

the Y YOUTH BASKETBALL 2011 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: 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

NAME _____ PHONE # _____

NAME _____ PHONE # _____

NAME _____ PHONE # _____

IS THERE ANYONE **NOT** ALLOWED TO PICK UP YOUR CHILD

NAME _____ PHONE # _____

NAME _____ PHONE # _____

NAME _____ PHONE # _____

PEE WEE & JUNIOR BASKETBALL SESSION 1109 October 17- November 20, 2011

_____ **PEE WEE BASKETBALL** _____ \$30 YMCA Members _____ \$40 Program Members

Mondays 5:45pm-6:30pm

_____ **JUNIOR BASKETBALL** _____ \$30 YMCA Members _____ \$40 Program Members

Mondays 6:45pm-7:30pm

My child has participated in youth basketball at the Oswego YMCA 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 _____

first name
last name
YOUTH BASKETBALL 2011

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 ____/____/____ ____/____/____ ____/____/____ ____/____/____

MMR ____/____/____ ____/____/____

Oral Polio ____/____/____ ____/____/____ ____/____/____ ____/____/____

Hepatitis B ____/____/____ ____/____/____

Hib (conjugate preferred) ____/____/____ ____/____/____ ____/____/____ ____/____/____

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 _____