2010-2011 YMCA School's Out Enrollment Record

Eau Claire YMCA 700 Graham Avenue Eau Claire WI 54701 (715) 836-8460

All registration information must be completely filled out before your child is registered. $25 registration fee must be included per child ($55 max per family)

Child(ren)'s Information:

First Child's Name:	Birth date:	Sex:	Grade:
Second Child's Name:	Birth date:	Sex:	Grade:

Parent or Guardian: (Bills will be sent to Primary caregiver unless otherwise specified)

Relationship	Name	Home Address	Zip Code	Home #	Cell #	Work Name	Work Phone #
Primary							
Secondary							
Email							

Emergency contact – List information of person to contact when parent or guardian cannot be reached.

Relationship	Name	Home Address	Zip Code	Home #	Cell #	Work Name	Work Phone #

Person(s) Authorized to Pick-up Child(ren) (other than parents or guardians)

Relationship	Name	Home Address	Zip Code	Home #	Cell #	Work Name	Work Phone #

Custody arrangements we should be aware of?____________________ **Human Service Contact**____________________

Office Use Only: Date:______ Paid Reg. Fee:______ Signatures:______ Confirmation:______ Chart:______ ProCare:______ Immunizations:______ Forms Comp:______ Copies:______

Immunizations and Health History

List the month and year your child(ren) received the following vaccinations. This information must be completed for licensing reasons every year. If this area is not completed the form **WILL NOT BE ACCEPTED**.
We do NOT keep these records "on file".

First Child:______________________________

List the MONTH, DAY and YEAR your child received each of the following immunizations. DO NOT USE a check mark. If you do not have an immunization record for this child at home, contact your doctor or public health agency to obtain the dates.

TYPE OF VACCINE	First Dose	Second Dose	Third Dose	Fourth Dose	Fifth Dose
DPT/DT/Td					
Polio					N/A
Hib					N/A
Hep B				N/A	N/A
Pneumococcal				N/A	N/A
MMR			N/A	N/A	N/A
Varicella			N/A	N/A	N/A

My child should not be immunized:

☐ personal conviction ☐ religious reason ☐ health reasons

Dates Attending:

( ) October 14 6:30-6:00
( ) October 15 6:30-6:00
( ) November 10 11:30-6:00
( ) November 24 6:30-6:00
( ) December 6 6:30-6:00
( ) December 23 6:30-6:00
( ) December 27 6:30-6:00
( ) December 28 6:30-6:00
( ) December 29 6:30-6:00
( ) December 30 6:30-6:00
( ) December 31 6:30-6:00
( ) January 12 11:30-6:00
( ) January 24 6:30-6:00
( ) March 9 11:30-6:00
( ) March 21 6:30-6:00
( ) March 22 6:30-6:00
( ) March 23 6:30-6:00
( ) March 24 6:30-6:00
( ) March 25 6:30-6:00
( ) April 22 6:30-6:00
( ) May 4 11:30-6:00
( ) Snowed Out Program (any ECASD day cancelled due to inclement weather).

Dates subject to change based on the finalization of the ECASD Calendar

Second Child:______________________________

List the MONTH, DAY and YEAR your child received each of the following immunizations. DO NOT USE a check mark. If you do not have an immunization record for this child at home, contact your doctor or public health agency to obtain the dates.

TYPE OF VACCINE	First Dose	Second Dose	Third Dose	Fourth Dose	Fifth Dose
DPT/DT/Td					
Polio					N/A
Hib					N/A
Hep B				N/A	N/A
Pneumococcal				N/A	N/A
MMR			N/A	N/A	N/A
Varicella			N/A	N/A	N/A

My child should not be immunized:

☐ personal conviction ☐ religious reason ☐ health reasons

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( ) May 4 11:30-6:00
( ) Snowed Out Program (any ECASD day cancelled due to inclement weather).

Dates subject to change based on the finalization of the ECASD Calendar

Child(ren)'s Medical Facility or Physician

Name: ______________________________

Phone #: ______________________________

Child(ren)'s Dentist or Dental Office

Name: ______________________________

Phone #: ______________________________

Parental Consent: I have had the opportunity to review the SACC policies and give my consent for any medical care or treatment to be used only if I cannot be reached immediately.

Parent Signature ____ **Date** ______________

DEPARTMENT OF CHILDREN AND FAMILIES **STATE OF WISCONSIN**
Division of Early Care and Education
DCF-F (CFS-2345) (R. 03/2009)

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(l)5., DCF 251.041(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statues].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION - First Child

Name (Last, First, MI)	Address - Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date - First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION

Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number - Home	Telephone Number - Work	Telephone Number - Cellular
Name	Telephone Number - Home	Telephone Number—Work	Telephone Number - Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name - Physician	Address - Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION

If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN

If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have
   - ☐ No specific medical condition
   - ☐ Asthma
   - ☐ Diabetes
   - ☐ Gastrointestinal or feeding concerns including special diet and supplements
   - ☐ Cerebral palsy / motor disorder
   - ☐ Epilepsy/seizure disorder
   - ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD or Autism
   - ☐ Other condition(s) requiring special care - Specify.
   - ☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
   - ☐ Food allergies - Specify food(s).
   - ☐ Non-food allergies - Specify.
2. Triggers that may cause problems - Specify.
3. Signs or symptoms to watch for - Specify.
4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form Authorization to Administer Medication should be attached to this form. Note: group child care centers and day camps may use their own form.
5. Identify any child care staff whom you have given specialized training/instructions to help treat symptoms.
   a.
   b.
   c.
6. When to call parents regarding symptoms or failure to respond to treatment.
7. When to consider that the condition requires emergency medical care or reassessment.
8. Additional information that may be helpful to the child care provider.

SIGNATURE—Parent or Guardian	Date Signed (mm/dd/yyyy)

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education **STATE OF WISCONSIN**
DCF-F (CFS-2345) (R. 03/2009)

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Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION - Second Child

Name (Last, First, MI)	Address - Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date - First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION
Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number - Home	Telephone Number - Work	Telephone Number - Cellular
Name	Telephone Number - Home	Telephone Number—Work	Telephone Number - Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name - Physician	Address - Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION
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☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN
If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have

   ☐ No specific medical condition

   ☐ Asthma ☐ Diabetes ☐ Gastrointestinal or feeding concerns including special diet and supplements

   ☐ Cerebral palsy / motor disorder ☐ Epilepsy/seizure disorder ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD or Autism

   ☐ Other condition(s) requiring special care - Specify.

   ☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

   ☐ Food allergies - Specify food(s).

   ☐ Non-food allergies - Specify.

2. Triggers that may cause problems - Specify.

3. Signs or symptoms to watch for - Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form Authorization to Administer Medication should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff whom you have given specialized training/instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE—Parent or Guardian	Date Signed (mm/dd/yyyy)

PARENT/GUARDIAN CONSENT FORM

Section #1: REASONABLE ACCDOMMODATIONS CLAUSE: Children with special needs or challenges will be accepted provided that "reasonable accommodations" can be made for their participation in the program and/or child's participation does not require an inordinate amount of staff time that would not allow for the safety and welfare of the other children in the program. I understand that if my child/ren requires an unusual amount of one on one attention, whether due to special needs or behavior, my child may be removed from the program. You are solely responsible for determining if your child/ren are physically fit for the activities contemplated in these programs. It is always advisable, especially if your child/ren have an illness, injury or impairment, to consult a physician before undertaking any active recreational program.
_____ (Parent/Guardian Initials)

Section #2: MEDICAL RELEASE: I understand that in the event medical intervention is needed, every attempt will be made to immediately contact the emergency persons listed. In the event they cannot be reached, I give consent for YMCA staff to act in my behalf in granting permission for my child/ren to receive emergency treatment. I agree that I will be responsible for the payment of any and all medical services rendered.
_____ (Parent/Guardian Initials)

Section #3: RELEASE FROM LIABILITY: I understand that all reasonable safety precautions are taken by the YMCA in the operation of its facility, equipment, and programs. However, participants and parent of children must recognize and accept that there are inherent risks when choosing to participate in day camp or any YMCA program. Risks that could cause sickness, injury or death. I agree that my child/ren's participation in the YMCA programs shall be undertaken at his/her sole risk, and that the YMCA, its director, employees, and volunteers shall not be liable for any claims, injuries, damages, losses, diseases, wrongful death, actions or causes of action whatsoever, to my child/ren or his/her property, arising out of or connected to participation in any YMCA programs. I agree to hold harmless and indemnify the YMCA, its director, employees, and volunteers from any and all liabilities and claims resulting from participation in this program.
_____ (Parent/Guardian Initials)

Section #4: MEDIA RELEASE: They YMCA occasionally uses photographs for media coverage an promotional materials.
☐ **I do** ☐ **do not** give my permission for my child/ren to appear in media coverage approved by the YMCA.
_____ (Parent/Guardian Initials)

Section #5: ACCURATE/COMPLETE INFORMATION: I hereby state that the information is accurate and complete. I understand that it is my responsibility to provide any changes/updates regarding emergency and health information to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize my child/ren's registration and/or participation in YMCA programs.
_____ (Parent/Guardian Initials)

Section #6: FIELD TRIP PERMISSION: I give permission for my child to participate in walking/student transit/YMCA small bus field trips scheduled during program hours. I understand that these trips are dependant on daily weather conditions and field trips will be planned and implemented with the physical ability and maturity of the children attending taken into consideration.
_____ (Parent/Guardian Initials)

Section #7: RESPONSIBILITY STATEMENT: I understand that the YMCA's reasonability for my child begins after s/he has entered the program area and has been signed in and ends when s/he leaves the program area and is signed out. I understand that I and/or an authorized adult must sign my child/ren in and out
_____ (Parent/Guardian Initials)

Section #8: PARENT HANDBOOK: I have received the YMCA School Age Child Care Handbook and/or Day Camp Brochure which included necessary program information for my child and me. I have read the information and agree to abide by the policies and procedure therein. I also understand that a copy of the Policies and HFS 46 licensing manual are available to me at the parent table.
_____ (Parent/Guardian Initials)

Section #9: INFORMATION RELEASE: I authorize the Eau Claire YMCA and my child's school to exchange and share information related to my child including: YMCA reports, behavior plans, school psychological evaluations, social work reports, IEP's and related evaluations/reports.
_____ (Parent/Guardian Initials)

Section #10: SCHEDULE/ATTENDANCE INFORMTION: I understand that written schedule changes and cancellations are required at least 2 weeks in advance to receive full credit and those changes need to be given to the SACC office. I also need to notify the program site staff of all extra curricular activities and illnesses that may affect my child's attendance.
_____ (Parent/Guardian Initials)

Section #11: ACCURATE/COMPLETE INFORMATION: I hereby state that all information I have provided is accurate and complete. I understand that it is my responsibility and required by licensing to provide any changes/updates regarding emergency and health information to YMCA.
_____ (Parent/Guardian Initials)

Section #12: PG MOVIES: The YMCA occasionally watches movies.
☐ **I do** ☐ **do not** give my permission for my child/ren to watch movies rated PG.
_____ (Parent/Guardian Initials)

I have carefully read and initialed each of the above parent/guardian consent sections. I fully understand that by signing this form I have given my parent/guardian consent for my child on all section contained within.

______________________________	______________________________	__________
Participant Name– Please Print	**Parent/Guardian Signature**	**Date**

2010-2011 School's Out Payment Agreement

Name of Child   Date

☐ **Express Payment Plan I - Automatic Bank Draft**
(monthly draft from checking or savings account - please attach a voided check)

I hereby authorize the YMCA to initiate electronic fund entries on the 12th of each month to my account indicated below and the financial institution named below to debit my account.

PRINT NAME ON THE ACCOUNT   ROUTING & ACCOUNT # (Attach Voided Check)

FULL NAME OF BANK   City

In the event my bank does not honor my draft, I understand that I am still responsible for that payment to the YMCA and for any service fee imposed by my bank. If more than two bank drafts are returned on my account I realize that my bank draft privileges will be revoked and I am responsible for the remaining balance due on my account payable on a cash basis only.

AUTHORIZED SIGNATURE   DATE

☐ **Express Payment Plan II - Credit Card**
(weekly charge to credit card - Visa, MasterCard, and Discover)

CREDIT CARD TYPE   YOUR NAME ON CARD (Print Clearly)

CREDIT CARD NUMBER   EXP. DATE

In the event my credit card does not honor my draft, I understand that I am still responsible for that payment to the YMCA and for any service fee imposed by my credit card company. If more than two payments are returned I realize that my credit card privileges will be revoked and I am responsible for the remaining balance due on my account payable on a cash basis only.

AUTHORIZED SIGNATURE   DATE

☐ **Payment Plan III - Cash/Credit**

- I do not wish to participate in either Express Payment Plan at this time.
- I understand that the weekly fee is due 2 weeks in advance.

AUTHORIZED SIGNATURE   DATE