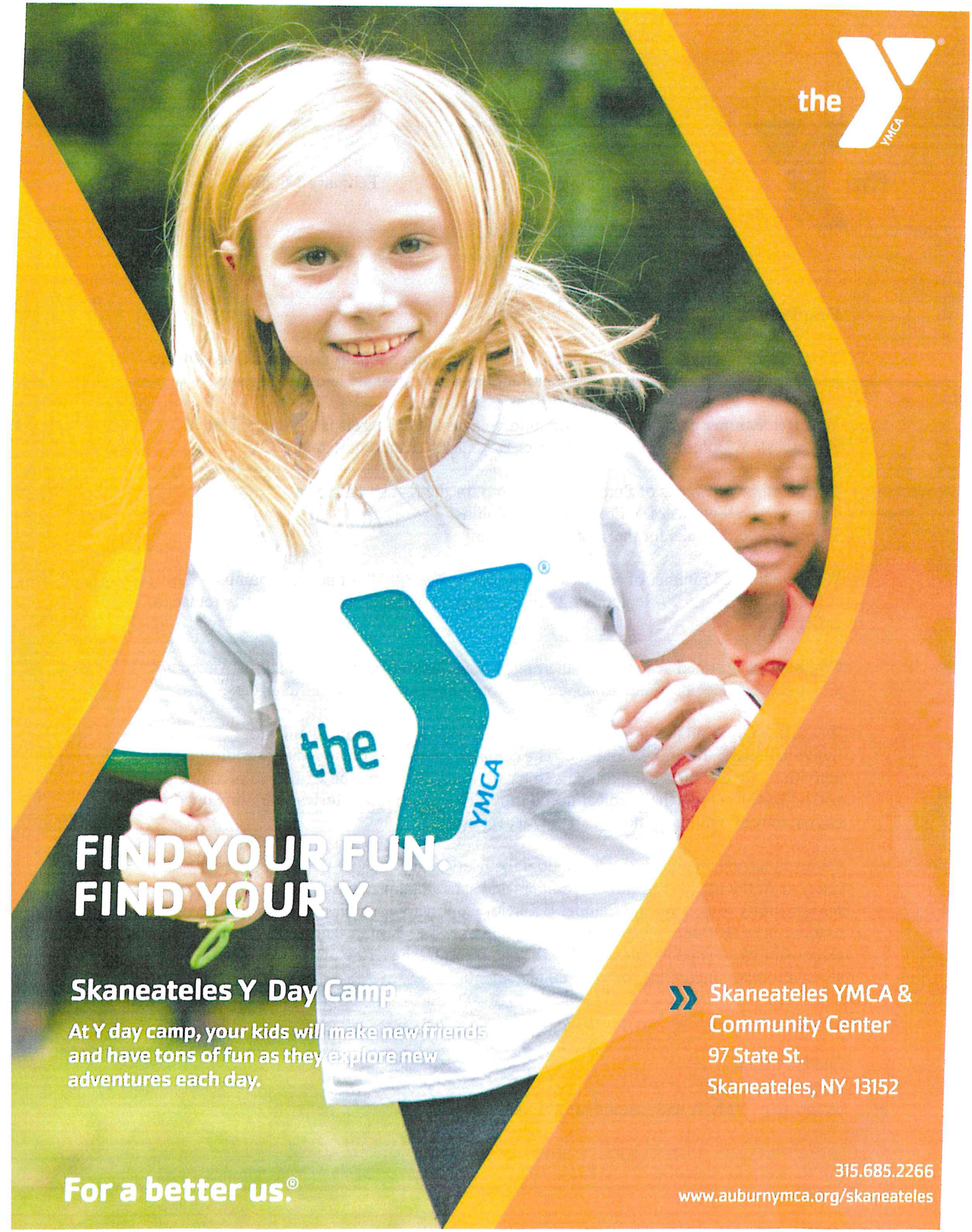
the
YMCA
FIND YOUR FUN.
FIND YOUR Y.
Skaneateles Y Day Camp
At Y day camp, your kids will make new friends and have tons of fun as they explore new adventures each day.
Skaneateles YMCA &
Community Center
97 State St.
Skaneateles, NY 13152
315.685.2266
www.auburnymca.org/skaneateles
For a better us.®

Summer camp documentation 2022

Child's Name:_____

Parent's Name:_____

Registration paperwork:_____

Physical:_____

Immunization:_____

Signature page:_____

Camp Safety page:_____

Sunscreen page:_____

Behavior page:_____

Medication page:_____

Payment:_____

Pre camp communication:_____

Staff signature:

Date:

Additional information:

February 17, 2022

Dear Parents,

Thank you for choosing the Skaneateles YMCA for your summer program needs. We are happy to serve the children of our community in a safe, friendly and inviting way.

We offer summer camp programs for children ages 2-12, Teasels is Training (2's), Y Frogs(3's), Y Dolphins (4's) and Summer Day Camp (Kindergarten-age 12)

There will be 10 weeks of Summer Day Camp for the K- age 12 group.
There will be 9 weeks of Y Frogs and Y Dolphins.
There will be 8 weeks for the Teasels in Training.

We have limited number of spaces available for weeks 8,9,10 for summer camp. August 15-19,22-26,29-September 2, this is when our college students typically return to college.

Children are grouped according to their age group due to licensing regulations we are not able to accept special friend group requests for children to be in specific groups.

Please keep in mind this is summer day camp is a group environment and not individualized babysitting/childcare. The campers spend the day together in multiple activities , we encourage the campers to try new activities , and be willing to participate with children outside their typical friend group. We always look forward to our campers having new and more friends when they leave camp .

Campers have a responsibility to conduct themselves in a manner that is in the best interests of the camp program, its campers and staff. Parents/Guardians have a responsibility to go over the Camper Behavior Contract with their camper(s), as we want to make sure all camper experiences a positive one. The YMCA camp staff has a responsibility to support your child in the camp setting, be a role model and to follow all safety protocol, including behavior management.

Sheila P. Card
Program Director
Skaneateles YMCA and Community Center

Skaneateles YMCA Summer Camp 2022 Registration

Camp registration should reflect your child's age at the start of summer camp.

Child's Full Name_____

Address_____Phone_____

City_____ Zip Code _____

Birth Date_____ Age_____ o Male o Female

Parent/Guardian #1_____Phone (Cell) #_____

Address_____Email_____

Employer_____Phone(Work)_____

Parent/Guardian #2_____Phone(Cell) #_____

Address_____Email_____

Employer_____Phone(Work)_____

In case of emergency, the following persons(after parents will be notified)

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Email address for notifications:_____

What would you like to tell us about your child that will help us support your child in their Skaneateles Y Summer Camp experience ?

People other than parents who have permission to pick up your child.

Name #1_____ Phone Cell #_____

Name #2_____ Phone Cell #_____

Child's Physician_____ Phone #_____

Child's Dentist_____ Phone #_____

Does your child have allergies and or medical conditions that we should be aware of?

Signature page

Medical Authorization

I, _____ authorize the YMCA to obtain emergency treatment for _____ in case of emergency

_____ _____

Parent Signature **date**

My child may be photographed for publicity and classroom use.

_____ _____

Parent Signature **date**

I understand that I must put in writing and submit to the Program Director , any changes or a withdrawal from Summer Camp, 2 weeks in advance of any changes to take place.

_____ _____

Parent Signature **date**

Skaneateles YMCA Summer Camp Behavior Policy

Enrollment or participation in youth programs at the YMCA is a privilege. The YMCA is committed to providing a safe and welcoming environment. To promote safety and comfort for everyone, all individuals are asked to behave in a courteous and polite manner at all times when participating in our programs. The objectives in all YMCA programs are to promote youth development, healthy lifestyles, and social responsibility through teaching and learning acceptable behaviors and promoting a positive self-image.

We ask children to:

- Cooperate and follow directions given by staff
- Respect other children and staff, as well as the equipment and facilities
- Stay in the program area with their class.

❖ Parents/guardians should note that major offenses, such as physical endangerment to another child or staff could result in immediate suspension and possible permanent removal from our summer camp programs for the remainder of the summer. If such behavior occurs, a phone call will be made to the parent and a meeting will need to be scheduled to discuss the problem.

Please read and discuss this policy with your child.

I HAVE READ, UNDERSTOOD, AND AGREE TO COMPLY WITH THESE POLICIES:

_____ _____

Child's Name **Parent/Guardian Signature**

2022 Skaneateles YMCA Summer Camp Safety

Dear Parents,

In the Skaneateles YMCA Y Summer Camp programs, children will be participating in swimming as part of the weekly schedule. Children will receive swim lessons as well as taking part in open swim and aquatic programs.

The Skaneateles YMCA , asks that you acknowledge that your child(ren) will be participating in swimming and ice skating while attending the Skaneateles YMCA Summer Camp

My son/daughter_____ has permission to attend the swimming and ice skating programming portion of the Skaneateles YMCA Summer Camp programs.

_____ _____

Parent signature date

SKANEATELES YMCA SUMMER CAMP 2022

RIGHTS AND RESPONSIBILITIES
RIGHTS OF PARENTS AND GUARDIANS

TO BE INFORMED BY THE CAMP DIRECTOR, OR HER DESIGNEE, OF ANY INCIDENT INVOLVING YOUR CHILD, INCLUDING SERIOUS INJURY, ILLNESS OR ABUSE

TO REVIEW INSPECTION AND INVESTIGATION REPORTS FOE A CAMP, WHICH ARE MAINTEAINEDMAINTAINED BY LOCAL HEALTH DEPARTMENT ISSUING THE CAMP A PERMIT TO OPERATE.

TO REVIEW THE REQUIRED WRITTEN CAMP PLANS.

RESPONSIBILITIES OF THE CAMP OPERATOR

TO INFORM YOU AND THE LOCAL HEALTH DEPARTMENT IF YOUR CHILD IS INVOLVED IN ANY SERIOUS INJURY, ILLNESS OR ABUSE INCIDENT

TO SCREEN THE BACKGROUND AND QUALIFICATIONS OF ALL STAFF.

TO TRAIN STAFF ABOUT THEIR DUTIES

TO PROVIDE SUPERVISION FO ALL CAMPERS DURING THE HOURS OF OPERATION OF DAY CAMP.

TO MAINTAIN ALL CAMP PHYSICAL FACILITIES IN A SAFE AND SANITARY CONDITION.

TO HAVE AND FOLLOW REQUIRED WRITTEN PLANS FOR CAMP SAFETY,HEALTH AND FIRE SAFETY.

TO NOTIFY THE PARENT OR GUARDIAN ,WITH THE ENROLLMENT APPLICATION THAT;

THE CAMP MUST HAVE A PERMIT TO OPERATE FROM THE NEW YORK STATE DEPARTMENT OF HEALTH .

Summer Camp Weeks and Themes:

Week One:	June 27-July 1	Best Summer Yet
Week Two:	July 5-8	Color Crazy
Week Three:	July 11-15	Sports Palooza
Week Four:	July 18-22	Lego Camp
Week Five:	July 25-29	CSI investigates
Week Six:	August 1-5	Cooking with Kids
Week Seven:	August 8-12	Campers Got Talent
Week Eight:	August 15-19	Nature Week
Week Nine:	August 22-26	Mystery Week
Week Ten:	August 29- Sept. 2	Summer Send off

**Weeks 8-10 Space is limited

OCFS-LDSS-7002 (11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WRITTEN MEDICATION CONSENT FORM

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.

LICENSED AUTHORIZED PRESCRIBER MUST COMPLETE THIS SECTION (#1 - #18)

(Parents may complete #1- #17 (omit #18) for over-the-counter topical ointments, sunscreen and topically applied insect repellent)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength): SUNSCREEN	5. Amount/dosage to be given:	6. Route of administration: Topical

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact prescriber at phone number provided below

☐ Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason the child is taking the medication (unless confidential by law): _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date prescriber authorized:	15. Date to be discontinued or length of time in days to be given *(this date cannot exceed 6 months from the date authorized or this order will not be valid)*:
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:

X

Reviewed 1/2013

OCFS-LDSS-7002 (11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WRITTEN MEDICATION CONSENT FORM

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the day care program is to administer the medication (i.e.: 12pm): _____

20. I, parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____
(child's name)

21. Parent or legal guardian's name (please print):	22. Date authorized:

23. Parent or legal guardian's signature:
X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:	25. Facility ID number:	26. Facility telephone number:

27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Authorized child care provider's name (please print):	29. Date received from parent:

30. Authorized child care provider's signature:
X

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____
(date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent or Legal Guardian's Signature:
X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Licensed Authorized Prescriber's Signature:
X

35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.

DATE:

By completing this section the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

36. Licensed Authorized Prescriber's Signature:
X

Reviewed 1/2013

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

Child Name:	Child date of birth:
Name of the child's health care provider:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Program Name:	License/Registration Number:	Program Telephone Number:
Child care provider's name (please print):		Date:
Child care provider's signature: **X**		

Signature of Parent:

X	Date:

the YMCA

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

WELCOME TO ALL

Program Scholarship Application

With a commitment to nurturing the potential of kids, promoting healthy living, and fostering a sense of social responsibility, the Y ensures that every individual has access to the essentials needed to learn, grow and thrive. The Y welcomes all who wish to participate and believes that no one should be denied access to the Y based on their financial means. Through our scholarship program, the Y provides assistance to youth, adults, and families based on individual needs and circumstances. A Y scholarship is a valuable thing to seek and, if received, of which to be proud. Scholarships reduce fees, not eliminate them. Because scholarship dollars are limited, and made available through the generosity of many donors, applicants are encouraged to pay as much as possible toward the program. Scholarship applications must be submitted at least 2 weeks prior to start of the program.

First Name _____ **Last Name**_____

Program applying for:

☐ **Summer Day camp** ☐ **Preschool**

☐ **Swim Lessons** ☐ **Swim Team**

☐ **Hockey Camp** ☐**Other**_____

Application will not be processed without Income Documentation: Please attach the following:

☐ 1040 Form from last year's taxes. OR

☐ Documents showing most recent 30-days of income for EVERYONE in the household.
**Including pay stubs or documentation of government assistance.

Hand in completed forms to a Member Services Desk Staff or mail application to:

Skaneateles YMCA & Community Center
97 State Street
Skaneateles, NY 13152
Attention: Scholarship Committee

Registration will not take place until scholarship has been awarded. You will be e-mailed or mailed a Scholarship Award Letter. To accept the award and register, bring both the award letter and completed registration paperwork to the Member Services Desk. Be prepared to pay at the time of registration.

Skaneateles YMCA-WEIU. 27 William Street. Auburn, NY 13021. 315-253-5304. www.auburnymca.org REV 3/2021

➢PROGRAM PARTICIPANT INFORMATION

❶ Name:_____ Age: _____

Date of Birth:_____ Gender: M F Grade: _____ Is child a Auburn or Skaneateles Y member? Y N

Has child received a Y scholarship in the past? Y N If yes, for what program? _____

❷ Name:_____Age: _____

Date of Birth:_____ Gender: M F Grade: _____ Is child a Auburn or Skaneateles Y member? Y N

Has child received a Y scholarship in the past? Y N If yes, for what program? _____

❸ Name:_____Age: _____

Date of Birth:_____ Gender: M F Grade: _____ Is child a Auburn or Skaneateles Y member? Y N

Has child received a Y scholarship in the past? Y N If yes, for what program? _____

➢PARENT /GUARDIAN INFORMATION

❶ Name:_____ Date of Birth:_____

Address:_____City_____State:___ Zip_____

Phone:_____ Cell:_____E-mail:_____

Employer_____ Occupation: _____

Preferred method of communication (circle one): PHONE E-MAIL MAIL

Preferred method of communication (circle one) : PHONE E-MAIL MAIL

❷ Name:_____ Date of Birth:_____

Address:_____City_____State:___ Zip_____

Phone:_____ Cell:_____E-mail:_____

Employer_____ Occupation: _____

Preferred method of communication (circle one): PHONE E-MAIL MAIL

➢ ALL PERSONS LIVING IN THIS HOUSEHOLD

☐ Parent/Guardian/Adult_____Relationship_____

☐ Parent/Guardian/Adult_____Relationship_____

☐ Parent/Guardian/Adult_____Relationship_____

☐ Parent/Guardian/Adult_____Relationship_____

☐ Parent/Guardian/Adult_____Relationship_____

☐ Child_____Age_____

☐ Child_____ Age_____

☐ Child_____ Age_____

☐ Child_____ Age_____

□ Child_____ Age_____

➢ FINANCIAL INFORMATION

❶ Is the child this application is for scholarship receiving benefits through the Department of Social Services?
If yes you may be eligible for partial assistance. If yes, please list your **Case Worker's Name:**_____
Case Number_____
Were you refereed by any agency if so, name of agency making referral:_____
Case Workers Name _____ **Phone** _____

❷ INCOME TAX..please include with your application documents to support one of the following:

↓I **Filed** Federal Tax forms last Year↓

□ 1040 Form

□I am an individual filing jointly. I am providing one form.

□We filed more than one tax form, we are providing ___forms

↓I did not **File** Federal Tax forms last Year↓
Or my household income has changed since I filed

□ Documents showing most recent 30 days of income (including pay stubs or documentation of government assistance)

❸ EXPENSES

□ Gross Monthly Income:
Wages_____
Food Stamps:_____
Support:_____
SSI:_____
Pension:_____
Public Assistance:_____
Other:_____
Total: $ _____

□ Monthly Expenses:
Rent_____
Utilities:_____
Food:_____
Insurance:_____
Medical:_____
Clothing:_____
Other:_____
Total: $ _____

❹ How much can you afford to pay?_____

➢TELL US MORE Please, briefly explain why you are requesting assistance and how a scholarship will benefit your child or family. Please include any additional information or extenuating circumstance that were not included above. Is this application being made for medical reason? If so please list medical condition and doctor's name. _____

_____

_____

_____

_____

If more space is needed, please use back of this sheet.

➢PLEASE READ AND SIGN BELOW

I certify that the above information is complete to the best of my knowledge and that I do not have additional income not represented above. If necessary, I agree to send additional information and documentation to support the above statements. I understand that scholarship assistance is based on need; in the event that I or my children must cancel our participation I will contact the YMCA immediately so sponsorship can be provided to others. I understand that if I falsify any of the above information, I will not be eligible for assistance now and in the future.

Signature:_____ **Date:** _____

_____

For office use:
□ Date Received_____ **□ Date Approved** _____ **Fee:** _____ **Total Fee:** _____