YMCA OF GREATER SPRINGFIELD 2020 CAMP REGISTRATION FORM

Mail or drop off forms to any YMCA Family Center
Or email your forms to CampRegistrationForms@springfieldy.org
Questions regarding camp will be taken **BY PHONE ONLY**
Please call: 413-739-6955 M-F 6am to 6pm

CAMPER'S NAME______________________________

1. Complete this registration form. Attach a copy of your child's ***immunization and physical forms including an Asthma Action Plan (required by DPH) if your child has asthma***. All forms must be submitted TOGETHER, will not accept partial or incomplete registrations.
(Forms can be found online athttp://www.springfieldy.org/camps/)
2. Mail, Email or Drop of your completed forms in a SEALED envelope or if email Labeled with your child's name in the subject line. Our registrars will call you once your child has been registered with confirmation. (NO camp questions will be taken in person ONLY OVER THE PHONE) 413.739.6955
3. Balances for each week are due 7 days prior.
4. All camp forms must be returned 15 days prior to the start of each session. At which time a 48 hour wait period from the time you submit completed forms to the time your child may start camp.
5. ***Automatic Withdrawals, via Bank Account, are mandatory for all camp session payments or payment in FULL is due at the time of registration.***

NOTE: Your child will ***NOT*** start camp without completing all above steps.

2020 CAMPER INFORMATION

Child (Camper) **Camp Attending**__________________________

First Name__________________________________ Last Name ____

Street Address ____ Apt. No.__________________ City________________________

State__________Zip_____________Home Phone___________________________ Cell_____________________________

Date of Birth ________/_______/_________ Age: __________ Sex: M F T Grade entering in fall: ___________

Please list any allergies that camper may have: ____

MOTHER (GUARDIAN 1)

Name ____ Occupation____

Work Phone: _______________________Cell Phone: _________________________ Email: ______________________________________

FATHER (GUARDIAN 2)

Name ____Occupation____

Work Phone: _______________________Cell Phone: _________________________ Email: ______________________________________

Emergency Contact 1 (Person to contact and release my child to in case of emergency when parent cannot be reached)

Name _______________________________ Work Phone: __________________________________Cell Phone: ___________________________

Emergency Contact 2

Name _______________________________ Work Phone: __________________________________Cell Phone: ___________________________

Is your child a member of the YMCA of Greater Springfield? ☐ Yes ☐ No Membership # Expiration Date_____________________

PERMISSION SLIP

I hereby authorize that my child _________________________is ready to experience an outdoor camp setting. I give permission for him/her to travel on the bus to camp/ or on all field trips. Permission is also granted for the camper to participate in all planned camp activities and programs, receive emergency medical attention (if parent/guardian is unavailable) and for the YMCA to take, have and use pictures as may be needed for public relations purposes.

I hereby authorize the YMCA of Greater Springfield to release my child to the following additional persons (other than parents and emergency contacts):

1. ____

2. ____

3. ____

Waiver of Liability

While it is the aim and the responsibility of the YMCA of Greater Springfield to provide your child with a safe and enjoyable experience, you must realize that participation in YMCA programs has some inherent risks. As a result we require the signing of the release set forth below.
I hereby release for myself and my child, our heirs, executors and administrators, and forever discharge the YMCA of Greater Springfield, its agents, servants, representatives and employees for any injuries, loss, liability, damage or costs which my child may receive/incur as a result of participation in any program/activity/service conducted and/or provided by the YMCA of Greater Springfield.

Sign: ____ **Date:**____

It is our aim to provide access to programs for all children and families. Financial assistance is available to those who qualify. Please contact our registration desk at 413-739-6955 for more information on financial assistance and find out what documentation is needed to determine your eligibility.

☐ **$10.00 Facility Maintenance Fee**
A one-time Facility Maintenance Fee of $10.00 will be charged to each camper upon their initial registration. The fee will go the general up keep of the camp property, which in turns helps to keep program fees down.

Office Use Only: Date Rec_____/______/_____ Amt Pd$_____________ Code_____________ Staff Initials_______________

Date Ent____ /______/______ Conf Mailed_______/_______/________

CAMPER'S NAME________________________________

ALL CAMP RATES

BREAKFAST CLUB	CAMP
Fees per session 6:00 – 7:30 am Member & Non-Member: $36 No Breakfast Club at Stony Brook Acres	Fees per session 7:30 am – 5:30 pm **FUN CITY** **STONY BROOK ACRES** Member $170 & Non-Member $200

Stony Brook Acres: *Tags $1.00*

CHOOSE YOUR LOCATION

☐ **CAMP FUN CITY**
AGES 6-12 YEARS

☐ **STONY BROOK ACRES**
AGES 6-15 YEARS

AGE YOUR CAMPER WILL BE AT THE START OF CAMP	☐ Breakfast Club 6am–7:30am			
☐ **Session 1** *June 29-July 3*	☐ **Session 2** *July 6-July 10*	☐ **Session 3** *July 13-July 17*	☐ **Session 4** *July 20-July 24*	☐ **Session 5** *July 27-July 31*
☐ **Session 6** *Aug 3-Aug 7*	☐ **Session 7** *Aug 10-Aug 14*	☐ **Session 8** *Aug 17-Aug 21*	☐ **Session 9** *Aug 24-Aug 28*	☐ **Session 10** *Aug 31-Sept 4*
☐ **Session 11** *Sept 8-Sept 11*				

VIOLATION OF POLICIES (SUBJECT TO CHANGE)

IMPORTANT: Given the current global pandemic we must do our very best to ensure that everyone is kept safe. We need you, parents, families, and caregivers to do your part to help us maintain that environment. We fully expect everyone to follow our camp policies, violations of our policy will result in strict responsive measures beginning with suspension from programs and facilities and up to termination, no-trespass and legal action. Please familiarize yourself without the below policy and the parent handbook.

DEPARTMENT OF PUBLIC HEALTH AND THE CDC

Our programs must adhere to the local and state health departments. The Y will follow closely the CDC guidelines for action during the pandemic. This can include, changing, adding, subtracting, suspending any part of the programs described in this brochure at any time without notice.

COMMUNICATION

All camp related questions must be made over the phone 413.739.6955 (Monday-Friday 7am-6pm) no in-person registrations or communication will be taken at our family centers. Forms may be mailed and we can register you right over the phone. Mail forms to 1500 Main Street, Springfield, MA 01105.

SANITATION

Our properties will be cleaned and sanitized daily by our internal staff. In addition, we will have our programs professionally cleaned and sanitized weekly. All staff will be required to wear face masks at work and have their temperature taken daily.

PICK-UP & DROP-OFF

All pick-up and drop-off must be made curbside. Parents may not get out of the vehicle for any reason unless instructed to do so by our staff. If you are on foot, please proceeded to thedesignated area for pick-up and drop-off respecting social distancing. (Violating this policy for any reason could result in termination.)

SOCIAL DISTANCING

We have created an environment to keep your child safe. We expect that you and your family will respect the social distancing set up in order to help other families feel at ease. Until the CDC lifts social distancing guidelines, we expect your full cooperation.

FOOD

Children may be sent with food from home, they may eat whatever they like, whenever they like. No refrigeration will be provided. The food you provide must be shelf stable or you must provide an ice pack for cold food. You may not provide any food to anyone else, including staff or other children for any other reason. The Y will provide free lunch for programs that qualify (CFC). All meals provided will come in sealed sanitized containers from the distributor. Food not purchased through our facilities will not be allowed for general consumption on the properties.

ELECTRONIC FUNDS TRANSFER (EFT)
RELEASE FORM

I give permission for the YMCA of Greater Springfield to automatically withdraw payments for my Child Care Services from the financial account listed below:

Child's Name: ______________________________

Child's date of Birth: __________________________

Printed Name on Account: _______________________

Routing Number: ______________________________

Account Number: ______________________________

Account type (please circle) Checking Savings

Camp payments are due the Monday prior to each new session.

***I understand and agree to the forms and policies stated above. I understand that if my EFT payment is returned, I will be subject to a $15 return fee.**

By signing this agreement, you acknowledge that using a bank account may take up to three business days to post to your account. You acknowledge that weekly payments must be paid prior to services rendered. Terminations are subject to two-week notices in which you are responsible for payment.

Account Holder's Signature: _______________________

Date: ___________

Mandatory Forms for Registration

Paperwork needed BEFORE registering
IEP/504/BIP plans must be submitted and reviewed before a child is registered for the program.

Paperwork needed for registration
Your registration will not be accepted if you do not have the following medical forms.

- Physical
- Immunization Record

If your child has any allergies, asthma, diabetes or seizures

- Individual Health Care Plan*
- Action Plan
- Medical Consent Form*

MEDICATIONS MUST be submitted on the first day your child attends in original boxing with your childs name and must be picked up on the last day of camp. All medications not picked up will be brought to the YMCA of Greater Springfield. **After 1 week medication that are NOT picked up will be discarded.**

EFT FORM*
Automatic payments are required for the 2020 camp year.
If an EFT payment is returned by your bank for any reason a service fee of $15 will be charged. Consecutive EFT returns will result in termination of services.

SUBSIDY
Parents/Guardians are responsible for renewing their voucher, EEC slot, or financial assistance paperwork in a timely fashion to prevent termination or a gap in service.

***I understand and agree to the forms and policies stated above. I understand that if my EFT payment is returned I will be subject to a $15 return fee. I also understand that if I do not pick up my child's medications within the time frame given that they will be discarded.**

Required Medical Forms Per EEC

Individual Health Care Plan: An IHCP is needed to ensure the child receives health care services he or she may need while attending the program.

Must have IHCP for any chronic medical condition

- Asthma
- Diabetes
- Seizures/Epilepsy
- **ANY** allergies

If parents indicate there is no action plan, then we MUST receive a letter from the doctor stating this

Medication Consent Form: The medication consent form is required for all medication provided at the site. It gives the program consent to administrate the medication as well as all medication information needed to ensure the medication is administrated correctly.

Medication Consent Form is required:

- For ALL medications provided to the program
- ADHD

Medication Administration Record: Is used to document the medication administered to a participant.
The **Medication Administration Record** should be stapled or copied together on the back of the **Medication Consent Form.**

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply…

Plan was created by:
___Parent
___Doctor or Licensed Practitioner
___Program's Health Care Consultant
___Older school age child (9+ yrs. of age)
___Other:___________________________

Plan is maintained by:
___Director
___Assistant Director
___Child's Educator
___Other: ____________________

Name of child:	**Date:**
Any change to the child's Heath Care Plan? **YES (indicate changes below) NO (updated physician/parental signatures required)**	
Name of chronic health care condition:	
Symptoms:	
Medical treatment necessary while at the program:	
Potential side effects of treatment:	
Potential consequences if treatment is not administered:	
Name of educators that received training addressing the medical condition:	
Person who trained the educator (Child's Health Care Practitioner, child's parent, program's Health Care Consultant):	

Name of Licensed Health Care Practitioner (please print):____________________________________

Licensed Health Care Practitioner authorization: ___________________________ Date: ___________

Parental/Guardian comment: ____ Date: ___________

For Older Children Only (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his/her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child: _______ Date of Birth: ____________ Back-up medication received? YES NO

Parent signature:____ Date: ____________

Administrator's signature: ____ Date: ____________

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11 (2)(b)

Name of child: ____

Name of medication: ____

Please check one of the following: Prescription: _____ Oral/Non-Prescription: ____

Unanticipated Non-Prescription for mild symptoms _________________

Topical Non-Prescription (applied to open wound/broken skin) ________________

My child has previously taken this medication _____________________________

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan ________

Dosage: ____

Date(s) medication to be given: ______________________________________

Times medication to be given: ____

Reasons for medication: ____

Possible side effects: ____

Directions for storage: ____
Name and phone number of the prescribing health care practitioner:
____
Child's Health Care Practitioner Signature ________________ Date: _________
I, ________________, (parent or guardian) give permission
(print name)
To authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature ____________________________ Date: ___________
For topical, non-prescription NOT applied to open wound/broken skin (parent signature only)

Massachusetts Asthma Action Plan

Name:		Date:
Birth Date:	Doctor/Nurse Name:	Doctor/Nurse Phone #:
Patient Goal:	Parent/Guardian Name & Phone #:	
Important! Avoid things that make your asthma worse:		

Personal Best Peak Flow: ______________________________

The colors of a traffic light will help you use your asthma medicine.

GREEN means Go Zone!
Use controller medicine.

YELLOW means Caution Zone!
Add quick-relief medicine.

RED means Danger Zone!
Get help from a doctor.

GO — You're doing well!

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play

Use these daily controller medicines

Peak flow from ___ to ___	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

CAUTION — Slow Down!

You have *any* of these:

- First signs of a cold
- Cough
- Mild wheeze
- Tight chest
- Coughing, wheezing or trouble breathing at night

Continue with green zone medicine and add:

Peak flow from ___ to ___	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

CALL YOUR DOCTOR/NURSE: ______________________

DANGER — Get Help!

Your asthma is getting worse fast:

- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Take these medicines and call your doctor now.

Peak flow from ___ to ___	MEDICINE/ROUTE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room and bring this form with you. DO NOT WAIT.

Make an appointment with your doctor/nurse within two days of an ER visit or hospitalization.

Doctor/NP/PA Signature ______________________________ **DATE** ______________

I give permission to the school nurse, my child's doctor/NP/PA or ______________________________ to share information about my child's asthma.

Parent/Guardian Signature ______________________________ **DATE** ______________

— SEE BACK OF SCHOOL COPY FOR STUDENT MEDICATION ADMINISTRATION AUTHORIZATION —

ADAPTED FROM NIH PUBLICATION (7/20/01)

Make copies of this plan for: patient/parent, provider, and school.

— IMPORTANT INSTRUCTIONS: SEPARATE THIS PAGE BEFORE WRITING —

Consent for administration of medication in school:

I consent to have the school nurse or school personnel designated by the school nurse administer the medication asprescribed on the reverse side of page.

Parent/Guardian Signature ______________________________________ DATE ________________________

Authorization for student self-administration of medication in school:

I have instructed this student in the proper way to use his/her medications. Medications administered must be consistent with school policy and a medication plan must be developed with the school nurse in accordance with the Massachusetts Regulations Governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.000) as printed below. Translated copies of the regulation can be obtained from the Massachusetts Department of Public Health, 250 Washington Street, Boston, MA 02118. It is my professional opinion that this student may self-administer the medication and may be allowed to carry and use his/her medications by him/herself.

COMMENTS/SPECIAL INSTRUCTIONS:

SIGNATURES	**DATE**
Student's Doctor/Nurse ______________________________________	________________________
Parent/Guardian ______________________________________	________________________
Medication administration plan completed ______________________________________	________________________
School Nurse's approval ______________________________________	________________________
SIGNATURE	

Listed below are regulations governing the self-administration of prescription medication 105 CMR 210.006

(A) Consistent with school policy, students may self-administer prescription medication provided that certain conditions are met. For the purposes of 105 CMR 2100.000, "self-administration" shall mean that the student is able to consume or apply prescription medication in the manner directed by the licensed prescriber, without additional assistance or direction.

(B) The school nurse may permit self-medication of prescription medication by a student provided that the following requirements are met:

(1) the student, school nurse and parent/guardian, where appropriate, enter into an agreement which specifies the conditions under which prescription medication may be self-administered;

(2) the school nurse, as appropriate, develops a medication administration plan (105 CMR 210.005 (E)) which contains only those elements necessary to ensure safe self-administration of prescription medication;

(3) the school nurse evaluates the student's health status and abilities and deems self-administration safe and appropriate. As necessary, the school nurse shall observe initial self-administration of prescription medication;

(4) the school nurse is reasonably assured that the student is able to identify the appropriate prescription medication, knows the frequency and time of day for which the prescription medication is ordered, and follows the school self-administration protocols;

(5) there is written authorization from the student's parent or guardian that the student may self-medicate, unless the student has consented to treatment under M.G.L. c. 112,§ 12F or other authority permitting the student to consent to medical treatment without parental permission;

(6) if requested by the school nurse, the licensed prescriber provides a written order for self-administration;

(7) the student follows a procedure for documentation of self-administration of prescription medication;

(8) the school nurse establishes a policy for the safe storage of self-administered prescription medication and, as necessary, consults with teachers, the student and parent/guardian, if appropriate, to determine a safe place for storing the prescription medication for the individual student, while providing for accessibility if the student's health needs require it. This information shall be included in the medication administration plan. In the case of an inhaler or other preventive or emergency medication, whenever possible, a backup supply of the prescription medication shall be kept in the health room or a second readily available location;

(9) the school nurse develops and implements a plan to monitor the student's self-administration, based on the student's abilities and health status. Monitoring may include teaching the student the correct way of taking the prescription medication, reminding the student to take the prescription medication, visual observation to ensure compliance, recording that the prescription medication was taken, and notifying the parent, guardian or licensed prescriber of any side effects, variation from the plan, or the student's refusal or failure to take the prescription medication;

(10) with parental/guardian and student permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the student is self-administering a prescription medication.