the YMCA
FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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ENRICHING KIDS INSIDE & OUT

Fit Kids After School Care 2022-2023
MARSHALLTOWN YMCA-YWCA

Fit Kids is available to all students in grades K-6. Transportation provided for students in Marshalltown and St. Francis School Districts only.

WHEN: After School, Aug 23-June 1

TIME: Monday-Friday
3:30-5:30 p.m.

LOCATION: Marshalltown YMCA-YWCA
Cultural Center
108 Washington St.
Marshalltown, IA 50158
Daisy Lopez
(daisy.lopez@ymca-ywca.org)
Brittany Wagner
(brittany.wagner@ymca-ywca.org)
Ashley Nelson
(ashley.nelson@ymca-ywca.org)

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REGISTRATION PACKET FOR FIT KIDS

This packet must be completed entirely before registering for Fit Kids After School Care. Please return the following items before attending the Fit Kids program.

◇ Completed Parental Emergency Medical Consent

◇ Completed School-age Assessment and Health Form

◇ Attached a copy of current immunization record, this must have a physician signature and cannot be the MyChart print out

◇ Permissions form

◇ Completed payment information and child's regular attendance schedule

◇ **NEW THIS YEAR**:
Registration must be done by WEDNESDAY for the following week. Payment will be based on what is registered for, and not based on attendance. Showing up on a day not registered for will result in a $10 drop-in fee in addition to the normal daily rate. If arriving at the building by bus, daily attendance will be counted. On school closure days due to weather, parents must establish contact through the Remind App or email, informing attendance within one hour of the school announcement. There must be 10 registered children to run no school or weather closure days. If arrival is outside of the one hour notification timeframe the $10 fee for drop-in care as well as the daily rate will be charged.

Daisy Lopez - Fit Kids Coordinator (daisy.lopez@ymca-ywca.org)

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Dates Fit Kids After School Care Is Closed
August 22
September 5
November 24 & 25
December 26
January 2
May 29

Parent Signature _____ Date _____

Daisy Lopez - Fit Kids Coordinator
(Daisy.lopez@ymca-ywca.org)
Brittany Wagner - Assistant Youth Director
(Brittany.wagner@ymca-ywca.org)
Ashley Nelson - Youth Director
(Ashley.nelson@ymca-ywca.org)

PARENTAL EMERGENCY MEDICAL CONSENT
This form must be presented upon admission for treatment

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.

I agree to pay all costs and fees as secured or authorized under this consent.

CHILD'S NAME:		**BIRTH DATE:**
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES		
1. NAME		RELATIONSHIP TO CHILD
ADDRESS		EMPLOYER
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME		RELATIONSHIP TO CHILD
ADDRESS		EMPLOYER
HOME NUMBER	CELL NUMBER	WORK NUMBER
EMERGENCY CONTACT PERSON(S)		
1. NAME		RELATIONSHIP TO CHILD
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME		RELATIONSHIP TO CHILD
HOME NUMBER	CELL NUMBER	WORK NUMBER
3. NAME		RELATIONSHIP TO CHILD
HOME NUMBER	CELL NUMBER	WORK NUMBER

PERSONS AUTHORIZED TO PICK UP CHILD	**ADDRESS**	**PHONE NUMBER**
1.		
2.		
3.		

Are there any custody or restraining orders for person(s) who may attempt to pick up or have contact with the child while in care at the center?

Name	**Name**

PHYSICIAN NAME	**DENTIST NAME:**
PHONE NUMBER	PHONE NUMBER
ADDRESS	ADDRESS
HOSPITAL PREFERENCE: UNITY POINT, NEAREST or Other (please specify)	
KNOWN ALLERGIES	DATE OF LAST TETANUS
PRESENT MEDICATION	
INSURANCE COMPANY	POLICY HOLDER ID

This consent will be in effect beginning (date)		**and be updated annually by the parent/legal guardian.**

SIGNATURE OF PARENT OR GUARDIAN	**DATE**		**SIGNATURE OF PARENT OR GUARDIAN**	**DATE**
UPDATE	**DATE**		**UPDATE**	**DATE**
UPDATE	**DATE**		**UPDATE**	**DATE**

SCHOOL-AGE ASSESSMENT & HEALTH FORM

1. **HEALTH STATEMENT** - To be completed by parent.

_____

Child's Full Name Birth Date

1. Significant illnesses and surgeries child has had (give age at time):

_____

_____

2. Any special health-related needs of child (allergies, medications, injuries, etc.):

_____

_____

2. **PHYSICAL ASSESSMENT** - To be completed by parent.

1. Is there any defect of vision, hearing or speech of which the child care program should be aware, or could compensate by appropriate action?

_____

_____

2. Is this child subject to any conditions which limit classroom activities or physical education?

_____

_____

3. Is this child subject to any condition which may result in an emergency situation?

_____

_____

4. Is this child subject to any mental or physical condition for which he/she should remain under periodic medical observation?

_____

_____

5. Other information you would like to share to better serve your child (IEP or behavior plan):

_____

_____

_____

_____

_____

_____

_____

_____

Parent's Signature_____ Date _____

SCHEDULE AND PAYMENT OPTIONS

Fees for Y members: $8 daily

Fees for Program Participants: $11 daily

This page must be completed to fully register for Fit Kids. Payments must be scheduled to draft weekly on Saturdays from a checking, savings or credit card account. Registration must be done and any changes to weekly schedule by the Wednesday the week before attending to avoid the $10 drop in fee. Payments are based on registered days and not on attendance.

Please indicate below your child's attendance schedule.

Child's Name_____ DOB_____

School attending_____ Grade_____

One week notice is required if permanent changes need to be made to this schedule.

Attendance schedule: (Circle all that apply)

Monday Tuesday Wednesday Thursday Friday OR Weekly M-F

All payments are drafted weekly on Saturdays. Please choose a payment method below.

CREDIT OR DEBIT CARD

Name on Card:_____

Credit/Debit Card Number_____

Type of Card: (Please circle one) Visa MasterCard Discover Expiration Date_____

CHECKING OR SAVINGS ACCOUNT

Name on Account:_____

Type of Account: (Please circle one) Checking Account Savings Account

Routing Number_____

Account Number_____

PLEASE ATTACH A COPY OF CREDIT/DEBIT CARD OR CHECK

I hereby authorize the Marshalltown YMCA-YWCA to charge my credit/debit card or checking / savings account for Fit Kids registrations on stated dates. It is my responsibility to notify the Marshalltown YMCA-YWCA of any changes to my bank information at least a week before the automatic payment or I will be responsible for any fees incurred. I understand that I am responsible for keeping my account current in order to attend the Fit Kids program.

A $30 service charge will be applied to accounts for any returned payments due to nonsufficient funds, closed accounts, expired CC, over limit, or stop payment. Participants will be notified at the time of returns. Participants have 30 days to take care of any balance assessed due to returned payments. If balances aren't current after 60 days the participant will be removed from the program.

Signature: _____ Date: _____

PERMISSION AGREEMENTS

Child's Name_____Date of Birth_____

Release of information Agreement

I, the undersigned parent/guardian, do hereby grant permission for my child's picture to be used in Marshalltown YMCA-YWCA publications or in the event a news publication is at the facility. I further give permission for my child's name to be used in conjunction with the photograph.

Parent/Guardian Signature_____ Date_____

Travel Permission Statement

I, the undersigned parent/guardian, do hereby grant permission for my child to leave the YMCA Cultural Center building. This could be a walking trip to the Marshalltown Public Library, Mega 10, Horne-Henry Center, or Marshalltown Aquatic Center. I understand that any other activities that would require my child to leave the center will have a specific permission slip. That slip will include the exact nature of the trip, transportation, time period, and arrival and departure times.

Parent/Guardian Signature_____ Date_____

Parent Email Statement

I, the undersigned parent/guardian, wish to provide my email address in order to receive Fit Kids updates.

Email address_____

Parent/Guardian Signature_____ Date_____

Parent Handbook Receipt Statement

I, the undersigned parent/guardian, acknowledge that I have received a copy of the Fit Kids Handbook. I agree to follow all policies and procedures outlined within.

Parent/Guardian Signature_____ Date_____

Please text "@fitkid1" to 81010 to receive the Remind App Fit Kids updates such as weather announcements and early dismissals. *Standard message rates apply*

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (___)_____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

Licensed Child Care Requirements

4 through 5 months
- 1 dose D/T/P
- 1 dose Polio
- 1 dose Hib
- 1 dose Pneumococcal

6 through 11 months
- 2 doses D/T/P
- 2 doses Polio
- 2 doses Hib
- 2 doses Pneumococcal

12 through 18 months
- 3 doses D/T/P
- 2 doses Polio
- 2 doses Hib or 1 dose received at ≥ 15 months of age
- 3 doses Pneumococcal if received 1 or 2 doses < 12 months of age; or 2 doses if has not received any previous doses; or received 1 dose ≥ 12 months of age

19 through 23 months
- 4 doses D/T/P
- 3 doses Polio
- 3 doses Hib with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 15 months of age
- 1 dose Measles/Rubella ≥ 12 months of age
- 1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease
- 4 doses Pneumococcal; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if not received any previous doses or has received no doses or has received 1 dose ≥ 12 months of age.

24 months and older
same requirements as the 19-23 months Except Pneumococcal. 4 doses Pneumococcal if received 3 doses < 12 months of age; or 3 doses if received 2 doses< 12 month of age; or 2 doses if received 1 dose < 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age.

Elementary/Secondary School Requirements

4 years of age and older
- 5 doses Diphtheria/Tetanus/Pertussis with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥4 years of age if born after September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
- 4 doses Polio with 1 dose received ≥ 4 years of age if born after September 15, 2003; or 3 doses, with 1 dose received ≥4 years of age if born on or before September 15, 2003.
- 2 doses Measles/Rubella; the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first.
- 3 doses Hepatitis B if born on or after July 1, 1994.
- 2 doses Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has a reliable history of natural disease.