Hello!

Please let me introduce you to a unique program called Circle of Champs.

Offered by the Capital District YMCA, Circle of Champs helps families with a child who has a life-threatening illness, by providing a support system for each family member.

All through the year, Circle of Champs families participate in a variety of fun events, and enjoy time together at the Y. Much more than any fun event, families cherish the time they spend together.

You don't need to be a member of the Y to join Circle of Champs, though we do offer free Y membership to our Champs families.

To help us provide the best possible support for you and your loved ones, please have your physician complete the medical form. Both forms can be sent to my attention.

Please share any questions you have about Circle of Champs, knowing that we have just one goal for this program: making your life and the lives of your loved ones a bit easier.

Kind regards,

Rusty Decker
Director of Operations
CAPITAL DISTRICT YMCA
Bethlehem Area Branch
900 Delaware Avenue
Delmar, NY 12054
P: 518.977.4131 (direct)
C: 518.378.0289
RDecker@CDYMCA.org
www.CDYMCA.org

Better Together, we're Building a Stronger Community

CAPITAL DISTRICT YMCA
Circle of Champs Program Enrollment Form

CHILD'S INFORMATION

Name _____ Birthdate ____/____/___ Age ____

Gender ☐ M ☐ F ☐ Other School _____ Grade in September _____

Address _____

City _____ State _____ Zip _____

How did you hear about Circle of Champs?

_____

_____

Please let us know your preferred method of communication:

☐ Facebook (private Champs group) ☐ Email ☐ Phone

PARENT & GUARDIAN INFORMATION

Name _____	Name _____
Address _____	Address _____
City, State, Zip Code _____	City, State, Zip Code _____
Home Telephone _____	Home Telephone _____
Work Telephone _____	Work Telephone _____
Email _____	Email _____

Siblings & Ages _____

PHYSICIAN AND MEDICAL INFORMATION

Physician Name _____

Hospital / Treatment Facility _____

Office Telephone _____ Fax _____

Address _____

Complete Street Address City State Zip Code

Emergency Contact _____ Phone _____ Relationship _____

Authorized Pickup *: Name_____ Relation_____

Name_____ Relation_____

* For the safety of your child, the person authorized for pick up needs to have at least one form of identification when picking up your child.

AGREEMENT

I hereby certify that my child is capable of safe participation in YMCA Circle of Champs activities. I assume all risk(s) and hazards incidental to the conduct of this program and for transportation to and from the program. I hereby authorize the YMCA to obtain medical treatment for my child in the event that I or my child's emergency contact cannot be reached. I give permission to the YMCA to take video and/or photographs of myself and/or my children for the purpose of promoting YMCA programs: ☐ Yes ☐ No

_____ _____

Signature Parent or Guardian Date

CAPITAL DISTRICT YMCA
Circle of Champs Medical Form

Attention Parents Please complete page 1 of this document prior to your child's medical professional completing page 2

My child is fit for and has permission to participate in swimming. ☐ Yes ☐ No

Any special challenges we should know about? _____
Please list all medications (oral, inhalants, injections) that give an allergic reaction.

_____
Please also list foods, insects, and any environmental sensitivity, the frequency, and usual treatment for the reaction.

_____
Please list all medications (oral, inhalants, injections) the child is bringing to activities.

_____
Please list all medications your child is routinely given at home.

_____

Parent Commitment

I certify that my child may attend YMCA Circle of Champs Programs and is capable of participating in program activities. I understand that summer camp does not carry health and accident insurance and that I am responsible for health-incurred costs.

I grant the YMCA Circle of Champs and its agent's full authority to take whatever action they deem necessary regarding my child's health and safety, and I fully release the Capital District YMCA from any liability in connection to those decisions.

Parent Authorization for Treatment

In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp director to hospitalize and secure treatment for my child.

The health history provided here is correct to the best of my knowledge, and my child, who is named above, has my permission to engage in all camp activities except as noted by me on this form and/or my child's physician.

Print Parent / Guardian Name_____

Signature _____

Date_____

Please record the most recent dates for your child's immunizations.

Tetanus / / Measles / / Polio / / Rubella / /
DPT / / Mumps / /

Attention Medical Professional Please complete page 2 of this form **Parents,** email or mail to Rusty Decker.
RDecker@CDYMCA.org or 900 Delaware Avenue, Delmar, NY 12054

To be filled out and signed by a physician

Please indicate if the child has a history of the following:

☐ Anemia	☐ Diabetes	☐ High Blood Pressure	
☐ Appendicitis	☐ Ear Infections	☐ Hyperkinesis	☐ Skin Problems
☐ Asthma	☐ Fainting	☐ Seizures	☐ Tonsillitis
☐ Contact Lenses	☐ Hay Fever	☐ Severe Headaches	☐ Swimmer's Ear

If a hepatitis carrier, what type? _____

Central Line ☐ Yes ☐ No Specifications _____

I have examined (child's full name) _____ and found her/him to be able to take part in YMCA Circle of Champs programs. I certify that she/he is currently affected by the following life-threatening illness:

Diagnosis: _____

Restrictions/Comments:

_____

_____

Doctor's Name _____ Signature _____

Doctor's Office/Practice _____

Phone _____