



PROGRAM REGISTRATION FORM - Children's Waiting Room

DEMOGRAPHIC INFO

Child's Name		DOB	Age	Gender
Parent(s)/ Guardian(s) Names				
Parent/Guardian 1 Phone Number		Parent/Guardian 1 Email		
Parent/Guardian 2 Phone Number		Parent/Guardian 2 Email		
Street Address			City, State, Zip	
Branch of Service	Rank	Command	Command Phone Number	
Caregiver (if other than parents are bringing student)		DOB	Phone	

EMERGENCY CONTACTS & AUTHORIZED PICK UPS

In case of emergency, we require two primary emergency contacts ***other than parents/guardians*** who may be reached during school hours and have children released to his/her care. Emergency Contacts must know how to reach you in case of emergency and do not need to be local.
 If for some reason I am called away from the Armed Services YMCA campus, I authorize the person(s) below to pick up my child:

Emergency Contact 1	Phone Number	Relationship
Emergency Contact 2	Phone Number	Relationship
Authorized Pick Up	Phone Number	Relationship
Authorized Pick Up	Phone Number	Relationship
Authorized Pick Up	Phone Number	Relationship

____ (Initial) I understand I must provide and will/have turned in annually an updated Immunization Records with Flu Shot and TB Test/Screening. I hereby approve the information on this form.

Parent/Guardian Signature	Date
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GENERAL MEDICAL ACTION PLAN

Must be completed and stamped by Child's Medical Provider if your child has conditions that may require medical intervention. This form will need to be returned to the Office Manager before your child can be registered.

SECTION 1: TO BE COMPLETED BY THE PARENT/GUARDIAN

Primary Contact Parent/Guardian's Name	Phone Number
Primary Care Clinic	Doctor's Name

My child has **NO KNOWN MEDICAL CONDITIONS** or allergies or special needs that require intervention.

My child has the following conditions that may require medical intervention

Specify conditions- e.g. allergies, asthma, special needs etc:

Parent/Guardian Authorization of Release of Medical Information & Emergency Care Authorization:

I, _____, hereby authorize the release of medical information relevant to this medical action form. If necessary, I authorize ASYMCA staff to take the notated actions or precautions for my child according to the physician's instructions. I understand that I am responsible for administering any medication and I will advise ASYMCA of any changes to this medical action plan.

In case of an emergency, and I am unable to give verbal consent, I hereby authorize the Armed Services YMCA Hawaii to refer my child or myself to the stated clinic and/or closest emergency room.

Parent/Guardian Signature	Date
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SECTION 2: TO BE COMPLETED AND STAMPED BY CHILD'S MEDICAL PROVIDER IF THE CHILD HAS KNOWN MEDICAL OR SPECIAL NEEDS CONDITIONS

Diagnosis	Trigger(s)	
Medication	Dosage	Side Effects
Contact Parents and/or emergency Services (911) if:		

Diagnosis	Trigger(s)	
Medication	Dosage	Side Effects
Contact Parents and/or emergency Services (911) if:		

Physician's Name	Phone Number
Physician's Signature	Date

ARMED SERVICES YMCA RELEASE AND WAIVER LIABILITY

I hereby voluntarily and knowingly assume all risks and dangers inherent and incidental to the activities of Armed Services YMCA programming for myself and my family members. I will not hold the Armed Services YMCA of Honolulu liable for any injuries incurred during programming or in transit to and from the program whether caused by equipment or the act or omissions of others excepting damage or injury solely caused by the willful misconduct or

negligence of the Armed Services YMCA of Honolulu, or its employees, volunteers, or agents

I forever discharge and hold harmless the Armed Services YMCA of Honolulu, United States of America, United States Navy, United States Air Force, United States Coast Guard, United States Marine Corps and United States Army and all of its officers and personnel, employees, representatives, and their successors or assigns, including the Commanding Officer of the base/garrison of all liability under the Federal Tort Claims Act (28 U.S.C. Sections 1346(b), and 2671-2680), or other statutes addressing personal injury or property losses. I also waive all claims, demands, damages, actions, or suits of any nature or legal basis against the Armed Services YMCA of Honolulu, as well as, those entities previously listed, their agencies, departments, officers, employees, personnel, and their successors or assigns arising from any injury or alleged injury, including death, and property damage or loss that occurs incident to my entering upon and engaging in any activities that are associated with the Armed Services YMCA of Honolulu. I do hereby authorize the Armed Services YMCA of Honolulu as agent for all Armed Services YMCA participants, to consent with respect to the minors, to any, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any licensed physician and surgeon licensed, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that the Armed Services YMCA Honolulu is not responsible for costs incurred for medical care. If I participate in the program, whether as coach, instructor, aide, spectator, or participant, I presently waive as to the Armed Services YMCA of Honolulu and staff, officers and directors thereof, any claim presently known or unknown for damage to property or personal injury whether caused by equipment or the acts or omissions of others including Armed Services YMCA of Honolulu personnel. **The undersigned understands the directive, set by the Memorandum of Understanding (MOUs) ASYMCA has with each branch of service, that requires a parent or guardian to remain on campus during the time their son/daughter is attending the Parent Participation Preschool.**

By signing below, you acknowledge that your household has received, read, and understood the **Armed Services YMCA Release and Waiver Liability.**

CONSENT TO PHOTOGRAPH, FILM, OR VIDEOTAPE FOR NON-PROFIT USE

I hereby grant full permission for myself, my child, and/or my family members to be photographed by the Armed Services YMCA Hawaii staff for any legitimate purpose without payment or compensation. I also hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies, or video tapes. I also grant to the Armed Services YMCA Hawaii the right to edit, use, and reuse said products for nonprofit purposes including use in print, on the internet, and all other forms of media. I also hereby release the Armed Services YMCA Hawaii and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

By signing below, you acknowledge that your household has received, read, and understood the **Consent to Photograph, Film, or Videotape for Non-Profit Use.** By not checking a box it is assumed that you are consenting.

I Consent to Photographs/Film/Video

I **DO NOT** Consent to photographs/Film/Video

TECHNOLOGY CONSENT FORM

We will be using technology in the classroom, specifically iPads and Smart Boards. iPads will be used primarily for documenting your child's growth in the classroom, and for sharing their progress with you. Occasionally children will write with the iPad or play age appropriate educational games. In keeping with NAEYC guidelines for technology in early childhood programs and Hawaii Early Learning and Development Standards "ethical use" of technology, staff will utilize the interactive technology in an intentional manner as part of a holistic approach to instruction. Wi-Fi will be turned off for the duration of the class to ensure your child's safety and privacy while using the iPads. Videos will be sent by the teacher after class on Fridays. If you wish to opt out, alternative learning experiences will be presented to your child during our technology time. Otherwise, please provide written consent below.

I hereby acknowledge and approve the information on this form.

Parent/Guardian Signature	Date
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PARENT STATEMENT OF UNDERSTANDING

I understand that the Armed Services YMCA (ASYMCA) staff and volunteers are not allowed to babysit or transport children at any time outside of the ASYMCA program. Immediate disciplinary action will be taken by the ASYMCA if a violation is reported and confirmed.

I understand that the ASYMCA staff are instructed to not have personal relationships outside of the ASYMCA program with youth participants under the age of 18 (babysitting, dating, etc.)

I understand that I am not to leave my child at the ASYMCA site unless a staff member or volunteer is there to receive and supervise my child.

I understand that the ASYMCA staff is not to give individual gifts to children/youth participants. When gifts are given they will be given to all children in the program. Should my child receive a personal gift from an ASYMCA staff member, I will report it to a supervisor.

I understand that my child will not be allowed to leave the program with an unauthorized person. Any person authorized to pick up my child, including siblings or other relatives, must be listed with the ASYMCA and that they will be required to show photo identification when picking up my child. All other arrangements must be made in writing. Arrangements made via telephone will be accepted and approved for emergency situations and on a case by case basis only.

I understand that the ASYMCA staff reserves the right to refuse release of my child to any individual who arrives to pick him/her up that appears to be under the influence of drugs or alcohol. I further understand the ASYMCA staff will have no recourse but to contact the police. The child's safety is of utmost importance; therefore, please do not put the staff in the position where they feel they must make a judgment call.

I understand that I can ensure my child's safety by taking an active interest in his/her ASYMCA experience. I will monitor volunteer and staff interactions with my child and ask specific questions about program activities and volunteer or staff relationships with my child.

I understand that the ASYMCA staff is instructed to respect my child's right not to be touched in ways that make him/her feel uncomfortable and his/her right to say no. Physical contact, which may include but not limited to tickling, wrestling, prolonged hugs, allowing youth to sit on the lap of staff members, etc. are prohibited. I further understand that the ASYMCA staff may contact assistance when my child needs help with his/her toileting needs and/or changing soiled clothes.

I understand that the ASYMCA staff are expected to demonstrate the ASYMCA Core Values of caring, honesty, respect, and responsibility in their interaction with other staff and volunteers and with children and youth participants in their programs. I further understand that my child is also expected to demonstrate the core values in his/her interaction with peers as well as with the ASYMCA staff.

I understand that I must do my part in ensuring the program environment is a safe place for children and staff. I am to direct any concerns or complaints to the appropriate Branch Director or to the Executive Director. I further understand that inappropriate language and/or behavior that may appear threatening, particularly in the presence of program participants, may result in disenrollment of my child from the program.

I understand that the ASYMCA is mandated by state law to report any suspected cases of child abuse or neglect to the appropriate authorities for investigation.

I understand that any alterations to the ASYMCA's registration form, including additions and deletions of information on authorized persons for pick up and permission for a child/youth to sign him or herself out, must be done in writing and signed by the child's parent/guardian.

Parent/Guardian Signature	Date
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Children's Waiting Room Late Pick-Up Policy

Please plan for the release and/or pick-up of your child **immediately following the conclusion of your medical appointment**. If you make arrangements for your child to be picked up by another adult, the Armed Services YMCA requires written consent before we will release your child.

A late fee will be assessed at a rate of \$10.00 for every 30 minutes or fraction thereof.

Please sign below in acknowledgment of this policy.

Child's Name: _____

Parent's Signature: _____ Date: _____

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: **Yes (higher risk for a severe reaction)** **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

- If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.
- If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.



1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR **MILD SYMPTOMS FROM MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS FROM A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

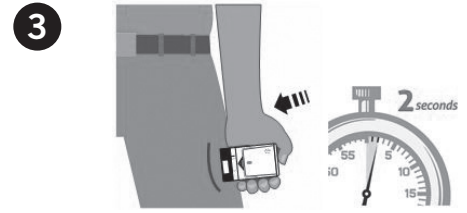
Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

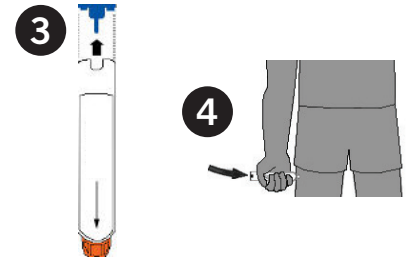
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.



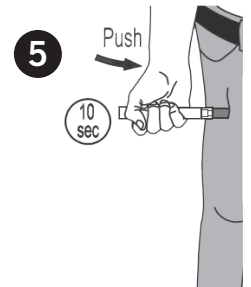
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



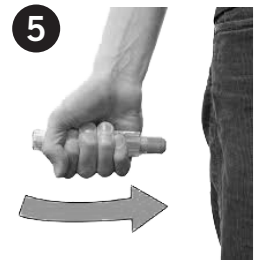
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____