YMCA OF TOPEKA
2026-2027 WINTER BREAK CAMP REGISTRATION FORM

PARTICIPATION REQUIREMENTS

Any student 5-12-years-old, that has completed Kindergarten and above at ANY school, can participate in **BREAK CAMP** but advanced registration (including KEY Academy participants) is required.

To register parents/guardians must fill out all KDHE forms.

KDHE forms must be completed before you can complete your registration for any camp program.

Forms and payment must be submitted in person at the YMCA of Topeka by **10PM** on **MON. 12/7**.

PROGRAM HOURS ARE 7:00AM-6:00PM

*12/24/26 Break Camp closes at 3:00pm

Required forms and payment must be submitted **IN PERSON** at the YMCA of Topeka. Registration not available online or at KEY Academy sites.

_____

PARTICIPANT NAME (FIRST AND LAST)

DATE OF BIRTH _____/____/_____

AGE 5 6 7 8 9 10 11 12 ____

_____

PARENT/GUARDIAN/CUSTODIAN FULL NAME (PRINT)

PRIMARY PHONE (___) ___-____ CELL WORK HOME

See our **BREAK CAMP** registration form for Fall, Winter, and Spring Break programs.

DROP-OFF TIME ____:____ AM PM

PICK-UP TIME ____:____ AM PM

Coverage is available from 7:00AM-6:00PM. Limit 10 hours/day/child.

WINTER BREAK CAMP PARTICIPATION

Check applicable dates and clarify intended drop-off/pick-up time.

MEMBERS $30/child/day **NON-MEMBERS** $37/child/day

DATES

- ☐ 12/21/26
- ☐ 12/22/26
- ☐ 12/23/26
- ☐ 12/24/26
- ☐ 12/28/26
- ☐ 12/29/26
- ☐ 12/30/26
- ☐ 12/31/27
- ☐ 01/01/27
- ☐ 01/04/27
- ☐ 01/05/27

PROGRAM SITE

YMCA of Topeka
3635 SW Chelsea Drive, Topeka, KS 66614

For general questions contact childcare@ymcatopeka.org.

For billing questions please contact us by phone at 785.271.7979 or by email at childcare-billing@ymcatopeka.org

NOTICE A minimum of ten (10) eligible students, per location, must register for BREAK CAMP for the program to be offered on that date - watch for confirmation emails. All adults (including parents/guardians) must be prepared, without exception, to show photo ID at pick-up. All YMCA child care and camp accounts must be current prior to participation. BREAK CAMP fees, while transferable, are non-refundable and must be paid, regardless of attendance without proper modification/cancellation prior to registration closing.

ENROLLMENT/INCOME ELIGIBILITY FORM FOR CHILD CARE CENTERS

PART 1 – CHILDREN'S INFORMATION—Required for all children in care.				
Child's Name	**Birthdate**	**Age**	**Circle Normal Days/ Print Normal Hours of Care**	**Circle Meals and Snacks Normally Received**
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours ________ to ________	Breakfast A.M. Snack Lunch P.M. Snack Supper Eve. Snack

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

☐ A family member in our household receives benefits from Food Assistance Program (FA), Temporary Assistance for Families (TAF), or Food Distribution Program on Indian Reservations (FDPIR). (Please complete Part 2 and 5.)

☐ One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)

☐ My child(ren) may qualify for Free/Reduced Price meals based on household income. (Please complete Part 4 and 5.)

☐ My child(ren) will not qualify for Free/Reduced Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING FA/TAF/FDPIR— Any household member receiving benefits can establish eligibility for all children in the household.	Case Number or Identification Number

PART 3 – FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children.	

PART 4 – TOTAL HOUSEHOLD GROSS INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2.

Tell us how much and how often. If no income, write "0". Use net income if self-employed.

List names (First and Last) of everyone in your household, including foster children	Earnings from Work Before Deductions	Weekly	Every 2 Weeks	2X Month	Monthly	Welfare, Alimony, Child Support	Weekly	Every 2 Weeks	2X Month	Monthly	Retirement, Pensions, Social Security, Other	Weekly	Every 2 Weeks	2X Month	Monthly
1.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
2.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
3.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
4.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
5.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐
6.	$	☐	☐	☐	☐	$	☐	☐	☐	☐	$	☐	☐	☐	☐

PART 5 – SIGNATURE AND CERTIFICATION—REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number (SSN) or check the box if no SSN. *See Privacy Act Statement on the back of this page.*

If you have listed a case number in Part 2 or are applying on behalf of a foster child or have checked the box that your child(ren) will not qualify for Free/Reduced Price meals, the last four digits of the SSN is not needed.

"I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of Adult	**Today's Date**	**Print Name of Adult Signing**
X______________________________________	__________________	**Social Security Number (SSN) (last four digits)** XXX-XX- ☐ Check if no SSN
Address	**City/State/Zip Code**	**Daytime Phone**

PART 6 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, the funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Food Assistance Program (FA), Temporary Assistance for Families (TAF) or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

DO NOT FILL OUT - CENTER USE ONLY

☐ Child(ren) are categorically free based on FA/TAF/FDPIR.

☐ Homeless, migrant, runaway or head start documentation from school, emergency shelter or agency.

☐ Foster child(ren) have been identified on this form and qualify for the free category.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice a Month x 24, Monthly x 12

☐ Child(ren) on this form who are not categorically eligible qualify as follows:
Check one: ☐ Free ☐ Reduced Price ☐ Paid

Household Size: _____

Total Income: $_____
☐ Annual ☐ Monthly ☐ Twice Per Month
☐ Every Two Weeks ☐ Weekly

X_____ _____
Signature of Determining Official **Today's Date**

X_____ _____
Signature of Confirming Official **Today's Date**

NOT VALID WITHOUT SIGNATURE AND DATE.
E/IEF Effective Date: If the institution is using the parent/guardian signature date as the effective date, the form must have been signed by the institution representative within the same month the parent signed the form or the immediately following month. If the institution representative does not evaluate and sign the E/IEF within these guidelines, the institution representative's signature date must be used as the effective date.

CCL. 358
Rev. 02/2026

Kansas Department of Health and Environment
Curtis State Office Building
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/280/Child-Care-Licensing

Child Health History
School Age Programs

In accordance with K.A.R. 28-4-590(d)(1), each school age program operator shall obtain a health history for each child or youth. Each health history shall be maintained in the child's or youth's file on the premises.

Child's First Day in Child Care_____ Name of Child Care Facility_____

Child's Name_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____ Name _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Child's Physician Name & Phone Number_____

Physician Address _____

Hospital Preference (for emergencies):_____

List any allergies or medical conditions of child:

_____

List any non-prescription or prescription medication the child will take during their time at the program:

_____

Provide additional information that will help staff meet the needs of the child (attach additional page if needed):

_____

Parent/Guardian Signature: _____ Date: _____

Child Health History (continued)
Immunizations

Child's Name:_____Date of Birth: _____
First Last MM/DD/YYYY

K.A.R. 28-4-590(d)(2), Each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.
K.A.R. 28-4-590(d)(4) Children or youth who are currently attending or who attended in the preceding school year a public or accredited non-public school in Kansas, Missouri, or Oklahoma shall not be required to provide documentation of current immunizations or exemptions from immunizations.

Do not provide immunization or exemption information if the child or youth is currently attending, or was attending during the previous school year at, a public or accredited non-public school.

Vaccine	Record the date (MM/DD/YY) each dose of vaccine was received				
	1st	2nd	3rd	4th	5th
Diphtheria, Tetanus, Pertussis (DTaP)					
Haemophilus influenzae type b (Hib)					
Hepatitis A (Hep A)					
Hepatitis B (Hep B)					
Measles, Mumps, Rubella (MMR)					
Pneumococcal disease (PCV15, PCV20)					
Poliomyelitis (IPV)					
Varicella (VAR)					
Respiratory syncytial virus (RSV) – Recommended, not required					
Rotavirus (RV) – Recommended, not required					
Influenza – Recommended, not required					

I attest that to the best of my knowledge the immunization information entered is true and correct.

Parent/Guardian Signature: _____ Date: _____

If your child is exempted from the law requiring immunizations, K.S.A. 65-508(g), check either (A) or (B) below and complete as required.

☐ (A) Certification from licensed physician stating that immunization would endanger the child's life. Child is exempt from the following immunizations:

_____DTaP _____Hib ____Hep A ____Hep B ____MMR ____PCV15/PCV20 ____IPV ____VAR

Physician's Signature (required): _____Date: _____

☐ (B) My child is exempt under the law from immunizations. As the parent or legal guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.

Parent/Guardian Signature: _____ Date: _____

CCL.359
Rev. 3/2017

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200 Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

Authorization for Self-Administration of Medication (Children/Youth in School Age Programs)

According to K.A.R. 28-4-590(e)(5)(A) any operator may permit a child or youth with a **chronic illness, condition requiring prescription medication on a regular basis, or a condition requiring the use of an inhaler** to administer the medication under staff supervision. The operator shall obtain written permission for the child or youth to self-administer medication from the child's or youth's parent or other adult responsible for the child or youth, and from the licensed physician or nurse practitioner treating the condition of the child or youth. Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. A record of administration must be kept.

_____

First and Last Name of Child or Youth

_____

Name of Medication (only one medication per authorization)

_____

Reason for Medication

_____

Dose Time to be Given **Start Date** **Stop Date****

_____

Print the Name of licensed Physician or Nurse Practitioner prescribing the medication Phone# of Health Care Provider

I authorize the self-administration of the above medication by my child or youth under staff supervision.

_____

Signature of Parent or Responsible Adult **Date Signed**

I authorize the self-administration of the above medication by the child or youth listed above under staff supervision.

_____

Licensed Physician or Nurse practitioner Signature **Date Signed**

****Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature and the licensed physician or nurse practitioner signature is required only once per year.**

THIS FORM IS TO BE USED TO DOCUMENT SELF ADMINISTRATION OF ONLY THE MEDICATION IDENTIFIED ABOVE. Provider or staff member supervising the self-administration of medication to note any comments or remarks about the child's or youth's appearance and/or condition on the back of the form.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

*Signature of Person Supervising Self-Administration of Medication _____Initialing as_____

*Signature of Person Supervising Self-Administration of Medication _____Initialing as _____

*Signature of Person Supervising Self-Administration of Medication _____Initialing as _____

*Signature of Person Supervising Self-Administration of Medication _____Initialing as _____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's or youth's appearance and/or condition.

CCL.010
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Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing

AD ASTRA PER ASPERA Kansas Department of Health and Environment

Authorization for Emergency Medical Care

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license	**License #**

I authorize ____(*caregiver/staff*) who is/are representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth____ (*child's first and last name)* while child or youth is in the facility's custody between ________________ and ______________________.
MM/DD/YYYY MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

____

____

____

Signature of Parent or Guardian	**Date Signed**

- -

The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is off premised from the facility.

CCL.026
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Authorization for Administering Medications to Children and Youth
Short-Term Medications (Prescription and Non-Prescription)

Prescription medication must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child or youth designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

Medication #1

_____
First and Last Name of Child/Youth Date of Birth

_____
Name of Medication

_____
Reason for Medication

_____
Dose Time to be Given Stop Date

_____
Name of Licensed Physician/PA/APRN prescribing the medication

I allow the above medication to be given to my child/youth by the designated person.

_____
Parent's Signature **Date**

Medication #2

_____
First and Last Name of Child/Youth Date of Birth

_____
Name of Medication

_____
Reason for Medication

_____
Dose Time to be Given Stop Date

_____
Name of Licensed Physician/PA/APRN prescribing the medication

I allow the above medication to be given to my child/youth by the designated person.

_____
Parent's Signature **Date**

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE.
Designated Person to note any comments or remarks about the child's/youth's appearance below on this form.
*Each designated person administering medication is to sign below on this form and identify initials used.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.

CCL.027
Rev. 07/2024

Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
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Kansas Department of Health and Environment

Authorization for Administering Medications to Children and Youth
Long-Term Medications (Prescription and Non-Prescription)

Prescription medications must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

First and Last Name of Child/Youth **Date of Birth**

Name of Medication (only one medication per authorization **Prescription OR Non-Prescription**

Reason for Medication

Dose **Time to be Given** **Start Date** **Stop Date****

Name of Licensed Physician, PA or APRN prescribing the medication

I allow the above medication to be given to my child/youth by the designated person.

Parent's Signature **Date Signed**

**Stop date not to exceed one year from the start date. A new authorization is to be completed any time the medication, dosage, times to be given, or instructions from the parent or health care provider change from the information included on this form. Additional copies of this form may be attached to this page if more space is needed to record the administration of the medication for up to one year if there are no changes in instructions. Above information must be completed on each page but the parent's signature is required only once per year.

This form is to be used to document administration of only the medication(s) identified above. Designated Person to note any comments or remarks about the child's/youth's appearance on the back of this form.
*Each designated person administering medication is to sign on the back side of this form and identify initials used.

Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials	Date mm/dd/yy	Time	*Initials

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.