

Camp Arrowhead 2021

Paperwork Checklist

*One Packet per Child Filled Out Yearly

- Health Enrollment Form

- Administration of Medication
 - If applicable, if not needed put N/A

- Child Medical/Physical Care Plan
 - If applicable, if not needed put N/A

- General Permission

- Permission to Pick-Up

- Routine Trip Permission

- Permission to Participate in Swimming

- Rockwall Release

- Current Picture of Participating Child

All of these forms must be turned in yearly to hold your spot for Camp Arrowhead.

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth	First Day at Program/Home	
Home Address			City	
State	Zip Code	Home Telephone Number		
Parent/Guardian Name			Relationship to Child	
Home Address			Home Telephone Number	
City			State	Zip
Email Address (if applicable)		Cell Phone		
Parent's Work/School Telephone Number		Parent's Work/School Name		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email				
Where can you be reached while your child is in this program/home?				
Parent/Guardian Name			Relationship to Child	
Home Address			Home Telephone Number	
City			State	Zip
Email Address (if applicable)		Cell Phone		
Parent's Work/School Telephone Number		Parent's Work/School Name		
Parent's Work/School Address			City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email				
Where can you be reached while your child is in this program/home?				
Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.				
Name		Name		
City	State	City	State	
Telephone Number	Relationship to Child		Telephone Number	Relationship to Child
Other numbers where emergency contact can be reached (if applicable)		Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital				
Street Address				
City	State	Telephone Number		

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or family child care home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

- No
 Yes - check all that apply Food Medication Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

- No
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

- No
 Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

- No
 Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

- No
 Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

- No
 Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.
 N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

- No
 Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

- No
 Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."
 N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> No (If no, fill out the following)
The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

<u>Give <i>Permission</i> to Transport</u>	OR	<u>Do Not Give <i>Permission</i> to Transport</u>
Program or Home Name Lakota Family YMCA	Do not sign both	Program or Home Name Lakota Family YMCA
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature _____ Date _____		Parent's Signature _____ Date _____

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services
**REQUEST FOR ADMINISTRATION OF MEDICATION
 FOR CHILD CARE**

Box 1	The following section must always be completed by the parent/guardian.	
Check all that apply and complete all of the information.		
<input type="checkbox"/> Prescription Medication <input type="checkbox"/> Nonprescription Medication <input type="checkbox"/> Food Supplement		
<input type="checkbox"/> Topical Product or Lotion <input type="checkbox"/> Refrigeration Required <input type="checkbox"/> Modified Diet		
Name of Child		Date of Birth Weight
Name of Medication		Exact Dosage
To be administered at the following times		For the following period of time
<input type="checkbox"/> I understand that my child must receive one dose of medication before arriving at the program (unless the medication is used for emergencies).		
Signature of Parent/Guardian		Date
Box 2	The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant.	
1. The medication contains codeine or aspirin. 2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions). 3. It is a sample medication without a prescription label. 4. The nonprescription medication is to be given longer than three consecutive days within a fourteen day period. 5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.		
Name of child		Name of medication, vitamin, diet, supplement
Dosage		Possible side effects to watch for are
Expiration date (May not exceed twelve months from the date of this request for medications of food supplements).		
Instructions		
This child is under my care and should receive the above medication as written.		
Signature of physician, dentist, advanced practice registered nurse or certified physician's assistant		
Date of signature		Phone number
Name of child		Name of medication, vitamin, diet, supplement

This form is valid for no longer than twelve months and must be kept on file at the center or home for at least one year following the last administration of the medication or product. One form must be used for each medication.

Ohio Department of Job and Family Services
**CHILD MEDICAL/PHYSICAL CARE PLAN
 FOR CHILD CARE**

Child's Name		Date of Birth	
Special Health Conditions			
Symptoms to watch for and emergency action to be taken if the following symptoms occur			
Activities/foods/environmental conditions to avoid, if applicable			
Medical procedures to be followed and expected benefit of treatment, if applicable			
Are any medications required? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, complete JFS 0 1217 "Request for Administration of Medication")</i> If yes, what medications?			
In an emergency does this child require additional assistance (more than other children of the same age or in the same group) to evacuate? <input type="checkbox"/> Yes <input type="checkbox"/> No			
In the event that the child care program must be evacuated, are there medications or supplies that must be taken with this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Training Instructions <i>(Trainer must be a parent or certified professional)</i>			
Signature of Trainer		Date	
Signature of trained providers, substitutes or child care staff members who have been made aware of the condition. <i>(There must always be a trained caregiver present when the child is present)</i>			
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
Signature	Date	I have been <input type="checkbox"/> Informed	I have been <input type="checkbox"/> Trained
<i>(Only trained providers, substitutes or child care staff members shall be permitted to perform medical procedures listed above.)</i>			
Additional services (educational/therapeutic) child is receiving			
Who provides the above services?			
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Phone Number	May we contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	

I give my permission for the staff listed above to perform the procedures in my child's Medical/Physical Care Plan.

Parent Signature	Date
Administrator/Provider Signature	Date

Note: A separate plan must be written for each condition that requires different actions to be taken



LAKOTA FAMILY YMCA

CHILD CARE GENERAL PERMISSION FORM

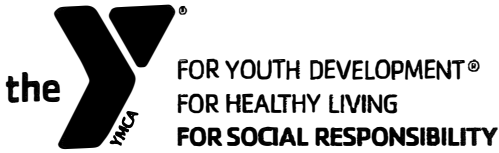
- I hereby grant permission for my child to use all indoor/outdoor play equipment and participate in all the activities at the center.
- I hereby grant permission for my child to be included in pictures, media print, electronic media and evaluations connected with any of the child care programs.
- I hereby grant permission for my child to participate in field trips taken by the center. Prior information will be given to the parent/guardian about the trip.
- I hereby grant permission for the School Age Child Care Director, Site Administrator, or Camp Arrowhead Directors to take whatever steps that may be necessary to obtain emergency medical/dental care if warranted as stated on the Health Enrollment Form.
- I understand that all expenses incurred in obtaining medical/dental treatment are my responsibility and not the Lakota Family YMCA's.
- I understand that the Lakota Family YMCA is not responsible for anything that happens as a result of false information given by the parent/guardian at the time of enrollment.
- I understand the Lakota Family YMCA will not assume responsibility for a child who has not been signed in upon arrival or signed out when they depart for the day. I understand that the person dropping off and/or picking up must be 16 years of age or older.

Child's Name _____

Signature of
Mother/Legal Guardian _____

Signature of
Father/Legal Guardian _____

Date _____



LAKOTA FAMILY YMCA

CHILD CARE PERMISSION TO PICK UP FORM

I give my permission for the following people to pick up my child, _____ from the Lakota Family YMCA Child Care Programs. I understand that the person picking up my child must be 16 years of age or older. They may also be asked for identification when picking up your child.

NAME	RELATIONSHIP TO CHILD	PHONE #

Parent/Guardian Signature _____
Date _____

- Please Note:
- Please let us know if there is a custody issue
 - Please let us know right away if there are changes to the above list
 - Please let us know if there is someone who may not pick up your child

Ohio Department of Job and Family Services
ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information	
Routine Trip Destination(s) Liberty Park, behind Lakota Family YMCA	
Date of Permission (<i>valid for one year</i>) 5/1/2021	
Mode of Transportation (<i>walking, school bus, public transportation, parent vehicles, provider vehicle and driver</i>) Walking	
During this trip children will have access to water that is 18 inches or more in depth. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are water activities planned in water that is 18 inches or more in depth? (if yes, a swimming permission slip is required) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Child's Information	
Child's Name	
My child is <input type="checkbox"/> not over 4 years and/or 40 lbs <input type="checkbox"/> over 4 years and 40 lbs <input type="checkbox"/> 8 years and/or over 4' 9"	
Signature	
I grant permission for my child to participate in the routine trips described above.	
Parent's Signature	Date

Ohio Department of Job and Family Services
**PERMISSION TO PARTICIPATE IN SWIMMING ACTIVITIES
 FOR CHILD CARE**

Written parental permission is required for the water activities your child will be engaging in (check all that apply for this activity)	
<input checked="" type="checkbox"/> Child swimming in water 18 inches or more in depth <input checked="" type="checkbox"/> Child participating in activities near water 18 inches or more in depth (no water activities planned) <input type="checkbox"/> Infants and toddlers using wading pools	
I give permission for my child to participate in the following swimming/water activities	
Swim Site Lakota Family YMCA- Indoor/outdoor Pools	
Date(s) May 1, 2021 - May 1, 2022	
Departure/Arrival Times from Center Varies	
Mode of Transportation (parent's driving, provider vehicle, public transportation, school bus, etc.) Walking	
Child's Name	Child's Date of Birth
My child is a <input type="checkbox"/> Swimmer <input type="checkbox"/> Non swimmer	
Parent's Signature	Date



LAKOTA FAMILY YMCA CLIMBING WALL RELEASE

ACKNOWLEDGMENT, WAIVER & RELEASE FROM LIABILITY AGREEMENT

Notice: This document is a legally binding agreement. By signing this agreement, you are acknowledging that you have read, understood and accepted the terms and conditions stated in this agreement. You further acknowledge and agree that you are waiving your rights to bring court action to recover compensation or obtain any other remedy for any injury to yourself or your property.

Acknowledgment: I acknowledge that there are significant elements of risk associated with the sport of rock climbing, bouldering and incidental weight training, team building and fitness training regimens. I further acknowledge the nature and extent of the risks inherent in rock climbing and the use of the Lakota YMCA facilities, including, but not limited to:

- Injuries resulting from falling and crashing into walls, rocks or other obstacles, whether such walls, rocks or other obstacles whether such walls, rocks or other obstacles are permanent or temporary;
- Injuries resulting from rope abrasion, entanglement and other injuries that may result from activities or other persons, including, but not limited to, climbing, belaying, rappelling, lowering on rope, rescue or emergency activities, as well injuries, abrasions or cuts resulting from contact with climbing walls, holds or equipment;
- Injuries resulting from falling climbers or falling or dropped items, including, but not limited to, ropes, holds, or climbing hardware;
- Injuries resulting from any equipment failures, including, but not limited to, failures of ropes, slings, climbing harnesses, anchor points, or any part of the climbing structure;
- Injuries or death resulting from not following proper and customary personal safety procedures and the Safety Policies and Procedures of the Lakota YMCA which form a part of this agreement;
- Injuries resulting from the negligence of other climbers, participants, or users of the facilities, including, but not limited to, belayers or spotters;
- Injuries resulting personal physical and mental limits, including, but not limited to, fatigue, chill or dizziness, which may diminish reaction time and increase risk of accident, personal strength, coordination, sense of balance, and ability to follow or give directions while climbing, belaying, lifting, spotting, or being a spectator.

I acknowledge that the above list is not inclusive of all possible risk associated with the use of the Lakota YMCA facility, and that other unknown and unanticipated risk may result in injury, illness, or death.

Release, Assumption of Risk and Responsibility: In consideration of, and in recognition of the inherent risks of the activity associated with the use of the Lakota YMCA facility, I and/or on behalf of any minor children for which I am responsible for, agree, on behalf of myself, my/our heirs, representatives, successors, executors, administrators and assigns, to hereby release, waive, discharge and agree not to sue the Lakota YMCA, its officers, directors, shareholders, agents and employees, from any and all claims or demands, obligations and/or causes of action of any nature whatsoever which I may have against the Lakota YMCA, its officers, directors, shareholders, agents or employees, on account of any personal injury, property damage, death or accident of any kind, arising out of or in any way connected with the use of the Lakota YMCA facility or equipment, whether my/our use is supervised or unsupervised and I/we agree to indemnify and hold harmless the persons or entities mentioned in this paragraph from any and all liabilities or claims made by other individuals or entities as a result of my/our actions.

- I further certify, acknowledge and agree on behalf of myself and/or any minor children for which I am responsible, that:
- I am (we are) physically and mentally capable of participation in the activity and/or use the equipment;
- I/ we assume responsibility for and voluntarily assume risk for any personal injury, death and related expenses involved in this activity;
- I/we assume responsibility for damage to my/our personal property; and
- I/we assume the risks for accidents or injury caused by the negligence of my/our belayer or spotter.

I further acknowledge on behalf of myself and on behalf of any minor for which I am responsible, that wearing appropriate clothing and footwear are basic safety precautions, and that wearing a UIAA approved helmet may help prevent head and or neck injuries.

Medical Authorization: I agree, on behalf of myself and on behalf of any minor children for which I am responsible, to authorize any medical treatment deemed necessary in the event of any injury or illness while participating in the use of the Lakota YMCA facility and/or its' equipment. I agree, on behalf of myself or on behalf of any minor children for which I am responsible, to pay all costs of any rescue and/or medical services as may be incurred on my/our behalf.

Promotional Authorization: I agree, on behalf of myself and on behalf of any minor children for which I am responsible, that any film or photographs of me/us, as users if the Lakota YMCA facility, become the property of the Lakota YMCA and may be used for promotional or commercial purposes.

IN WITNESS WHEREOF, I have signed this agreement in Middletown, Ohio this _____ day of _____ 2020.

User _____ Printed Name _____ Date of Birth _____

I, as parent, guardian or responsible party of the above-named minor child under the age of 18 years, hereby acknowledge reading, understanding and agreeing to the terms and conditions of this agreement.

Parent/Guardian/Responsible Party Signature _____ Printed Name _____

Safety Policies and Procedures of the Lakota YMCA

The following are the Safety Policies and Procedures of the Lakota YMCA. They are not all inclusive and the user of the Lakota YMCA facility recognized that they have responsibility to conduct themselves and any and all persons under their control or supervision, including minor children, in a proper, courteous and safe manner during all times they are on the Lakota YMCA property.

In consideration for the use of the Lakota YMCA facility and equipment, you agree to accept full responsibility for your own safety and the safety of others while on the premises and to abide by and help enforce the following Safety Policies and Procedures.

All persons using or being a spectator of the Lakota YMCA facility shall have signed an Acknowledgement Waiver & Release from Liability Agreement, and if requested to gain access to the facility, present a photo identification.

Each new user of the facility shall be required to demonstrate safe belaying and tie-in techniques to an authorized instructor of the Lakota YMCA. Only approved climbers/spectators will be allowed in the climbing area. New belayers shall take a training session and be qualified by an authorized instructor of the Lakota YMCA before receiving approval for climbing.

No un-belayed climbing over ten (10) feet the landing zone shall be permitted. Failure to strictly comply with this Policy may result in immediate expulsion from the facility and withdrawal of any future climbing privileges.

Climbing above the ten (10) feet restriction over the landing zone shall be roped and belayed using an approved belay device. All rope climbers and belayers shall wear approved harnesses.

Climbers must tie the rope directly into the two parts of their harness (not their belay loop) with a figure eight (8) retrace knot.

Helmets are required for all climbers, unless a helmet Waiver is signed.

Lead climbers and their belayers both demonstrate the proper understanding of leading and belaying techniques to an authorized instructor of the Lakota YMCA before using the lead route wall.

All users of the Lakota YMCA facility have an affirmative duty to inform employees of the Lakota YMCA as well as fellow climbers/belayers and any situation seen as unsafe or not in compliance with these Safety Policies and Procedures. All climbers are requested to assist and encourage less experienced climbers.

All accidents or equipment damage or failures shall be reported to an employee of the Lakota YMCA immediately.

The Lakota YMCA reserves the right to deny access to its facilities to any person, permanently or for a specific period of time, for any breach of this agreement or failure to strictly adhere to the Safety Policies and Procedures, or for any conduct that is viewed as unsafe, inappropriate or unhealthy including, but not limited to, horseplay, foul or rude language or defiance of a Lakota YMCA employee's request.

The Lakota YMCA is a Drug, Tobacco, and Alcohol-Free Zone for all persons.

I have read, and understood and agreed, on behalf of myself and/or on behalf of any minor children I am responsible for, to the above Safety Policies and Procedures.

Signature _____

Printed Name _____ Date _____

Helmet Waiver

I agree, on behalf of myself and/or on behalf of any minor children for which I am responsible for, that there are inherent dangers involved with climbing activities and that I/we assume all risks associated with such activities. I/we realize that I/we are subject to injury from this activity. I/we further understand that the Lakota YMCA Safety Policies and Procedures require the use of and wearing of safety protective helmets, which could prevent injury to my/our head, including, but not limited to, permanent brain damage. Against the advice of the Lakota YMCA, and its insurance company, I/w am refusing this critical safety precaution and hereby waive and release the Lakota YMCA its officers, directors, shareholders, employees and agents from any and all liability associated with my voluntary refusal to wear a safety helmet.

Signature _____

Printed Name _____ Date _____

Belay Check

Pass Top Rope

Pass Lead

Date: _____

Date: _____

Instructor: _____

Instructor: _____

Instructor Signature

Instructor Signature