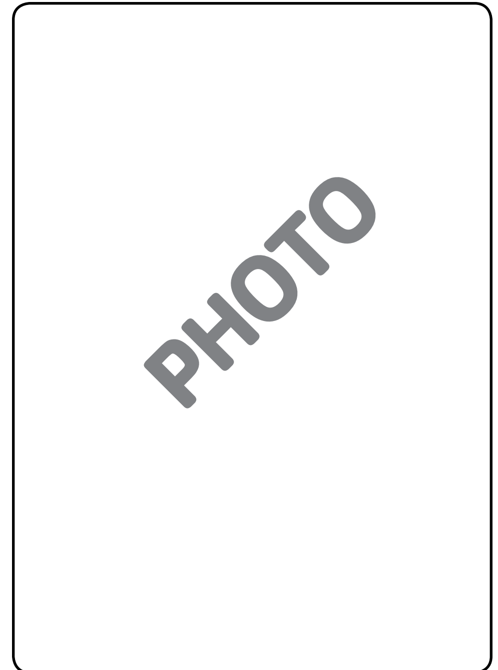
Hamilton Elementary School
YMCA UPK Program
44 Westfall Dr.
Tonawanda, NY 14150

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA BUFFALO NIAGARA

UNIVERSAL PRE-KINDERGARTEN ENROLLMENT FORM



Name ______________________________

School ______________________________

Age ______________________________

Site ______________________________

Start Date ______________________________

ALLERGIES/MEDICATION

Will your child require prescription medications? ☐ Yes ☐ No

Does your child have allergies? ☐ Yes ☐ No

If "yes" to either question, please describe in detail inside.

Transportation to and from our UPK prorgram MUST be provided by the parent/guardian. The YMCA can not provide transportation.

I have transportation for my child to and from the UPK program. ☐ Yes ☐ No

You may use my child's photo in promotional materials. ☐ Yes ☐ No

You may use my child's photo within the classroom. ☐ Yes ☐ No

CHILD INFORMATION

Name ______________________ Nick Name ______________ ☐ Male ☐ Female

Age as of 12/1/ 21______________ Date of Birth __________ Home Phone ______________________

Home Address ______________ City ______________ State ______ Zip ______

APPLICANT INFORMATION

Name of person applying for child ______________________ Relationship to child ______________

Address ______________ City ______________ State ______ Zip ______

Employer ______________________ Day Phone ______________________

Cell Phone ______________________ E-mail Address ______________________

In case of an emergency, notify: (List contact information for hours during Day Care - for example work address and phone if at work)

Mother ______________________ DOB __________ Address ______________________

Day Phone ______________________ Cell Phone ______________________

Father ______________________ DOB __________ Address ______________________

Day Phone ______________________ Cell Phone ______________________

Other ______________________ Address ______________________

Day Phone ______________________ Cell Phone ______________________

Physician or Medical Svc ______________ Address ______________ (p) ______

Names of individuals authorized to pick up child who are NOT listed above:

Name ______________ Relationship ______________ (p) ______

Name ______________ Relationship ______________ (p) ______

Name ______________ Relationship ______________ (p) ______

Name ______________ Relationship ______________ (p) ______

HEALTH INFORMATION

The following information must be filled in by the parent/guardian. The intent of this information is to provide staff the background to provide appropriate care. Provide complete information so that we can be aware of your child's needs. In addition to this form current immunization records and a physical are needed.

Allergies Describe reaction and management of the reaction

- Medications (e.g., penicillin) __________ ______________________
- Food (e.g., eggs, dairy) __________ ______________________
- Other (e.g., insect stings, hay fever) __________ ______________________

Medications
Medications require a separate form. Please contact the Child Care Program Director for more information.

Insurance
Is participant covered by family medical/hospital insurance? ☐ Yes ☐ No Carrier/plan name ______________________

Name of insured ________________________________ Relationship to child ________________________________

Policy holder SS# or insurance ID # ______________ Group # ______________ Carrier Address ______________________

Health History
Any activities that child cannot participate in or needs one-on-one assistance? ☐ Yes ☐ No

If yes, please explain ____

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Is your child currently being treated or followed by a medical professional for any of the following:

Asthma	☐ Yes	☐ No	Diarrhea/constipation	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Seizures/Convulsions	☐ Yes	☐ No

Please explain any "YES" answers ____

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Any additional information about the child's behavior and physical, emotional or mental health the staff should be aware of?

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Special Information – AFO's, walkers, wheelchairs, assistance with toileting, behavior issues, Diets, habits, etc.

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, ____________________________, give permission for ____________________________ to discuss my child's medical
(Mother, Father, Guardian) (Health care provider)

information, diagnosis and treatment, including medications with a representative of the YMCA's UPK program.

Signature of parent or guardian ________________________________ Date ______________________

Health Care Provider's phone ________________________________ Fax ______________________

As the Y is for youth development, we would like to know why you chose the YMCA. (Ex: I wanted my child to improve his or her social skills. I wanted to help my child stay healthy by being more physically active. I wanted my child to improve his or her academic performance.)

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AGREEMENT

- **Field Trips and Transportation:** My child ☐ **is** ☐ **is NOT** permitted to take part in field trips or excursions away from the facility under proper supervision, including transportation provided by or arranged for by the UPK program.
- **Emergency Medical Care:** I agree that in the case of accident or injury, emergency medical care may be given in the event I or the person(s) designated cannot be reached.
- **Correct Information provided:** I have provided special information on this registration to assist the facility in caring for this child (diet, habits, allergies, medical issues, etc)
- **Parent Handbook:** I accept the policies and procedures contained in the Preschool Education parent handbook. I have read and fully understand all policies and procedures contained within and agree to abide by them. I further understand that failure to abide by the policies and procedures contained in this handbook could result in dismissal from the program.

Signature of Parent/person(s) legally responsible: ______________________________ Date:__________

OFFICE USE ONLY

______ Received Preschool Education parent handbook

______ Program Director notified of allergies & medication

______ Form is complete (check boxes, allergy/medications)