



# FUN HAPPENS HERE



## CAMP OSAGE-SUMMER CAMP OSAGE PRAIRIE YMCA

Spend the summer at the Y!

At the Y, we believe all kids deserve the opportunity to discover who they are and what they can achieve. Summer camp at the Y provides children with supervised activities outdoors, swimming, skating that cultivate values, develop skills, and nurture relationships.

**ENROLLMENT STARTS  
MARCH 17TH**

**DATES** June 2–August 13  
Monday–Friday, 7:30am–5:30pm

**AGES** 5-12

**RATES**

**Registration Fee:** \$50

**Weekly Fee:**

Members: \$125; Community Members \$187

**Summer School Fee:**

Members: \$50; Community Members \$75

**MUST BRING** - swimsuit (M/W/F), water bottle, sunscreen and wear tennis shoes daily.



**DATE**

**SUMMER SCHOOL**

June 2 -June 6

Summer School

June 9- June 13

Summer School

June 16– June 20

June 23–June 27

June 30–July 3 (Closed 4th)

July 14- July 18

July 21- July 25)

July 28- August 1

August 4- August 8

August 11-August 13

**QUESTIONS?** Call 417-667-9622 or visit our website [opymca.org](http://opymca.org)  
**Osage Prairie YMCA** • 4500 W Highland Ave, Nevada, MO 64772



**CHILD CARE ENROLLMENT FORM**

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
CHILD'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		

**IDENTIFYING INFORMATION**

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS

EMAIL ADDRESS

EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
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EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
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PARENT/GUARDIAN NAME	TELEPHONE NUMBER
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ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS

EMAIL ADDRESS

EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
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EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER
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If you or a member of your immediate family ever served in the U.S. Armed Forces, [click here for more information about military-related services in Missouri](http://www.dese.mo.gov/veterans-services) or visit [www.dese.mo.gov/veterans-services](http://www.dese.mo.gov/veterans-services).

**EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY OTHER THAN PARENT (AT LEAST ONE EMERGENCY CONTACT IS REQUIRED)**

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

The Department of Elementary and Secondary Education does not discriminate on the basis of race, color, religion, gender, gender identity, sexual orientation, national origin, age, veteran status, mental or physical disability, or any other basis prohibited by statute in its programs and activities. Inquiries related to department programs and to the location of services, activities, and facilities that are accessible by persons with disabilities may be directed to the Jefferson State Office Building, Director of Civil Rights Compliance and MOA Coordinator (Title VI/Title VII/Title IX/504/ADA/ADAAA/Age Act/GINA/USDA Title VI), 5th Floor, 205 Jefferson Street, P.O. Box 480, Jefferson City, MO 65102-0480; telephone number 573-526-4757 or TTY 800-735-2966; email [civilrights@dese.mo.gov](mailto:civilrights@dese.mo.gov).

**COMMENTS ON CHILD'S DEVELOPMENT  
(PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)**

**RELATED CHILD**

Yes     No                      CHILD'S RELATION TO CHILD CARE PROVIDER

**ETHNIC AND RACE INFORMATION (YOU ARE NOT REQUIRED TO ANSWER THIS SECTION)**

Are you of Hispanic or Latino origin?  Yes  No

What is your race? (Select one or more.)	<input type="checkbox"/> American Indian or Alaskan native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> White
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**CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED**

CACFP REQUIREMENT

Will child attend: <input type="checkbox"/> Full time <input type="checkbox"/> Part time  Check what days your child will attend.	When does your child usually arrive each day?	When does your child usually leave each day?	Describe any changes or variations in usual attendance, including shift changes.
Monday	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Tuesday	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Wednesday	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Thursday	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Friday	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Saturday	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
Sunday	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	

**MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY**

Breakfast    Morning snack    Lunch    Afternoon snack    Supper    Evening snack    None

**HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY**

<input type="checkbox"/> New Year's Day	<input type="checkbox"/> Easter	<input type="checkbox"/> Labor Day
<input type="checkbox"/> Martin Luther King, Jr.'s Birthday	<input type="checkbox"/> Truman Day	<input type="checkbox"/> Columbus Day
<input type="checkbox"/> Lincoln's Birthday	<input type="checkbox"/> Memorial Day	<input type="checkbox"/> Veterans Day
<input type="checkbox"/> Washington's Birthday	<input type="checkbox"/> Juneteenth	<input type="checkbox"/> Thanksgiving Day
	<input type="checkbox"/> Independence Day	<input type="checkbox"/> Christmas Day

## AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in the event of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make the necessary arrangements, or in a critical emergency requiring medical care, I authorize

\_\_\_\_\_ (CHILDCARE FACILITY NAME)

to contact the following:

### PHYSICIAN OR CLINIC

NAME

TELEPHONE NUMBER

### PREFERRED HOSPITAL

NAME

TELEPHONE NUMBER

### ACKNOWLEDGMENTS

<b>A</b>	I have received a copy of this facility's policies pertaining to the admission, care, and discharge of children.	PARENT/GUARDIAN INITIALS
<b>B</b>	I have been informed that a copy of the licensing rules for child care home or the licensing rules for group child care homes and centers is available at this facility for review.	PARENT/GUARDIAN INITIALS
<b>C</b>	The provider and I have agreed on a plan for continuing communication regarding my child's development, behavior, and individual needs.	PARENT/GUARDIAN INITIALS
<b>D</b>	When my child is ill, I understand and agree that s/he may not be accepted for care or remain in care.	PARENT/GUARDIAN INITIALS
<b>E</b>	I understand that, before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations or exemption from immunizations.	PARENT/GUARDIAN INITIALS
<b>F</b>	I <input type="checkbox"/> do <input type="checkbox"/> do not give permission for field trips/excursions. I understand that I will be notified in advance when they are planned.	PARENT/GUARDIAN INITIALS
<b>G</b>	I <input type="checkbox"/> do <input type="checkbox"/> do not give permission for the facility to transport my child.	PARENT/GUARDIAN INITIALS
<b>H</b>	I have been informed and have received a copy of the facility's safe sleep policy when enrolling a child less than one (1) year of age.	PARENT/GUARDIAN INITIALS
<b>I</b>	I have been notified that I may request notice at initial enrollment or at any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.	PARENT/GUARDIAN INITIALS

PARENT/GUARDIAN SIGNATURE

DATE

**CACFP  
REQUIREMENT**

FIRST ANNUAL UPDATE

PARENT/GUARDIAN SIGNATURE

DATE

SECOND ANNUAL UPDATE

PARENT/GUARDIAN SIGNATURE

DATE

THIRD ANNUAL UPDATE

PARENT/GUARDIAN SIGNATURE

DATE

### USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**  
U.S. Department of Agriculture  
Office of the Assistant Secretary for Civil Rights  
1400 Independence Avenue, SW Washington,  
D.C. 20250-9410; or
2. **fax:**  
(833) 256-1665 or (202) 690-7442; or
3. **email:**  
[program.intake@usda.gov](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.



MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION  
 OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE  
**MEDICATION AUTHORIZATION**

**SAVE**  
**PRINT**  
**RESET**

**MEDICATION REQUIREMENT**

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

I AUTHORIZE CHILD CARE PERSONNEL TO ADMINISTER THE FOLLOWING MEDICATION TO MY CHILD:

(PROPER NAME OF MEDICATION)

CHILD'S FULL NAME	DATE MEDICATION TAKEN FROM	UNTIL
DOSAGE	TIME(S) OF DAY	

POSSIBLE SIDE EFFECTS

SIGNATURE OF PARENT(S) OR GUARDIAN

DATE

**RECORD OF ADMINISTRATION**

STAFF NAME	DATE	MEDICATION NAME	DOSAGE	TIME

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MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION  
OFFICE OF CHILDHOOD - CHILD CARE COMPLIANCE  
**PERMISSION FOR CHILD TO LEAVE FACILITY**

**SAVE**  
**PRINT**  
**RESET**

NAME OF CHILD	
ACTIVITY	
LOCATION	
METHOD OF TRANSPORTATION (WALK, BUS, CAR, ETC.)	
TRANSPORTED BY (PERSON RESPONSIBLE FOR SUPERVISION)	
TIME OF LEAVING	TIME OF EXPECTED RETURN
DATE OF ACTIVITY	PERMISSION GRANTED EFFECTIVE
SIGNATURE (PARENT(S), GUARDIAN OR DESIGNEE)	FROM:
	TO: DATE