YMCA of Natrona County
Amanda Konings
1611 Casper Mountain Rd
(307)234-9187

Child Enrollment Record

Child's name: ____

Date of Birth:________________________ Date of Enrollment:________________________

Home address:____

Parent/Legal Guardian Name:____

Address if different from the child's:___________________________Phone:______________

Place of employment and address: ____

Work phone: _______________________________

Parent/Legal Guardian Name: ____

Address if different from the child's:____________________________ Phone:___________

Place of employment and address: ____

Work phone: _______________________________

Persons authorized to remove the child from care without prior notice:

Name: Address: Phone:

____

Person(s) who can assume responsibility for the child in the event of an emergency if parent(s)/ guardian(s) can not be reached immediately:

Name: Address: Phone:

____

____

Signature of Parent/Guardian: ____

Date: ____

All child records must be reviewed and updated as necessary on at least an annual basis.

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Emergency Medical Authorization

Child's Name:____

Doctor Name:____Phone:__________________

Dentist Name:____Phone:_________________

Health Information such as allergies, chronic conditions, or frequent hospitalizations:____

Social or Family information, or special concerns:_______________________________________

I, _____________________________________ hereby give permission to; Facility Name, Director Name, to obtain medical or surgical care from a health care facility, physicians or dentists for my child, whose full name is

____ ,

and date of birth is ______________________, should the need arise.

It is understood that a conscientious effort will be made to locate me before action will be taken. If this is not possible, treatment as deemed necessary by the physicians/dentists may be taken. I further consent to transportation, by the provider or ambulance, of the above named child to the nearest or most appropriate medical facility.

_______________________________________ _________________________

Signature or Parent or Guardian Date

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Consent for Child Care Program Activities

Name of Child: ____

Consent is given for the items initialed below:

WALKING TRIPS

_______ Walking trips to the following locations: ___________________________________

Motor Vehicle Transportation

_______ Transportation by vehicle to the following locations

____

Specify other Activities (e.g., trips to neighborhood playgrounds, special trips)

________ ____

Child will be restrained during vehicular transport by use of: ___________________________

Signature of Parent/Guardian: ____

Date: ____

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TOPICAL OVER THE COUNTER (OTC) MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT

Child's Name____
Date of Birth_____/____/___

Today's Date_____/____/___

I give permission for the administration of following non-ingestible over the counter medications. Mark all that apply, and note specific brand or note if you have no brand preference:

☐ Diaper Rash Cream/Ointments:____

☐ Insect Repellent:____

☐Sunscreen:____

☐ Cortisone/Anti-Itch Creams/Ointments:_____________________________________

☐ Medicated Lip Treatments: ____

☐ OTC Antibiotic Creams/Ointments:_______________________________________

☐ Teething Tablets/Ointments:____

☐ Burn Creams/Sprays:____

☐ Other Non-Ingestible OTC's: (Please Specify) _________________________________

☐ ____

☐ ____

☐ ____

To administer a non-ingestible over the counter (OTC) medication:

• The OTC medication must be in its original container, with manufacturer's instructions must be followed.

____

Parent/Guardian Signature **Date**

When an over the counter medication is used parents must be notified that day.