

Youth Achievement Center & Youth Support Programs, Inc.

314 Delaware Street Leavenworth, Kansas 66048

(913) 682-8222

Fax 913-682-7672qz

Email dkgregor1@kc.rr.com

Date of birth : _____ Child's Name: _____

Parent's Name: _____

Address: _____ City, State & Zip _____

Home telephone #: _____ Work telephone #: _____

Employer Name & Address: _____

My child does not have permission to leave the facility early. I or a person listed on the emergency contact will pick my child up at the end of regular program hours unless I notify the center. (Signature) _____

Emergency contact: Name _____

Relationship _____ **telephone number** _____

Publicity Release

I (signature) _____ give The Youth Support Programs, Inc. organization permission to use my child's name and photograph in any and all forms of media

Release that will further the mission of the organization .These publicity release's will include television , radio , newspaper articles, and other printed materials .

Following information is needed to better serve your child

Income Guidelines: this information will not limit your child's access to any of our programs. Please circle the annual income that best reflects your family.

\$ 5,000.00 – 10,000.00 \$10,000- \$20,000 - \$20,000 - \$30,000 - \$30,000- \$40,000
above \$40,000.00

Child's personal information

Name and ages of others living in the home: _____

Parents name and address not living in the home: _____

Summer camp 2009: ages 6 – 16 years

Check camp session you wish to attend , space is limited ,we will notify you if your child is able to attend .

Camp days are Monday through Thursday . Camp hours are noon – 5 pm

- Session 1 June 15 – 25
- Session 2 July 6 – 16
- Session 3 July 20 -30

application not necessary if you have a current one on file



AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

| | |
|--|--------------------------|
| Name of facility exactly as stated on the license/certificate. | License or Certificate # |
|--|--------------------------|

I hereby authorize _____ (Name of individual/staff member) and/or _____ (Name of individual/staff member) who is (are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of _____ and _____ MM/DD/YYYY MM/DD/YYYY

| | |
|---------------------------------|-------------|
| Signature of Parent or Guardian | Date Signed |
|---------------------------------|-------------|

| | |
|---|-------------|
| Witness to Parent's or Guardian's signature only if required by the local hospital or clinic. | Date Signed |
|---|-------------|

Notarization of Parent's or Guardian's signature only if required by local hospital or clinic.

| |
|---|
| <u>State of Kansas</u> County of _____ Signed or attested before me on _____ by _____ MM/DD/YYYY Name of Person (Seal, if any.) _____ Signature of notarial officer _____ Title (and Rank) My appointment expires: _____ |
|---|

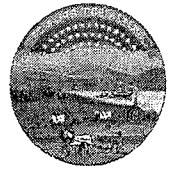
Complete information regarding health care insurance, if applicable.

Health Insurance Policy Name: _____ Policy Number _____
 Medical Assistance Program _____ Card Number _____
 Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.



HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d)(1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

| | | | |
|---|--------------------|-------------------------------|--|
| First and Last Name of the Child or Youth | Gender (M or F) | Date of Birth (MM/DD/YYYY) | First day at this program: (MM/DD/YYYY) |
|---|--------------------|-------------------------------|--|

| |
|--|
| First and Last Name of the Child's or Youth's Mother or Guardian |
|--|

| | | | |
|---------------------------------------|------|-------------|---------------------|
| Mother/Guardian's Home Street Address | City | Zip Code +4 | Home Phone # () |
|---------------------------------------|------|-------------|---------------------|

| | | | |
|--|------|-------------|---------------------|
| Mother/Guardian's Work Place Name & Street Address | City | Zip Code +4 | Work Phone # () |
|--|------|-------------|---------------------|

| |
|--|
| First and Last Name of the Child's or Youth's Father or Guardian |
|--|

| | | | |
|---------------------------------------|------|-------------|---------------------|
| Father/Guardian's Home Street Address | City | Zip Code +4 | Home Phone # () |
|---------------------------------------|------|-------------|---------------------|

| | | | |
|--|------|-------------|---------------------|
| Father/Guardian's Work Place Name & Street Address | City | Zip Code +4 | Work Phone # () |
|--|------|-------------|---------------------|

| |
|---|
| Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.) |
|---|

| | | | |
|--|------|-------------|-------------------------------|
| Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed. | City | Zip Code +4 | Phone # during program hours: |
|--|------|-------------|-------------------------------|

| | | | |
|---|------|-------------|---------------------|
| First and Last Name of Physician & Street Address | City | Zip Code +4 | Phone Number () |
|---|------|-------------|---------------------|

| |
|---|
| Name of Hospital Preference in case of emergency. |
|---|

| Yes | No | N/A | Complete the following information about medications for this child or youth. |
|-----|----|-----|--|
| | | X | Will this child or youth need to take any nonprescription or prescription medication during their time at the program? |
| | | | If yes above, is there signed permission on file? |

Circle any of the following conditions or difficulties that affect this child or youth.

| | | | |
|-------------------------|------------------------------|-------------------------|--------------------------|
| Allergies | Frequent sore throats/ colds | Ear Infections or Aches | Heart or Lung Conditions |
| Skin Problems | Asthma | Headaches | Diabetes |
| Vision | Speech/Communication | Hearing | Emotion/Behavior |
| Other: Please describe. | | | |

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)

Complete the following information about this child's or youth's immunization status.

| | | |
|-----|----|--|
| Yes | No | |
| | | Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year? |
| | | If yes, are this child's or youth's immunizations current? |
| X | X | If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history. |

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

| | | 1 | 2 | 3 | 4 | 5 |
|------------------------|---|----|----|----|----|----|
| | DPT, DT*, TD (*DT only if child is allergic to DTP) | // | // | // | // | // |
| | POLIO | // | // | // | // | |
| | MMR | // | // | | | |
| Single Dose Only | RUBEOLA (MEASLES) | // | // | | | |
| | MUMPS | // | // | | | |
| | RUBELLA (GERMAN MEASLES) | // | // | | | |
| | HIB (Hemophilus Infl. B) *RECOMMENDED | // | // | // | // | |
| | HBV (Hepatitis B Vaccine) *RECOMMENDED | // | // | // | | |
| | VAR (Varicella-Chicken Pox) *RECOMMENDED | // | | | | |

| | | |
|---|---------------------------------|----------------|
| Print the First and Last Name of the Person Completing this Health History form | Relationship to the Child/Youth | Date Completed |
|---|---------------------------------|----------------|

| | |
|--|--|
| If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information? | What is that person's relationship to the child/youth? |
|--|--|

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

| | |
|--|-------------|
| Signature of person completing this form | Date Signed |
|--|-------------|