



YMCA of Greater Michiana
Benton Harbor-St. Joseph YMCA • Building Blocks Preschool

Young Adventure Care 2020

Parent's Name: _____ Phone _____

Child's Name: _____ Age _____

Price & Cancellation Policy

Cancellations are due in writing one week before the first day of care. A 50% refund will be issued if less than one week's notice is given to cover costs.

Monday–Thursday Members: \$85/week
9:00 AM–12:00 PM Non-Members: \$110/week

Monday–Friday \$175/week
7:30 AM–5:00 PM

Select your week(s):

<input type="checkbox"/>	JUNE 8–1 Princesses & Superheroes
<input type="checkbox"/>	JUNE 15–18 Under the Milky Way
<input type="checkbox"/>	JUNE 22–25 Food, Fun, & Fitness
<input type="checkbox"/>	JUNE 29–JULY 2 Party in the USA
<input type="checkbox"/>	JULY 6–9 Buggin' Out
<input type="checkbox"/>	JULY 13–16 Ooey Goey Mess
<input type="checkbox"/>	JULY 20–23 Mermaids & Pirates
<input type="checkbox"/>	JULY 27–30 Diggin' Dinos
<input type="checkbox"/>	AUGUST 3–6 Shark Week

CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

For Provider Use Only:		Date of Admission	Date of Discharge	
Name of Child (Last, First, Middle Initial)				Child's Date of Birth
Address (Number and Street, Building/Apartment Number)			City	State Zip Code
Parent/Legal Guardian's Name		Home Phone ()	Parent/Legal Guardian's Name (Optional)	
Home Address (if not child's address)		Cell Phone ()	Home Address (if not child's address)	
City	State	Zip Code	City	State Zip Code
Email Address (optional)			Email Address	
Employer Name		Work Phone ()	Employer Name	
Name of Child's Physician or Health Clinic			Physician's or Health Clinic's Phone Number ()	
Hospital Preferred for Emergency Treatment (optional)				
Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)				

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

See Reverse Side

Emergency Contact & Release of Child: List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	()	()
2.	()	()
3.	()	()

Release of Child Only: List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	()	2.	()
3.	()	4.	()

Parent/Legal Guardian Initials:

_____ I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian _____ Date Signed _____

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

MEDICATION PERMISSION AND INSTRUCTIONS
CHILD CARE HOMES AND CENTERS
 Department of Licensing and Regulatory Affairs
 Bureau of Community and Health Systems
 Child Care Licensing Division

If you are giving or applying any medication to a child in care, the following must be completed by the parent for **each** medication. An interruption in medication will require a new permission form.

TO BE COMPLETED BY PARENT

I give my permission for _____ to give or apply the medication
 (Caregiver, Facility)

_____, to my child _____, as follows:
 (Specify, prescribed medication/over the counter product) (Child's Name)

DIRECTIONS:

1. Date to Begin Giving Medication	2. Date to Stop Medication
3. Times Medication is to be Given	4. Amount (dosage) of Medication Each Time Given
5. Storage of Medication	
6. Other Directions, if Any	
Signature of Parent	Date

TO BE COMPLETED BY THE CAREGIVER GIVING THE MEDICATION:

DATE	TIME	AMOUNT GIVEN	CAREGIVER'S NAME	CAREGIVER'S SIGNATURE

It is recommended this form be reviewed with the parent every 3 months if the medication is ongoing.

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