3 (July 24-28) _____
WEEK 4 (July 31-Aug 4) _____
WEEK 5 (Aug 7-11) _____
WEEK 6 (Aug 14-18) _____

My Child will attend the following programs:
Kindergarten Readiness Class 8:00am-11:30am (mandatory) _____
Kindergarten Readiness Day Camp 11:30-5:00pm (optional) _____

Child's Name_____ Nick Name_____ Age_____

Birth Date _____ School in Fall _____ Gender ☐ M ☐ F

Home Address _____City, State, Zip_____

Parent/Guardian's Name_____ Phone Number Home_____

Parent/Guardian's Address_____ Phone Number Cell _____

Parent E-mail Address _____

****

Parent/ Guardian's Name _____ Phone Number Home_____

Parent/Guardian's Address _____ Phone Number Cell _____

Parent E-mail Address _____

CAN CHILD BE PICKED UP BY BOTH PARENTS? ☐ YES ☐ NO
If not, provide written documentation.

Child lives with ☐ both parent's ☐ mother ☐ father ☐ other _____

Custody Restrictions? Please elaborate_____

Does your child currently have an IEP, behavioral plan or physician care plan in place? YES ____ NO____

If YES, a copy of the plan must be provided.

Emergency Contact in Case Parents Cannot Be Contacted

Name _____ Phone _____ Relationship _____

List All Persons, Other Than Parents Who Have Permission To Pick Up Your Child
(Must be over the age of 18 years.)

Name _____ Phone _____ Relationship_____

Name _____ Phone _____ Relationship_____

Name _____ Phone _____ Relationship_____

YWCA of the Niagara Frontier

PARENT ACKNOWLEDGMENT STATEMENT

PARENT ACKNOWLEDGEMENT

- **Medical Release Consent** - In an emergency concerning my child, (i.e. accident or sudden medical problem), I do authorize the YWCA staff/volunteer to be my agent in obtaining emergency medical treatment. I understand that the 911 Emergency team and emergency department staff at Eastern Niagara Hospital/or nearest hospital will be utilized.
- **Photo Release/Consent** - I understand that any photographs taken of me/my children while at the YWCA will be used for public relations purposes and promotions of YWCA programs and services.
- **Acknowledgement of Parent Responsibility** – I understand that I am responsible to notify the YWCA of any changes in writing of my child's normal schedule.
- **Liability Waiver** - We agree to hold the YWCA and the Program staff harmless with regard to any injuries that may be sustained by our child during the operation of this program. Furthermore, we understand that the YWCA is NOT insured against any such contingencies. I give my permission that this disclosure information relating to my child, such as pictures, name and other pertinent information may be used at the discretion of the YWCA staff.
- I understand that I am to contact the Summer Day Camp Director at 433-6714 if there are any questions or concerns.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

_____ _____

Signature Date

HEALTH HISTORY FORM

Child's Name:_____ Date of Birth: _____

Child's Primary Care Physician's Name/Group _____ Phone #: _____

Preferred Hospital: _____ Phone # _____

Child's Dental Care: _____ Phone #_____

In case of an emergency, and the ***YWCA of Niagara*** is unable to reach the parent/guardian, the following individual(s) have permission to make decisions regarding the care of my child/me, including permission to pick up my child/me from the YWCA in case of an emergency or dismissal from the ***YWCA of the Niagara Frontier.***

Name_____ Relationship to child/staff_____

Address_____ City/State/Zip_____

Home Phone (_____)_____ Cell Phone(_____)_____

HEALTH HISTORY – Indicate and explain as necessary.

Autism	_____	Seizures	_____	**ALLERGIES:**			
Asperger's	_____	ADD/ADHD	_____	Bee Sting	_____	Other	_____
ODD	_____	Hearing	_____	Lactose Intolerant	_____	Wheat	_____
Asthma	_____	Vision	_____	Peanut	_____	Amoxicillin	_____
Diabetes	_____	Motor Delays	_____	Tree Nuts	_____	Penicillin	_____

Child has any special needs/services: Early Intervention/Special Education _____ Occupational Therapy _____ Speech/Language _____ Physical Therapy _____

Learning Disability _____

Other diseases or details of above_____

Dates of operations or serious injuries/illness_____

Chronic or recurring illness_____

Is the child currently taking any prescribed medications? _____**yes** _____**no.** Please be sure to consult with your physician about bringing these medications to the YWCA of the Niagara Frontier along with the **MEDICATION CONSENT FORM**.

ARE YOU COVERED BY ANY HOSPITALIZATION/MEDICAL CARE POLICY? YES_____ **NO**_____

Name of Primary Insurance Company_____ Phone (_____) _____

Address_____

Policyholder's Name_____ Policyholder's Birthdate _____

Policy # (including 3 letters):_____ Is policy through employer? _____yes _____no

---

PARENT/GUARDIAN AUTHORIZATION: To the best of my knowledge, this health history is correct and the designated child/staff may engage in all YWCA activities (except where noted by the examining physician or myself). I authorize the YWCA staff to supervise self-administration of sunscreen products by my child. In an emergency, I authorize the YWCA Day Camp Director to act for me/my child according to her/his best judgement where medical or surgical treatment is required. I accept responsibility for all medical bills resulting from the illness or injury while I/my child is in the care of the YWCA.

Please initial:

- I consent to emergency medical treatment for my child _____
- I provided information on my child's special needs to the program to assist in caring for my child _____
- I agree to review and update this information whenever a change occurs and at least once every year _____
- A current copy of my child's physical and immunization records has been provided to the program. _____

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**