FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

INDIVIDUAL CARE REGISTRATION MATERIALS

Individual Care Plan
Medication Treatment Form
Emergency & Allergy Action Plans
Food Allergy/Intolerance Health Care Provider Statement

YMCA OF SNOHOMISH COUNTY
ymca-snoco.org

YMCA OF SNOHOMISH COUNTY
INDIVIDUAL CARE PLAN

This form will be:

1. Completed by Program Director and parent/guardian
2. Signed by Program Director and parent/guardian
3. Reviewed and updated periodically
4. Used to develop a plan for reasonable accommodation
5. Copied and submitted to Association Office
6. Adhered to by all involved YMCA staff

Child's Name _____ Requested Start Date_____

Branch _____ Child Care Site_____

1) Check all conditions/diagnosis that apply to your child:

☐ Asthma	☐ ADD/ADHD	☐ Aspberger Syndrome	☐ Autism
☐ Anxiety	☐ Bipolar Disorder	☐ Cancer	☐ Cerebral Palsy
☐ Celiac Disease	☐ Learning Disability	☐ Down's Syndrome	☐ Epilepsy
☐ Drug Affected	☐ Diabetes	☐ Food Allergies	☐ Hemophilia
☐ Rett Syndrome	☐ Spina Bifida	☐ Intellectual Disorder	☐ Hypertension
☐ Tourette Syndrome		☐ Juvenile Attachment Disorder	
☐ Development Delay		☐ Sensory Integration Disorder	
☐ Fetal Alcohol Syndrome			

2) List expected symptoms or behaviors: (when listing more than one use a.-z. to label)
_____
_____
_____

3) List symptoms or behaviors of concern:
_____
_____
_____

4) List responses required of staff: (complete Emergency Action Plan when appropriate)
_____
_____
_____

5) List training that may be required of staff in order to adequately care for your child:
_____
_____
_____

6) List required medications: (complete Medication Authorization Form)
_____
_____
_____

7) Has your child required psychiatric counseling or hospitalization? _____
If yes, explain? _____
_____
_____

8) Indicate Professional Involvement/Support: (check all that apply)

☐ Pediatrician	☐ Homeopath	☐ Psychological Services
☐ Occupational Therapy	☐ Physical Therapy	☐ Speech Therapy
☐ Teacher	☐ Instructional Aid	☐ Medical Specialist
☐ School Counselor	☐ Naturopath	☐ Other: _____

9) Actions/skills your child needs help with: (check all that apply)

Communication:
☐ Using words, signs or symbols to express meaning to others
☐ Responding to other's communication appropriately
☐ Other _____

Mobility:
☐ Walking or standing ☐ Using hand(s), arm(s) ☐ Uses walker or wheelchair
☐ Other _____

Self-Help:
☐ Dressing or undressing ☐ Eating or drinking ☐ Using the toilet
☐ Recognizing dangerous situations ☐ Other _____

Intellectual
☐ Choosing an activity on own ☐ Staying with an activity for 15 min. or more
☐ Handling transitions or changes in routine
☐ Understanding safety rules and demonstrating ability to comply for safety
☐ Other _____

Social/Emotional:
☐ Maintaining relationships with peers ☐ Sharing and taking turns
☐ Expressing anger or frustration appropriately ☐ Impulse control
☐ Other _____

10) Describe your child's strengths:
_____
_____
_____

11) What has been done in previous group environments that you have found to be especially helpful in accommodating your child's individual needs?
_____
_____
_____

12) What has been done in previous group environments that you have found to need improvement in making accommodations for your child's individual need?_____
_____
_____

13) What are you looking for in a YMCA experience for your child?
_____
_____
_____

14) Please describe as detailed as possible what you believe will help your child to participate successfully in the YMCA child care program.
_____
_____
_____
_____
_____

COMPLETE THIS PAGE WITH YOUR PROGRAM DIRECTOR

15) Mutually agreed upon Individual Care Plan
Details:_____

The Emergency Action Plan must be completed when it is a possibility that the child has a condition or may have a reaction that requires immediate medical treatment as indicated in the Individual Care Plan.

I understand that this Individual Care Plan may be reviewed as necessary at which time changes may or may not be deemed necessary.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of YMCA Program Director Date

_____ _____
Signature of YMCA Site Director Date

FOR OFFICE USE ONLY

Application Date: _____ Approval Date: _____ Review Date: _____

YMCA OF SNOHOMISH COUNTY
MEDICATION TREATMENT FORM

Child's Name _____

Medication Name _____

Start Date _____ Stop Date _____

Medication Being Given For _____

Possible Expected Side Effects _____

Time Medication Is To Be Given By Staff _____

Time Medication Last Given By Parent _____

Amount To Be Given At Each Time (Dosage) _____

Medication procedure (special way to take pills) _____

Special Storage Requirements if Any (ex. Refrigeration) _____

I understand that medication must be a prescription with the exception of antihistamines, non-aspirin pain relievers, non-narcotic cough suppressants, decongestants ointments intended for itching, diaper rash or sunscreen. All medication must be in the original container.

Children with Severe Allergic Reaction or Food Intolerance require an additional form.

I have provided instruction to the staff who will be administering the medication on specialized medication administration procedures (i.e. nebulizer, epi-pen, or preference for swallowing pills)

I understand and agree that the YMCA staff. can not be held responsible for allergic reactions or other complications resulting from administration of the above medication given according to the directions.

Signed _____ Date _____
(Parent or Guardian)

Staff Record (to be completed by the staff person who will be administering the medication)

I have been instructed in how to administer medication and understand that I must document administration of medication every time and give a written explanation why a medication that should have been given was not.

Signature of Staff Person _____

Staff Signature needed on both pages

Child's Name _____

Name of Medication _____

Date	Time	Amount Given	Staff Administering	Staff Initials

Staff Record (to be completed by the staff person who will be administering the medication)

I have been instructed in how to administer medication and understand that I must document administration of medication every time and give a written explanation why a medication that should have been given was not.

Signature of Staff Person _____

YMCA OF SNOHOMISH COUNTY
EMERGENCY ACTION PLAN
SEVERE ALLERGIC REACTION

Child's name: _____ **Allergy to:** _____

Birth date: _____ Site: _____

Asthmatic ☐ Yes* ☐ No *High risk for severe reaction

- **Signs of an allergic reaction**

System	Symptoms
Mouth	Itching & swelling of the lips, tongue, mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lung	Shortness or breath, repetitive coughing, and /or wheezing
Heart	"Thready" pulse, "passing out"

The severity of symptoms can quickly change. All above symptoms can potentially progress and become life threatening.

If ingestion is suspected, and/or child having any of the above symptoms:

1. _____ **Administer prescribed epinephrine (EpiPen™) immediately**
   location of (EpiPen™): _____

   and / or (please circle one)

2. _____ **Administer other prescribed medication** _____
   Medication and dosage

   _____
   Medication and dosage

3. **Call 911**
4. **Call parent** _____ **Phone:**_____
5. **Call child's doctor: Dr.**_____ **Phone:** _____
6. **Stay with the child at all times**

OTHER IMPORTANT INFORMATION:

_____ _____

Parent signature /Date Doctor's Signature /Date

YMCA OF SNOHOMISH COUNTY
EMERGENCY ACTION PLAN

Child's name: _____ Birth date: _____

Condition: _____

Emergency Contact Person: _____ Relationship: _____

Best phone number: _____ Secondary number: _____

Secondary Contact Person: _____ Relationship: _____

Best phone number: _____ Secondary number: _____

Describe behaviors, actions or symptoms that will indicate when emergency actions must be taken. Please also note any pre-emergency symptoms that staff should be aware of.

_____
_____
_____
_____
_____
_____
_____

Staff will call 911 immediately.

Describe in detail step-by-step actions for staff to take while waiting for medical aid to arrive. Including administering medications (completed Medication Authorization Form must be attached). Also indicate below when medication is to be given.

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Parent Signature Date

YMCA OF SNOHOMISH COUNTY
FOOD ALLERGY/INTOLERANCE
HEALTH CARE PROVIDER STATEMENT

Name of Child: _____ Birth Date: _____

Name of Parent: _____

Dear _____,

A patient of yours is enrolled in our program. We have been advised the child is allergic or intolerant to the food(s) indicated below. To comply with the standards of our program, we need to know the nature of the child's intolerance or allergy and appropriate food(s) to substitute to assure the child's nutrition is not compromised. Thank you for your attention to this matter.

Please complete the following concerning this child's food intolerances or allergies. For severe and potentially life-threatening allergies, also complete the Severe Allergic Reaction Emergency Plan. Please print or type. Thank you.

List each food separately	Briefly describe how the child reacts to the food	List appropriate substitute food(s)
	Severe or potentially severe reaction Yes* ☐ No ☐	
	Severe or potentially severe reaction Yes* ☐ No ☐	
	Severe or potentially severe reaction Yes* ☐ No ☐	

*Complete the Severe Allergic Reaction Emergency Plan

Additional information concerning the intolerance or allergy: _____

_____

_____

Print or type the following:

Name and title of health care practitioner _____

Practitioner Phone number: _____ Fax number: _____

Mailing address: _____
Street address

_____
City State Zip

_____ _____
Health Care Practitioner's Signature Date

Please return this form to: