Ann Arbor YMCA
PERMISSION & HEALTH FORM

Last Name: _____ **First Name:** _____

Date of Birth: _____/_____/_____

■ SECTION 1: CONTACT INFORMATION

Primary Parent or Guardian: _____

Home Address: _____

Home Phone: _____ Work or Cell Phone: _____

Employer/School Name: _____

Employer Address: _____

Employer/School Phone: _____ Daily Work/School Times: _____

Secondary Parent or Guardian: _____

Home Address: _____

Home Phone: _____ Work or Cell Phone: _____

Employer/School Name: _____

Employer Address: _____

Employer/School Phone: _____ Daily Work/School Times: _____

If not available in an emergency, notify:

Name: _____

Relationship: _____

Home Phone: _____ Work or Cell Phone: _____

Address: _____

■ SECTION 2: AUTHORIZATIONS (MUST BE COMPLETE TO PARTICIPATE)

FIELD TRIP PERMISSION: I give permission for my child _____, to to go on any field trips supervised by the Ann Arbor YMCA Staff. I understand that many trips consist of short walks to nearby locations. I understand further that I will be notified in advance about any longer trips and that, if any vehicle is used to transport my child, each child will be required to wear a seat belt or be placed in a car seat that I would provide.

Parent/Guardian Signature _____ Date _____

PHOTOGRAPHY AND RECORDING PERMISSION: I hereby irrevocably release, consent and allow the Ann Arbor YMCA and its agents to use and reproduce any and all photographs or video footage taken of me or my dependent(s) for Ann Arbor YMCA purposes. I understand that I/my dependent(s) receive no reimbursement for allowing my photo to be taken or for the use of the photo or video.

Parent/Guardian Signature _____ Date _____

LIABILITY: I understand the physical activities which my child may participate in at the YMCA include, but may not be limited to: swimming, mountain biking, and playing sport agree to assume all liability and release the YMCA from any liability for the risk of injury, illness or death on account of my child's presence in a YMCA facility or on account of my child's involvement in any activity at a YMCA facility whether caused by negligence of the YMCA or another person on the premises or at the sponsored activity.

Parent/Guardian Signature _____ Date _____

SWIMMING: I give permission for my child _____, to swim during planned trips to the pool. A lifeguard will always be present when my child swims during a YMCA program.

Parent/Guardian Signature _____ Date _____

SUNSCREEN/BUG SPRAY: My child (circle one) **SHOULD** **SHOULD NOT** wear sunscreen while being outdoors. Please apply first application at home. Sunscreen should be supplied by you, the parent. I understand that selecting "should" allows staff to apply sunscreen to my child. Special arrangements for consistent application can be made with the staff.

My child (circle one) **SHOULD** **SHOULD NOT** wear bug spray while being outdoors. Please apply first application at home. Bug spray should be supplied by you, the parent. I understand that selecting "should" allows staff to apply bug spray to my child. Special arrangements for consistent application can be made with the staff.

Parent/Guardian Signature _____ Date _____

PHYSICAL HEALTH: I hereby attest that my child _____, is in good health. Further more any activity restrictions, allergies, medications taken by the child, or any other needs are listed in the Health Information Form. Immunization records or appropriate waivers are up to date and on file with my child's school.

Parent/Guardian Signature _____ Date _____

PARENT PLANNER ACKNOWLEDGMENT: I have read and understand in full the content of the Parent Planner. Furthermore I agree to follow the policies and guidelines covered in the planner.

Parent/Guardian Signature _____ Date _____

■ SECTION 3: PARTICIPANT RELEASE FORM

The participant may be picked up from Ann Arbor YMCA Programs by the following person(s):

❑ Mother(s) and/or Father(s) ❑ Mother only ❑ Father only

OR, Ann Arbor YMCA has my permission to release the above named participant to the following people:

Name	**Relationship**	**Phone Number**

Parent/Guardian Signature _____ Date _____

Ann Arbor YMCA
PERMISSION & HEALTH FORM

Last Name: _____ **First Name:**_____

Date of Birth: ____/____/____

■ SECTION 4: PERMISSION TO TREAT (Required for Participation)

I give permission to the Ann Arbor YMCA, licensed by the Department of Human Services, to provide routine health care, dispense medications and secure emergency medical and/or emergency surgical treatment to my child while in care.

Parent/Guardian Signature_____ Date _____

■ SECTION 5: MEDICATION (All medications must be sent to camp in original containers)

❑ The participant does not take any medications on a routine basis **OR**

❑ The participant takes the following **routine medications** (including over-the-counter/non-prescription medications):

Name of Medication	Strength (e.g. "100 mg")	Dosage (e.g. "12 pills")	Time of day (e.g. "before dinner")	Prescribing Physician	Reason for Taking	Other Instructions

❑ The participant takes the following medications **AS NEEDED** (includes inhalers, epi-pens, oral medications, topical medications or skin medications)

Name of Medication	Strength (e.g. "100 mg")	Dosage (e.g. "12 pills")	Time of day (e.g. "before dinner")	Prescribing Physician	Reason for Taking	Other Instructions

■ SECTION 6: ALLERGIES/DIETARY RESTRICTIONS (To medicine, food, insect stings or bites, etc.)

❑ The participant does not have any known allergies **OR**

❑ The participant has the following known allergies (peanut, seafood, bee stings, etc.): ❑ **IF APPLICABLE, PLEASE ATTACH COPY OF ALLERGY PLAN**

Allergy	Reaction	Management of Reaction

■ SECTION 7: PARTICIPANT'S HEALTH CARE PROVIDERS

Preferred Hospital in event of Emergency:_____

Primary Physician or Health Clinic: _____ Phone: _____

Address: _____ Health Insurance Carrier: _____ Policy #:_____

■ SECTION 8: HOSPITALIZATION/SURGERY HISTORY

Has the participant ever been hospitalized overnight, had any serious injuries (including sports-related injuries) or had any type of surgery?

❑ No ❑ Yes – Please explain below

Age **Problem/Type of Surgery**

_____ _____

_____ _____

■ SECTION 9: GENERAL HEALTH HISTORY (Please attach a copy of Immunization Record – REQUIRED)

Please check below if the participant has or has had any of the following medical problems:

❑ Asthma	❑ Eating Disorder	❑ Depression	❑ Scoliosis	❑ Diarrhea/Constipation
❑ High Blood Pressure	❑ Seizures/Epilepsy	❑ Sleep Problems	❑ Hernia	❑ Head Injury
❑ Headaches	❑ Bladder/Kidney Infection	❑ Hay Fever/Allergies	❑ Mononucleosis	❑ Anemia
❑ Diabetes	❑ Heart Problems	❑ Vision or Hearing Problems	❑ Back Problems	❑ Heat Illness

❑ Chicken Pox (age: ___)	❑ Sickle Cell Anemia or Trait	❑ Abnormal/painful menses	❑ Passed out during or after exercise
❑ Bleeding or Clotting Disorder	❑ Anaphylactic Reaction	❑ ADD/ADHD/Learning Disorder	❑ Chest pain during or after exercise

❑ Skin problems (circle any that apply): rash eczema blisters itch acne infection warts scabs fungal

❑ Other: _____

Please explain any special conditions/activity restrictions: _____

_____

❑ **IF APPLICABLE, PLEASE ATTACH COPY OF ASTHMA PLAN**