



**FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY**

**YMCA of Metro Chicago  
PARTICIPANT EMERGENCY INFORMATION PACKET**

**PERSONAL INFORMATION PLEASE PRINT**

Child's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Family e-mail address: \_\_\_\_\_

Name of School child attends: \_\_\_\_\_ **Grade in Fall:** \_\_\_\_\_

Parent/Guardian #1: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Title: \_\_\_\_\_ Workhours: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Parent/Guardian #1: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Title: \_\_\_\_\_ Workhours: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ **Child lives with:**  Both Parents  Mother  Father  Other \_\_\_\_\_

**ADULTS AUTHORIZED TO PICK-UP MY CHILD/EMERGENCY CONTACTS OTHER THAN PARENT/GUARDIAN**

**(minimum of 2 are required)**

	Name/Age	Relationship	Address	Preferred Phone
1.				
2.				
3.				
4.				
5.				
6.				

**UNAUTHORIZED PICK-UP: People who CANNOT pick up your child from YMCA Session program:**

1. Name \_\_\_\_\_ Relationship: \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship: \_\_\_\_\_

**AUTHORIZED PICK-UP/EMERGENCY PICK-UP:** I, \_\_\_\_\_ authorize the people listed above to pick up my child and be contacted in the event of an emergency from the \_\_\_\_\_ YMCA. In doing so, I relieve the YMCA of Metropolitan Chicago, its centers and employees of all responsibility for my child after he/she has been released from the program. Attempts will be made to reach the parent/legal guardian first. Initials \_\_\_\_\_

**INSURANCE INFORMATION**

Is the participant covered by family medical/hospital insurance?  Yes  No

If yes, indicate carrier or plan name \_\_\_\_\_ Group

# Doctor name \_\_\_\_\_ Phone number \_\_\_\_\_ Carrier address

City/State/Zip \_\_\_\_\_ Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

The following questions are asked so that we may best serve your child in programs.

Any information that you choose to disclose is confidential.

While in program, are there any health conditions that you would like us to be aware of?

No  Yes, \_\_\_\_\_

While in program, will your child need to take medication?

No  Yes, \_\_\_\_\_

While in program, are there allergies that we should be aware of?

No  Yes, \_\_\_\_\_

Allergic reaction (describe) \_\_\_\_\_

Treatment \_\_\_\_\_

Does your child require a modification, due to disability, in order to participate?

No  Yes If you have any questions, please contact [inclusion@ymcachicago.org](mailto:inclusion@ymcachicago.org)

Are there activities that your child should be exempt from due to health reasons? \_\_\_\_\_

Are all immunizations up to date?

No (please provide exemption letter)  Yes Date of last Tetanus \_\_\_\_\_

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### MEDICAL RELEASE:

I do hereby give permission for the YMCA of Metropolitan Chicago staff to transfer child named above off property for the purpose of medical care as deemed appropriate by the Director and in the event that I cannot be reached in an EMERGENCY, I hereby give my permission to the physician selected by the Director, to hospitalize, to secure proper treatment for and to order injection, anesthesia or surgery for my child as named above. Initials \_\_\_\_\_

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Please describe your child's interactions with children of the same age \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_

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### SWIMMING ABILITY

Non Swimmer  Fair Swimmer  Good Swimmer

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Does your child have any fears that we should be aware of? \_\_\_\_\_

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Is there any other information that you would like to share so that we may better understand and work with your child? \_\_\_\_\_

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### YMCA PARENT HANDBOOK

I/We have read and understand and adhere to the policies and procedures set forth in the Parent Handbook.

Initials \_\_\_\_\_

### YMCA CHARACTER PLEDGE

My child and I have read and understand the character pledge found in the Parent Handbook.

Initials \_\_\_\_\_

# TALENT RELEASE FORM

In consideration of my participation in activities to be conducted and/or sponsored by the YMCA, the receipt and sufficiency of which is hereby acknowledged, I hereby freely and without restraint consent to and grant the YMCA of Metropolitan Chicago and its agents, successors, licensees, assigns, and affiliated entities (collectively, the "YMCA") the right to publish, print, photograph, videotape, record or otherwise reproduce my voice, appearance, opinions, statements, biographical information, name, place of residence (city and state) and other personal information concerning me, to own all the results thereof as a work for hire for copyright purposes, and to exhibit, display distribute, transmit and/or otherwise exploit any and all such reproductions containing my voice, opinions, statements, appearance, and/or other contributions, altered as the YMCA may see fit, in any and all media now or hereafter known, including without limitation by means of internet, email, still photography, billboard, radio, television, video, soundtrack recordings, printing, merchandising, public displays, exhibitions, and in advertising and/or publicity in connection therewith, and the right to use my name, city and state of residence in any connection with any of the foregoing. The rights granted by me hereunder are granted for the entire universe and shall inure in perpetuity and no further compensation shall be payable to me at any time in connection there with.

I hereby release the YMCA from any and all claims and demands arising out of or in connection with the uses stated above, including without limitation any and all claims for libel, slander, invasion of privacy, infringement of my right of publicity, defamation, copyright or trademark violation, and any other personal and/or proprietary rights, and I agree that I shall not now or in the future assert or maintain any such claim against the YMCA with respect to the subject matter herein. The release shall be governed by Illinois law without regard to its conflict of laws principles.

SIGNATURE OF PARENT/LEGAL GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

## FACILITY USER/FIELD TRIP AGREEMENT:

I agree to follow all rules and regulations of the YMCA of Metropolitan Chicago ("YMCA") while in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, and understand and agree that I may be expelled at any time, with no refund of any monies paid, for failure to abide by such rules and regulations.

IN CONSIDERATION OF BEING PERMITTED TO UTILIZE THE FACILITIES, SERVICES AND PROGRAMS OF THE YMCA FOR ANY PURPOSE, INCLUDING BUT NO LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT OR PARTICIPATION IN ANY PROGRAM AFFILIATED WITH THE YMCA WITHOUT RESPECT AS TO LOCATION, I HEREBY AGREE TO THE FOLLOWING:

1. I UNDERSTAND THAT ACTIVITIES AT THE FACILITY OR ELSEWHERE, INCLUDING USE OF EQUIPMENT AND PARTICIPATION IN PROGRAMS, CAN INVOLVE MOVEMENT, STRAIN AND OTHER ELEMENTS THAT CREATE RISK OF SERIOUS INJURY OR DEATH. I HEREBY ASSUME FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE OR LOSS, regardless of severity, that I or my minor child/ward may sustain from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any Facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, or while being transported to and from field trip locations outside the YMCA premises, except for any injury damage or loss that is caused solely by the YMCA's gross negligence.

2. I, FOR MYSELF, ANY PERSONAL REPRESENTATIVES, ASSIGNS, HEIRS AND NEXT OF KIN, HEREBY FULLY RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE the YMCA or Metropolitan Chicago, its operating centers, their respective officers, directors, Board of Managers, Trustees, members, volunteers, employees or agents (the "Releasees") and each of them from any and all claims for injuries, damage or loss that I or my minor child/ward may incur whether in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA premises, except for any injury, damage or loss that is caused solely by the YMCA's gross negligence.

3. I HEREBY AGREE TO INDEMNIFY AND HOLD HARMLESS the Releasees and each of them from any loss, liability, damage or cost they may incur from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the YMCA without respect as to location, or while being transported to and from field trip locations outside the YMCA premises, except for any loss, liability, damage or cost that is caused by the YMCA's gross negligence.

I further expressly agree that this Agreement is intended to be as broad and inclusive as is permitted by the law of the State of Illinois and if any portion thereof is held invalid, it is agreed that the remaining Agreement shall, notwithstanding, continue in full legal force and effect.

THIS AGREEMENT APPLIES TO ALL PAST, PRESENT AND FUTURE VISITS AND USES BY ME TO ANY YMCA FACILITY OR PROPERTY.

I HAVE READ AND VOLUNTARILY SIGNED THIS FACILITY USE/FIELD TRIP AGREEMENT, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE AGREEMENT. THIS AGREEMENT CONTAINS A WAIVER AND RELEASE.

Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed name of Parent/Legal Guardian \_\_\_\_\_

## AUTHORIZATION FOR SUNSCREEN

By signing this form, I acknowledge that I will sufficiently apply sunscreen to all of my child's exposed skin, and agree that YMCA of Metropolitan Chicago Staff may reapply the sunscreen that I provide, labeled with my child's name.

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Daytime phone number: \_\_\_\_\_



**State of Illinois**  
**Certificate of Child Health Examination**

FOR USE IN DCFS LICENSED  
CHILD CARE FACILITIES  
CFS 800  
Rev 11/2013



Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle		Month/Day/Year			
Address				Parent/Guardian	Telephone #	Home	Work
Street	City	Zip Code					

**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)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		
MMR Combined Measles Mumps Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps											
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

COMMENTS:

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
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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	
Vision																	
Hearing																	

Code:

P = Pass

F = Fail

U = Unable to test

R = Referred

G/C = Glasses/Contacts

<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
Last	First	Middle	Month/Day/Year			

**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES</b> (Food, drug, insect, other)			<b>MEDICATION</b> (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during the night	Yes	No	Hospitalizations? When? What for?	Yes	No	
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No	
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No	
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No	
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No	
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No	
Heart murmur/High blood pressure?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> •Bridge <input type="checkbox"/> •Plate <input type="checkbox"/> Other			
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.			
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			<b>Parent/Guardian</b>			
Ear/Hearing problems?	Yes	No	<b>Signature</b>	<b>Date</b>		
Bone/Joint problem/injury/scoliosis?	Yes	No				

**PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA**

<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>LEAD RISK QUESTIONNAIRE</b> 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 <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> (Blood test required if resides in Chicago.)				
<b>TB SKIN OR BLOOD TEST</b> 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. <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test:</b> Date Read / / <b>Result:</b> Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ <b>Blood Test:</b> Date Reported / / <b>Result:</b> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____				

<b>LAB TESTS (Recommended)</b>	<b>Date</b>	<b>Results</b>	<b>Date</b>	<b>Results</b>
Hemoglobin or Hematocrit			Sickle Cell (when indicated)	
Urinalysis			Developmental Screening Tool	

<b>SYSTEM REVIEW</b>	<b>Normal</b>	<b>Comments/Follow-up/Needs</b>	<b>Normal</b>	<b>Comments/Follow-up/Needs</b>
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Antagonist ) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

<b>NEEDS/MODIFICATIONS</b> required in the school setting	<b>DIETARY</b> Needs/Restrictions
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**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)