



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of Metro Chicago DROP IN CHILDCARE REGISTRATION

PARTICIPANT INFORMATION PLEASE PRINT

First _____ Preferred Name _____ M.I. ____ Last _____
Birthdate ____ / ____ / ____ Gender _____ YMCA Center/Site: _____

CONTACT INFORMATION

Parent/Guardian 1

First _____ M.I. ____ Last _____
Address _____ City _____ State _____ Zip _____
Phone _____ Work Phone _____
Email _____ Date of Birth: ____ / ____ / ____

Parent/Guardian 2

First _____ M.I. ____ Last _____
Address _____ City _____ State _____ Zip _____
Phone _____ Work Phone _____
Email _____ Date of Birth: ____ / ____ / ____

The YMCA of Metropolitan Chicago invites persons with disabilities to participate in its programs and facilities.

Do you need a modification, due to disability, in order to participate in this program? Yes No inclusion@ymcachicago.org

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

Any information that you choose to disclose is confidential.

Are all immunizations up to date? _____ No (please provide exemption letter) _____ Yes _____ Date of last tetanus

While in program, are there allergies that we should be aware of? _____ No _____ Yes

Allergic reaction (describe) _____

Treatment _____

Are there activities that should be limited due to health reasons? _____

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, or his/her designate "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.

Parent/Guardian Signature _____ Date _____