SCHOOL AGE PROGRAM ENROLLMENT FORM

CHILD(REN) INFORMATION

Child's Name (Last, First)	Gender	Home Address (Street, City, State, Zip Code)	DOB	First Day of Attendance
1.				
2.				

PARENT OR GUARDIAN INFORMATION (All parents/guardians are permitted to visit during center hours and are allowed to pick up child(ren) unless prohibited or restricted by a court order) **Attach court order, if any**

Father/ Guardian	Name (Last, First)	Home Address (Street, City, State, Zip)	Cell Phone #	Home Phone #
	Place of Employment or where reachable	Email address where reachable while child is in care	Work Phone #	Does this child reside at this location?
				☐ YES ☐ NO
Mother / Guardian	Name (Last, First)	Home Address (Street, City, State, Zip)	Cell Phone #	Home Phone #
	Place of Employment or where reachable	Email address where reachable while child is in care	Work Phone #	Does this child reside at this location?
				☐ YES ☐ NO

PERSON(S) OTHER THAN PARENTS AUTHORIZED TO PICK-UP CHILD(REN) Provide information requested for each person. If no one, write "**NONE**."

Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Telephone #
	Place of Employment or where reachable	Email address where reachable while child is in care	Work Phone #	Cell Phone #
Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Telephone #
	Place of Employment or where reachable	Email address where reachable while child is in care	Work Phone #	Cell Phone #

EMERGENCY CONTACT Provide information for the person to contact in the event parents or guardians cannot be reached.

This person is authorized to pick up the child. ☐ YES ☐ NO **(Check Box)**

Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Home Phone #
	Place of Employment or where reachable	Email address where reachable while child is in care	Work Phone #	Cell Phone #

Health History

Child's Name

Child's physician or medical facility (name, address, phone number)

1. Circle any special medical condition that your child may have:

☐ No Specific Medical condition	☐ Cerebral palsy/motor disorder	☐ Asthma	☐ Diabetes
☐ Epilepsy/seizure disorder	☐ Cognitively Disabled/LD	☐ ADD/ADHD	☐ Autism
☐ Gastrointestinal or feeding concerns including special diet and supplements	☐ Food Allergies Specify._____	☐ Non-food Allergies Specify._____	☐ Milk Allergy If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

2. Triggers that may cause problems—Specify.

3. Signs or symptoms to watch for—Specify.

4. Steps the child care provider should follow. If medications are necessary, a copy of the Authorization to Administer Medication, should be attached. Indicate any child care staff who have received specialized training/instructions to help treat symptoms.

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

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

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

Immunization History

Type of Vaccine	First Dose Mo/day/yr	Second Dose Mo/day/yr	Third Dose Mo/day/yr	Fourth Dose Mo/day/yr	Fifth Dose Mo/day/yr
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus Influenzae Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) required only if the child has not had chickenpox					

Has the child had chickenpox? ☐ YES year_____ ☐ NO or Unsure (vaccine is required)

☐ For religious reasons this child should not be immunized.

☐ For personal conviction reasons, this child should not be immunized.

☐ For health reasons this child should not receive immunizations. _____

Physician's Signature Required

Health History

Child's Name

Child's physician or medical facility (name, address, phone number)

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

☐ No Specific Medical condition	☐ Cerebral palsy/motor disorder	☐ Asthma	☐ Diabetes
☐ Epilepsy/seizure disorder	☐ Cognitively Disabled/LD	☐ ADD/ADHD	☐ Autism
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Physician's Signature Required

PARENT AGREEMENT:

Please initial at each space and sign at the bottom indicating that you understand and agree to the policies below:

_____ I understand that a copy of this program's policies and a summary of the Wisconsin Rules for Licensed Child Care Centers and Day Camps are available upon request.

_____ I agree to pay my child's tuition fees when due and I understand if tuition is not paid, care will be terminated.

_____ I understand that if I receive W2 assistance that an additional form is required to be completed for Billing and Registration.

_____ I understand that my registration fees and deposits are non-refundable and non-transferable.

_____ In the event of program withdrawal, I agree to give Billing and Registration a two weeks notice. If a two week notice is given the Y will issue a100% refund (minus the deposit). If the cancellation is not within two weeks only a 50% refund will be issued (minus the deposit).

_____ I understand that parents or an authorized person are expected to sign children in and out of the program each day and to bring photo identification. Parents are also expected to pick up children by 6:00 pm or late fees will be assessed.

_____ I understand the YMCA's behavior guidance policy and am aware that if my child fails to meet expectations and standards set forth by the YMCA, care may be suspended or terminated.

_____ I understand that the YMCA is not responsible for lost or stolen items and personal items or toys from home are not permitted in programming.

_____ I authorize the Oshkosh YMCA to transport my child via bus, emergency vehicle, or by walking for daily trips to Camp, special events, weekly field trips, or on an emergency basis.

_____ I ☐ GIVE or ☐ DO NOT GIVE (Check box) permission for photographs and or videos to be taken of my child for YMCA use only. (YMCA Facebook Page, YMCA Website, or YMCA promotional items)

_____ I hereby give consent for emergency medical care or treatment to be used only if I cannot be reached immediately.

_____ I have been informed of the number of pets in the center and their degree of contact with the enrolled children. (WE DO NOT HAVE ANY PETS)

_____ I authorize the Oshkosh YMCA to use the following bug spray and sunscreen for my child:
BUG SPRAY: Repel Bug spray-DEET 40 SUNSCREEN: Equate Sunscreen-SPF 50
☐ I authorize STAFF TO APPLY the bug spray and sunscreen each day as needed.
☐ I authorize my child to SELF APPLY the bug spray and sunscreen each day as needed.
(Check box)

PARENT SIGNATURE:_____ DATE:_____

UPDATES:_____ _____ _____ _____

Oshkosh Community YMCA
School Age Child Care Department
Emergency Information Card

Child's Name:_____
DOB:_____
Address:_____ City:_____ Zip:_____
Mother/Guardian Name:_____ Phone:_____
Father/Guardian Name:_____ Phone:_____
Emergency Contact:_____
Relationship to child:_____ Phone:_____

Child's Physician:_____ Phone:_____

Please list any special medical concerns or allergies:

In the event of an emergency, I authorize any medical treatment necessary. I understand that in the event of such an emergency I will be contacted first and this waiver will only be necessary if I or my emergency contact person cannot be reached.

Signature:_____ **Date:**_____

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School Age Child Care Department
Emergency Information Card

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Address:_____ City:_____ Zip:_____
Mother/Guardian Name:_____ Phone:_____
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Child's Physician:_____ Phone:_____

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Signature:_____ **Date:**_____