FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LAKOTA FAMILY YMCA

CAMP ARROWHEAD
REGISTRATION FORM

SUMMER 2022

1. CAMPER AND PARENT INFORMATION *Indicates A Required Field (Please print legibly or type.)

*Camper First Name: _____ *Last Name: _____

*Birthdate _____ Gender: MALE ☐ FEMALE ☐

***Grade Starting in August 2022 School Year – Check Box**

1st (Sioux) ☐ 2nd (Cherokee) ☐ 3rd (Comanche) ☐ 4th (Navajo)

5th (Apache) ☐ 6th (Hopi) ☐ 7th (Iroquois) ☐ 8th-10th (CIT)

*Shirt Size: ☐ Youth Small ☐ Youth Medium ☐ Youth Large or Adult ☐ S ☐ M ☐ L ☐ XL

*Address: _____

*City: _____ * Zip Code: _____

*Primary Parent Full Name _____

*Phone # (____) _____-_____ *Email _____

2. CAMP REGISTRATION PAYMENT IS DUE AT SIGN UP.

This is a $50 NON-REFUNDABLE/NON-TRANSFERABLE DEPOSIT for each week checked below.

Camp Arrowhead		CAMP TYPES (Select weeks below)			*Please Note:* *CIT Campers Are for 8th grade and older children ONLY.*
Week #	Camp Week Dates	Day 9a - 4p	EXT. DAY 7a - 6p	C.I.T. 7a – 6p	To avoid paying a **Late Registration Fee** of $ 35.00, Register by the following dates:
1	05/23 - 05/27	☐	☐	☐	Register by 05/18/22
2	05/31 - 06/03 No Camp Monday, May 30th	☐	☐	☐	Register by 05/25/22
3	06/06 - 06/10	☐	☐	☐	Register by 06/01/22
4	06/13 - 06/17	☐	☐	☐	Register by 06/08/22
5	06/20 - 06/24	☐	☐	☐	Register by 06/15/22
6	06/27 - 07/01	☐	☐	☐	Register by 06/22/22
7	07/05 - 07/08 No Camp Monday, July 4th	☐	☐	☐	Register by 06/29/22
8	07/11 - 07/15	☐	☐	☐	Register by 07/06/22
9	07/18 - 07/22	☐	☐	☐	Register by 07/13/22
10	07/25 - 07/29	☐	☐	☐	Register by 07/20/22
11	08/01 - 08/05	☐	☐	☐	Register by 07/27/22
12	08/08 - 08/12	☐	☐	☐	Register by 08/03/22

****** TOTAL # WEEKS PRE REGISTERED _____ X $50.00 = $ _____ DUE TODAY**

I've selected the week or weeks I want my child to attend and understand weekly fees will be charged to my credit card each Friday for the upcoming week. Ifully accept all remaining balances. (**Please sign and date below) REQUIRED**

Signature:_____ **Date:**_____

3. BILLING INFORMATION: PARENT(S)/GUARDIAN(S) INFORMATION

PARENT/GUARDIAN 1:	PARENT/GUARDIAN 2:
NAME: _____	**NAME:** _____
RELATIONSHIP TO CHILD: _____	**RELATIONSHIP TO CHILD:** _____
PRIMARY NUMBER: _____	**PRIMARY NUMBER:** _____
SECONDARY NUMBER: _____	**SECONDARY NUMBER:** _____
OTHER NUMBER: _____	**OTHER NUMBER:** _____
EMAIL: _____	**EMAIL:** _____

- **Who is the Primary Responsible Parent/Guardian for billing? _____**
- **Do you need your Child Care split 50/50 between Parents/Guardians? ☐ YES ☐ NO**
    - **If one credit card does not process, the full payment will be taken out of the other Parent/Guardians account once all other options have been exhausted.**

4. FEES, BILLING POLICIES AND PROCEDURES

(See Camp Arrowhead Registration and Information Sheet for more information.)

Fees:	**Member Rates:**	**Day Camp: $153**	**Ext. Day Camp: $190**	**CIT: $122**
	Non-Member Rates:	**Day Camp: $196**	**Ext. Day Camp: $235**	**CIT: $155**

DEPOSIT OF $50 FOR ALL PRE-REGISTERED WEEKS REQUIRED.

Payments:

- If you are using a credit card for multiple weeks of camp, credit card(s) **MUST** be on file with the Lakota Family YMCA. It is your responsibility to keep this information up to date with the Lakota Family YMCA.
- By registering for this program, you authorize all childcare related fees to be charged to your credit card on file.
- Payments will be deducted from your account the Friday prior to the week registered. Only the balance for the week will be charged unless requested.
- **Cancelled weeks must be received in writing via our Cancellation Form, 1 weeks prior, the deposit of $50 for a week will not be refunded or transferred to another week or child.**
- There will be no balances on accounts carried over from week to week.

Credit Card Declines: Credit cards may decline up to 3 times with no additional fees. The 4th time and all other declines thereafter will be charged a $15.00 fee. *Compromised credit cards will be waived a declined fee until it becomes abused.

Late Fee: A $35 late fee per child will be accessed to your account(s) if we do not receive your payment by Monday at 8:00am the week you will attend. Your child(ren) will not be permitted to use our services until the account is paid in full.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

5. PAYMENT INFORMATION COMPLETED BY FRONT DESK (If using multiple payment options, both credit cards need to be available at time of registration or it will not be completed. Please allow the front desk to scan in the payment method onto the account and list the last 4 digits below.

Card 1:

CARD HOLDER NAME: _____

LAST 4 DIGITS OF CREDIT _____

EXP. DATE: _____ / _____ **% OF CHARGES TO THIS CARD:** _____

STREET ADDRESS: _____

ZIP CODE: _____

SIGNATURE: _____

Card 2:

CARD HOLDER NAME: _____

LAST 4 DIGITS OF CREDIT CARD NUMBER TO BE BILLED: _____

EXP. DATE: _____/_____ **% OF CHARGES TO THIS CARD:** _____

STREET ADDRESS: _____

ZIP CODE: _____

SIGNATURE: _____

Camp Arrowhead 2022
Paperwork Checklist

- ☐ **Health Enrollment Form**
- ☐ **Administration of Medication**
  - If applicable, if not needed put N/A
- ☐ **Child Medical/Physical Care Plan**
  - If applicable, if not needed put N/A
- ☐ **General Permission**
- ☐ **Permission to Pick-Up**
- ☐ **Routine Trip Permission**
- ☐ **Permission to Participate in Swimming**
- ☐ **Rockwall Release Waiver**
- ☐ **Current Picture of Participating Child**

All forms must be turned in yearly to hold your spot for Camp Arrowhead.

Ohio Department of Job and Family Services

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name	Date of Birth	First Day at Program/Home
Home Address		City
State	Zip Code	Home Telephone Number

Parent/Guardian Name #1	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone *(if applicable)*
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Parent/Guardian Name #2	Relationship to Child
Home Address ☐ Same as Child's	Home Telephone Number ☐ Same as Child's
City	State / Zip
Email Address *(if applicable)*	Cell Phone
Parent's Work/School Name	Parent's Work/School Telephone Number
Parent's Work/School Address	City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No

If you answered yes, please indicate which information above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ Email

Where can you be reached while your child is in this program/home?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. At least one person listed must be able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Name	Name
City / State	City / State
Telephone Number / Relationship to Child	Telephone Number / Relationship to Child
Other numbers where emergency contact can be reached *(if applicable)*	Other numbers where emergency contact can be reached *(if applicable)*

Name of Physician or Clinic/Hospital	
Street Address	
City / State	Telephone Number

Child's Name

Allergies, Special Health or Medical Conditions, and Medical Foods

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

☐ No

☐ Yes - *check all that apply* ☐ Food ☐ Medication ☐ Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor your child for symptoms to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or special health or medical condition? (*check one*)

☐ No

☐ Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

☐ No

☐ Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

☐ No

☐ Yes - written instructions from the child's health care provider must be on file.

☐ N/A - program does not provide meals or snacks to the child.

Child's Name

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff **or medical personnel** in an emergency situation.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

Diapering Statement

Is your child toilet trained? ☐ Yes *(If yes, skip to Emergency Transportation Authorization section)*
☐ No (If no, fill out the following:)

The program's policy is to check diapers every _____ hours. Please indicate if you want your child's diaper checked according to the program's policy or another:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**Do Not Give *Permission* to Transport**	
Program or Home Name Lakota Family YMCA		**OR**	Program or Home Name Lakota Family YMCA	
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.		**Do not sign both**	**does not have permission** to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:	
Parent's Signature	Date		Parent's Signature	Date

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the program's or home's policies and procedures/handbook. ☐ Yes ☐ No *(check one)*

This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care.

Parent/Guardian Signature(s)	Date
Administrator/Designee Signature	Date

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note:
This is a prescribed form which must be used by child care providers to meet the requirements to rules 5101:2-12-15, 5101:2-13-15, and 5101:2-14-04. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Ohio Department of Job and Family Services

REQUEST FOR ADMINISTRATION OF MEDICATION FOR CHILD CARE

This form is to be completed for each prescription or non-prescription medication that a child needs to receive while in care.

It is not required to be completed for topical products, lotions, or if the medication is required by a health care plan (JFS 01236).

Child's Name	Date of Birth *(if needed to determine the correct dosage)*	Weight *(if needed to determine the correct dosage)*

Box 1 The following section must always be completed by the parent/guardian.

Name of medication	Dosage	
	☐ See attached	
To be administered at the following times	For the following period of time	Medication expiration date

I understand:

1. *This form expires twelve months from the date of my signature, if box 2 has not been completed.*
2. *That my child must receive at least one dose of medication at home prior to the program administering the medication (unless the medication is used for emergencies).*

Signature of Parent/Guardian	Date

Box 2 The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant when any of the following apply:

1. The nonprescription medication contains codeine or aspirin;
2. A physician's instruction is needed for a nonprescription medication;
3. The child does not meet the minimum age or weight requirements as listed on the label instructions on the nonprescription medication;
4. The nonprescription medication is to be given longer than three consecutive days within a fourteen-day period;
5. The intended use differs from the manufacturer's instructions or use

Instructions

☐ See Attached

Possible side effects to watch for are

☐ See Attached

The child is under my care and should receive the above medication as written. I understand this form expires twelve months from the date of my signature.

Signature of licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant	Date of Signature

Phone Number

Ohio Department of Job and Family Services

CHILD MEDICAL/PHYSICAL CARE PLAN FOR CHILD CARE

A separate plan must be written for each condition that requires different actions to be taken and must be kept at the program for at least one year.

This form shall be completed when a child has a condition that requires one of the following:

- Monitoring the child for symptoms which require staff to take action
- Ongoing administration of medication or medical foods.
- Administering procedures which require staff to be trained on those procedures
- Avoiding specific food(s), environmental conditions or activities
- School-age child to carry and administer their own emergency medication

If the medication is documented on this form, then a JFS 01217 is not required.

Child's Name	Date of Birth

Special Health Condition

Does the condition require medication?

☐ Yes

☐ No

☐ **Check here if questions 1 through 7 are included on a separate sheet with physician's instructions.**

1. What are the symptoms to watch for?

2. When should the medication or medical food be administered?

3. What are the instructions for administration?

4. What triggers the need for medication or medical foods?

5. What are the expected results of the medication or medical foods?

6. What are the actions to be taken if symptoms do not subside?

7. What are the activities, foods, environmental conditions to avoid? ☐ Not applicable

Training instructions *(include all steps to administer the medication or perform the medical procedure)*

☐ Included on attached physician's instructions

If expected result of medication or medical food does not occur:

☐ Check here if Emergency Medical Services (9-1-1) is to be contacted

NOTE: If Emergency Medical Services (9-1-1) is to be contacted, the parent/guardian is also to be contacted immediately.

If the child care program must be evacuated, are there medications or supplies that must be taken with this child or does the child need additional assistance? *(Check all that apply)*

☐ Medication ☐ Supplies ☐ Assistance ☐ N/A

Parent Provided Training AND grants permission to perform the procedure	**Complete Only One Section**	**Certified Professional Training** AND parent grants permission to perform the procedure
My signature indicates I have provided training for the medical procedure and I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.		*My signature indicates I have provided training for the medical procedure*
Parent Signature		Certified Professional's Name *(please print)*
Date of Signature		Certified Professional's Signature
		Date of Signature / Phone Number
		My signature indicates I give my permission for the staff listed to perform the procedures in my child's medical/physical care plan.
		Parent Signature
		Date of Signature

Signatures of all child care staff members who have been trained in performing the procedure for this child.

Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date
Printed Name	Signature	Date

My signature indicates that I have reviewed the instructions for care, the form for completion and ensured staff are informed and trained.

Administrator/Provider Signature	Date of Signature

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, a new form must be completed.

Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

LAKOTA FAMILY YMCA

CHILD CARE GENERAL PERMISSION FORM

- I hereby grant permission for my child to:
    - Use all indoor/outdoor play equipment and participate in all activities at the center.
    - Be included in pictures, media print, electronic media and evaluations connected with any of the other child care programs.
    - Participate in field trips taken by the center. Prior information will be given to the parent/guarding about the trip.
- I hereby grant permission for the Child Care Director, Site Administrator or Camp Arrowhead Directors to take whatever steps that may be necessary to obtain emergency medical/dental care if warranted as state on the Health Enrollment Form.
- I understand that all expenses incurred in obtaining medical/dental treatment are my responsibility and not the Lakota Family YMCA's.
- I understand that the Lakota Family YMCA is not responsible for anything that happens as a result of false information given by the parent/guardian at the time of enrollment.
- I understand the Lakota Family YMCA will not assume responsibility for a child who has not been signed in upon arrival or signed out when they depart for the day. I understand that the person dropping off and/or picking up must be 16 years of age or older and on the Permission to Pick Up Form.

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: ____ / ____ / ____

LAKOTA FAMILY YMCA

CHILD CARE PERMISSION TO PICK UP

I give permission for the following people to pick up my child,

_____

from the Lakota Family YMCA Child Care Programs. I understand that the person picking up my child must be at least 16 years of age or older. They may also be asked for identification when picking up my child.

- Please make us aware of any custody issues.
- Please let us know right away if there are any changes to the above list.

NAME	RELATION TO CHILD	PHONE NUMBER

Parent/Guardian Name: _____

Parent/Guardian Signature:

Date:

Ohio Department of Job and Family Services

PERMISSION TO PARTICIPATE IN WATER AND SWIMMING ACTIVITIES FOR CHILD CARE

Written parental permission is required for the water activities your child will be engaging in when:
(check all that apply for this activity)

- ☐ Water is directly accessible to child (no water activities planned)
- ☑ Child swimming or playing in water 18 inches or more in depth
- ☐ Infants and toddlers using wading pools

The program is providing additional adults or child care staff members that exceed the licensing ratio requirements for the water/swimming activity.
(The program is to meet the minimum ratio requirements outlined in rule).

☐ Yes ☐ No

Swim Site
Lakota Family YMCA Indoor and/or Outdoor Pool/Bubble

Date(s)
May 1, 2022 - April 30, 2023

Departure/Arrival Times from Program
Varies

Mode of Transportation *(parents driving, provider vehicle, public transportation, school bus, etc.)*
Walking

I give permission for my child to participate in the swimming/water activity listed above.

Child's Name	Child's Date of Birth

My child is a ☐ Swimmer ☐ Non swimmer

Parent's Signature	Date

Ohio Department of Job and Family Services

ROUTINE TRIP PERMISSION FOR CHILD CARE

Routine Trip Information

Routine Trip Destination(s)

Liberty Park

Date of Permission *(valid for one year)*

May 1, 2022-April 30, 2023

Mode of Transportation (*walking, school bus, public transportation, parent vehicles, provider vehicle and driver)*

Walking

During this trip children will have access to water that is 18 inches or more in depth.

☐ Yes ☑ No

Are water activities planned in water that is 18 inches or more in depth? ☐ Yes ☐ No
(if yes, a swimming permission slip is required)

Child's Information

Child's Name

My child is

☐ not over 4 years and/or 40 lbs ☐ over 4 years and 40 lbs ☐ 8 years and/or over 4' 9"

Signature

I grant permission for my child to participate in the routine trips described above.

Parent's Signature	Date

LAKOTA FAMILY YMCA
CLIMBING WALL RELEASE

ACKNOWLEDGMENT, WAIVER & RELEASE FROM LIABILITY AGREEMENT

Notice: This document is a legally binding agreement. By signing this agreement, you are acknowledging that you have read, understood and accepted the terms and conditions stated in this agreement. You further acknowledge and agree that you are waiving your rights to bring court action to recover compensation or obtain any other remedy for any injury to yourself or your property.

Acknowledgment: I acknowledge that there are significant elements of risk associated with the sport of rock climbing, bouldering and incidental weight training, team building and fitness training regimens. I further acknowledge the nature and extent of the risks inherent in rock climbing and the use of the Lakota YMCA facilities, including, but not limited to:

- Injuries resulting from falling and crashing into walls, rocks or other obstacles, whether such walls, rocks or other obstacles whether such walls, rocks or other obstacles are permanent or temporary;
- Injuries resulting from rope abrasion, entanglement and other injuries that may result from activities or other persons, including, but not limited to, climbing, belaying, rappelling, lowering on rope, rescue or emergency activities, as well injuries, abrasions or cuts resulting from contact with climbing walls, holds or equipment;
- Injuries resulting from falling climbers or falling or dropped items, including, but not limited to, ropes, holds, or climbing hardware;
- Injuries resulting from any equipment failures, including, but not limited to, failures of ropes, slings, climbing harnesses, anchor points, or any part of the climbing structure;
- Injuries or death resulting from not following proper and customary personal safety procedures and the Safety Policies and Procedures of the Lakota YMCA which form a part of this agreement;
- Injuries resulting from the negligence of other climbers, participants, or users of the facilities, including, but not limited to, belayers or spotters;
- Injuries resulting personal physical and mental limits, including, but not limited to, fatigue, chill or dizziness, which may diminish reaction time and increase risk of accident, personal strength, coordination, sense of balance, and ability to follow or give directions while climbing, belaying, lifting, spotting, or being a spectator.

I acknowledge that the above list is not inclusive of all possible risk associated with the use of the Lakota YMCA facility, and that other unknown and unanticipated risk may result in injury, illness, or death.

Release, Assumption of Risk and Responsibility: In consideration of, and in recognition of the inherit risks of the activity associated with the use of the Lakota YMCA facility, I and/or on behalf of any minor children for which I am responsible for, agree, on behalf of myself, my/our heirs, representatives, successors, executors, administrators and assigns, to hereby release, waive, discharge and agree not to sue the Lakota YMCA, its officers, directors, shareholders, agents and employees, from any and all claims or demands, obligations and/or causes of action of any nature whatsoever which I may have against the Lakota YMCA, its officers, directors, shareholders, agents or employees, on account of any personal injury, property damage, death or accident of any kind, arising out of or in any way connected with the use of the Lakota YMCA facility or equipment, whether my/our use is supervised or unsupervised and I/we agree to indemnify and hold harmless the persons or entities mentioned in this paragraph from any and all liabilities or claims made by other individuals or entities as a result of my/our actions.

I further certify, acknowledge and agree on behalf of myself and/or any minor children for which I am responsible, that:
I am (we are) physically and mentally capable of participation in the activity and/or use the equipment;
I/ we assume responsibility for and voluntarily assume risk for any personal injury, death and related expenses involved in this activity;
I/we assume responsibility for damage to my/our personal property; and
I/we assume the risks for accidents or injury caused by the negligence of my/our belayer or spotter.

I further acknowledge on behalf of myself and on behalf of any minor for which I am responsible, that wearing appropriate clothing and footwear are basic safety precautions, and that wearing a UIAA approved helmet may help prevent head and or neck injuries.

Medical Authorization: I agree, on behalf of myself and on behalf of any minor children for which I am responsible, to authorize any medical treatment deemed necessary in the event of any injury or illness while participating in the use of the Lakota YMCA facility and/or its' equipment. I agree, on behalf of myself or on behalf of any minor children for which I am responsible, to pay all costs of any rescue and/or medical services as may be incurred on my/our behalf.

Promotional Authorization: I agree, on behalf of myself and on behalf of any minor children for which I am responsible, that any film or photographs of me/us, as users if the Lakota YMCA facility, become the property of the Lakota YMCA and may be used for promotional or commercial purposes.

IN WITNESS WHEREOF, I have signed this agreement in Middletown, Ohio this _____day of _____ 202_2_____.

User _____ Printed Name_____ Date of Birth_____

I, as parent, guardian or responsible party of the above-named minor child under the age of 18 years, hereby acknowledge reading, understanding and agreeing to the terms and conditions of this agreement.

Parent/Guardian/Responsible Party Signature_____Printed Name_____

Safety Policies and Procedures of the Lakota YMCA

The following are the Safety Policies and Procedures of the Lakota YMCA. They are not all inclusive and the user of the Lakota YMCA facility recognized that they have responsibility to conduct themselves and any and all persons under their control or supervision, including minor children, in a proper, courteous and safe manner during all times they are on the Lakota YMCA property.

In consideration for the use of the Lakota YMCA facility and equipment, you agree to accept full responsibility for your own safety and the safety of others while on the premises and to abide by and help enforce the following Safety Policies and Procedures.

All persons using or being a spectator of the Lakota YMCA facility shall have signed an Acknowledgement Waiver & Release from Liability Agreement, and if requested to gain access to the facility, present a photo identification.

Each new user of the facility shall be required to demonstrate safe belaying and tie-in techniques to an authorized instructor of the Lakota YMCA. Only approved climbers/spectators will be allowed in the climbing area. New belayers shall take a training session and be qualified by an authorized instructor of the Lakota YMCA before receiving approval for climbing.

No un-belayed climbing over ten (10) feet the landing zone shall be permitted. Failure to strictly comply with this Policy may result in immediate expulsion from the facility and withdrawal of any future climbing privileges.

Climbing above the ten (10) feet restriction over the landing zone shall be roped and belayed using an approved belay device. All rope climbers and belayers shall wear approved harnesses.

Climbers must tie the rope directly into the two parts of their harness (not their belay loop) with a figure eight (8) retrace knot.

Helmets are required for all climbers, unless a helmet Waiver is signed.

Lead climbers and their belayers both demonstrate the proper understanding of leading and belaying techniques to an authorized instructor of the Lakota YMCA before using the lead route wall.

All users of the Lakota YMCA facility have an affirmative duly to inform employees of the Lakota YMCA as well as fellow climbers/belayers and any situation seen as unsafe or not in compliance with these Safety Policies and Procedures. All climbers are requested to assist and encourage less experienced climbers.

All accidents or equipment damage or failures shall be reported to an employee of the Lakota YMCA immediately.

The Lakota YMCA reserves the right to deny access to its facilities to any person, permanently or for a specific period of time, for any breech of this agreement or failure to strictly adhere to the Safety Policies and Procedures, or for any conduct that is viewed as unsafe, inappropriate or unhealthy including, but not limited to, horseplay, foul or rude language or defiance of a Lakota YMCA employee's request.

The Lakota YMCA is a Drug, Tobacco, and Alcohol-Free Zone for all persons.

I have read, and understood and agreed, on behalf of myself and/or on behalf of any minor children I am responsible for, to the above Safety Policies and Procedures.

Signature_____

Printed Name_____Date_____

Helmet Waiver

I agree, on behalf of myself and/or on behalf of any minor children for which I am responsible for, that there are inherent dangers involved with climbing activities and that I/we assume all risks associated with such activities. I/we realize that I/we are subject to injury from this activity. I/we further understand that the Lakota YMCA Safety Policies and Procedures require the use of and wearing of safety protective helmets, which could prevent injury to my/our head, including, but not limited to, permanent brain damage. Against the advice of the Lakota YMCA, and its insurance company, I/w am refusing this critical safety precaution and hereby waive and release the Lakota YMCA its officers, directors, shareholders, employees and agents from any and all liability associated with my voluntary refusal to wear a safety helmet.

Signature_____

Printed Name_____Date_____

Belay Check

Pass Top Rope
Date:_____
Instructor:_____

Pass Lead
Date:_____
Instructor:_____

_____
Instructor Signature

_____
Instructor Signature