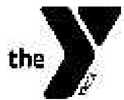

GYMNASTICS CHILD HEALTH FORM & EMERGENCY AUTHORIZATION

One form per participant is required. Both sides must be filled out completely in order to process your registration.

PLEASE PRINT CLEARLY

Child's First Name ______________________________ Last Name ____ Male ☐ Female ☐

Child's Date Of Birth ___/___/___ Age ______ Grade Entering in Fall ______ Child's School: ____

Parent/Guardian 1	Parent/Guardian 2
Parent/Guardian 1: Name____	Parent/Guardian 2: Name____
Address ____	Address ____
Home Phone#___________________ Cell Phone# _________________	Home Phone#___________________ Cell Phone# _________________
Work Phone# _________________ Email _________________________	Work Phone# _________________ Email _________________________

Emergency Contact (Besides Parent/Guardian)

1. Name ___________________________________ Home Phone______________ Work Phone_________________ Cell Phone_________________
2. Name ___________________________________ Home Phone______________ Work Phone_________________ Cell Phone_________________

PEOPLE ALLOWED TO PICK UP YOUR CHILD		IS THERE ANYONE **NOT** ALLOWED TO PICK UP YOUR CHILD	
NAME________________________________	PHONE # ______________	NAME________________________________	PHONE # ______________
NAME________________________________	PHONE # ______________	NAME________________________________	PHONE # ______________
NAME________________________________	PHONE # ______________	NAME________________________________	PHONE # ______________

_____ **Level I** **Monday and/or Wednesday 5:30-6:30pm**

Monday: ___$7.50 YMCA Members ___$30 Program Members

Wednesday: ___$7.50 YMCA Members ___$30 Program Members

_____ **Level II** **Monday & Wednesday 6:30-8pm**

___$25 YMCA Members ___$80 Program members

_____ **Level III** **Monday & Wednesday 6-8pm**

___ $45 YMCA Members ___ $100 Program Members

Has your child participated in the YMCA Gymnastics program before? ___ Yes ___ No

Parental / Guardian Consent

Recognizing that the YMCA will do its best to ensure a safe experience, I understand that certain dangers or accidents may occur. I hereby release the Oswego YMCA from any and all responsibility and liability of any nature, including claims of injury, illness, death, loss or damage, resulting from my child's participation in any program activities.

Medical Consent

As the parent, legal guardian, or authorized representative, I hereby give consent to the Oswego YMCA to provide all emergency dental or medical care prescribed by a duly licensed physician (MD or DO) or dentist (DDS) for the above named child. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of the child.

Participation Agreement *Please go over these items with your child.*

Please initial each statement; this will indicate your understanding and acceptance of each statement.

_____ Participant agrees to abide by rules and regulations set by the program for the health, safety and welfare of the participants.

_____ All medications will be brought directly to the site staff in accordance with the Medications Policy.

_____ Willful destruction of property will be the responsibility of the participant's parent / guardian.

_____ Participants must remain within established boundaries wherever the program occurs on and off YMCA property.

_____ Participants are not allowed to be in possession of any tobacco, alcohol, illegal drugs, firecrackers, firearms, or knives.

_____ The YMCA is not responsible for lost, damaged or stolen personal belongings.

_____ Any participant who poses a threat to themselves or to others will be dismissed from the program with no refund.

_____ The Program Director reserves the right to determine what constitutes a violation of these rules and will enforce them as necessary. We reserve the right to dismiss any participant from the program at the parent/guardian's expense and liability for violating any of the above.

Media Release

I give my permission for any pictures taken of my child(ren) participating in Oswego YMCA events to be used for publicity purposes in all media forms.

By Signing Below, I Agree That:

√ I have read and understand the parent/guardian consent.
√ I have read and understand the Medical Consent
√ The named minor has my permission to participate in the YMCA SACC program.
√ I give my permission for any pictures taken of my child participating in YMCA events to be used for publicity purposes.

____ ____ ____________

Signature of Parent/ Guardian Or Authorized Representative **Print Name** **Date**

Rev 9/26/11

first name

last name

GYMNASTICS

HEALTH INFORMATION

Child's Last Name_______________________ First____________________ Middle____________________

SECTION 1: TO BE FILLED OUT BY PARENT OR GUARDIAN:

HEALTH HISTORY (CHECK THOSE THAT APPLY)

Has your child had any of the following diseases?
Sickle Cell [ ]
Chicken Pox [ ]
Rubella [ ]
Measles [ ]
Mumps [ ]
Rheumatic Fever [ ]
Scarlet Fever [ ]
Poliomyelitis [ ]
Tuberculosis [ ]
Epilepsy [ ]
Diabetes [ ]
Hepatitis [ ]
Other (please list)
____
____

Does your child have any allergies?
Hay Fever [ ]
Poison Ivy [ ]
Bee Stings [ ]
Insect bites [ ]
Penicillin [ ]
Other (please list)
____
____

Does your child have a tendency to get:
Constipation [ ]
Diarrhea [ ]
Eczema [ ]
Stomach Aches [ ]
Head Aches [ ]
Ear Infections [ ]
Eye Infections [ ]
Respiratory Infections [ ]
Other (please list)
____
____

Does your child wear glasses? [ ] Yes [ ] No
If your child is a girl, has she begun to menstruate? [ ] Yes [ ] No
Does your child have any chronic or recurring illness? [ ] Yes [ ] No
Does your child have hearing difficulty? [ ] Yes [ ] No
If not, does she know about the menstrual cycle? [ ] Yes [ ] No
If yes, what is the nature of this illness?______________________

IS YOUR CHILD TAKING ANY PRESCRIBED MEDICATION REGULARLY? [ ] Yes [ ] No

Please list: _______________ ____

Psychiatric Treatment (explain) _________________________________ Physician's Name ____________________________

Activities to be encouraged or restricted by physician's advice?____

Physician's Name____ Phone # __________________________

Dentist's Name____ Phone # __________________________

I hereby certify the information contained herein is true and accurate.

Signature of Parent/Guardian ____________ Print Name ____________ Date ____________

SECTION 2: REQUIRED FOR DAY CAMP ONLY

To be filled out by licensed physician or attach copy of current record.

IMMUNIZATION HISTORY (Required for Day Camp Only)

DPT Series ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
Oral Polio ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
Hib (conjugate preferred) ___/___/___ ___/___/___ ___/___/___ ___/___/___
MMR___/___/___ ___/___/___
Hepatitis B ___/___/___ ___/___/___
Other: Type __________ ___/___/___
Other: Type __________ ___/___/___

HEALTH EXAMINATION (Required For Day Camp Only)

Height____________________ Weight_______________________

Please mark any abnormalities found in the following:

Teeth / Gums______________ Abdomen________________ Extremities_______________ Lungs______________

Skin______________ Neck________________ Back / Spine______________ Cardiovascular_________________

I certify that the medical history of the child on this form is correct, and that the person herein described has permission to engage in all activities.

____ ____________
Physician's Signature Date

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