2015 Monday August 31st 2015 Kid's Day Out Enrollment Form

CHILD(REN) INFORMATION

Child's Name (Last, First)	Sex	Home Address (Street, City, State)	Zip Code	Telephone #	DOB
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 Code	Telephone #
	Place of Employment or where reachable	Address (Street, City, State, Zip)	Work Phone #/ Email	Cell Phone #
Mother / Guardian	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Telephone #
	Place of Employment or where reachable	Address (Street, City, State, Zip)	Work Phone #/Email	Cell Phone #

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	Address (Street, City, State, Zip)	Work Phone #	Cell Phone #
Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Telephone #
	Place of Employment or where reachable	Address (Street, City, State, Zip)	Work Phone #	Cell Phone #

EMERGENCY CONTACT Provide information for the person to contact when parents/guardians cannot be reached. ☐ YES ☐ NO This person is authorized to pick up the child.

Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Telephone #
	Place of Employment or where reachable	Address (Street, City, State, Zip)	Work Phone #	Cell Phone #

PARENT CONSENT/AUTHORIZATION Please initial each line & provide signature at bottom of page stating you have read and understand each item.

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

_____ **I authorize the YMCA to take my child on all fieldtrips, whether by bus transportation or by walking during program hours.**

_____ **I ☐ give or ☐ do not give permission for promotional photographs to be taken of my child. (Please check the appropriate box)**

_____ **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 understand that my $20 registration fee per week per child is non-refundable and non-transferable.**

PARENT SIGNATURE_____ **DATE**_____ **OVER ►**

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 ☐ ADD/ADHD ☐ Special Diet ☐ Emotional Disorder

☐ Gastrointestinal or feeding concerns including special diet/supplements

☐ Other condition(s) requiring special care—specify._____

☐ 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 medications are necessary, a copy of the CFS-59, Authorization to Administer Medication, should be attached. Indicate any child care staff who have received specialized training/instructions to help treat symptoms.

A.
B.
C.

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
DTP/DT/Td DIPHTHERIA-TETANUS-PERTUSSIS					
POLIO					
HAEMOPHILUS INFLUENZA b (HIB)					
HEPATITIS B					
MEASLES, MUMPS, RUEBELLA (MMR)					
VARICELLA (Chicken Pox)					

☐ For religious reasons, this child should not be immunized.

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

Please submit new Immunization each program.

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Mail To: YMCA Summer Camp, 324 Washington Avenue, Oshkosh, WI 54901 **For Information call:** (920) 236-3380 ext. 388