Y Early Learning Program Wrap Care Registration Form

Child's Name _____

Child Start Date _____ **School District Child Resides In** _____

YMCA ELP WRAP CARE OPTIONS
Please select the YMCA ELP Wrap Care you wish to register for:

3 Year Old – Four Day ELP Wrap Care | Monday– Thursday
- ☐ 12:20–3:50 PM

4 Year Old – Five Day ELP Wrap Care | Monday – Friday
- ☐ Morning Wrap Care: 8:50–11:50 AM
- ☐ Afternoon Wrap Care: 12:20–3:50 PM

2023–2024 YMCA ELP WRAP CARE PRICING

AGES	DAYS	MONTHLY FEE
Age 4	5 Days	$400
Age 3	4 Days	$320

ADDITIONAL CARE OPTIONS
- Free AM Care 8:00–8:50 AM provided by the YMCA for all ELP Wrap Care Students
- AM & PM Care available for 4 year olds through the YMCA's Y BASE Program from 6:30–8:50 AM & 4:00–6:00 PM

A $50 DEPOSIT IS DUE AT THE TIME OF REGISTRATION.
Please note, registrations will not be processed without a non-refundable deposit and Payment Authorization Form.

☐ **I authorize the Y to charge the payment method on file for the $50 deposit.**

CONTACT US

SOUTHWEST YMCA
11311 W Howard Ave, Greenfield 53228
414-329-3871
registrar@gwcymca.org

PAYMENT INFORMATION
Registration will not be processed unless it is accompanied by a non-refundable $50 deposit and a Payment Authorization Form. It is your responsibility to contact the YMCA Registrar in writing by the 10th of the prior month to terminate your monthly payment plan or to change your payment information. A $15 late fee will be assessed for all late payments, returned checks, or problem payments with monthly drafts. I understand that I am financially responsible for all payments. Should my monthly amount not be honored by my financial institution for any reason, I agree to be responsible for that payment plus a $15 service charge assessed by the YMCA. If full payment is not made, I agree to pay for all extra fees incurred for the collection of funds. I understand that it is my responsibility to notify the YMCA of Greater Waukesha County of any change in my bank account or credit card information, including the expiration date, and those changes must be submitted in writing at least 10 days in advance of the billing date. I understand that no refunds are given.

_____ Initial

PARENT/GUARDIAN AUTHORIZATION
- I understand that I am responsible for the monthly tuition or my spot may be forfeited.
- I understand that no refunds are given.
- I understand that to withdraw my child from the program, I must provide written notice to the YMCA Registrar by the 10th of the prior month. No credits will be issued.
- I grant permission for the applicant to participate in all planned activities and trips by walking, van, or bus.
- I understand my child must be potty trained to attend ELP Wrap Care.
- I understand my child may not attend class if they display symptoms of a communicable illness.
- In case of accident or illness, the YMCA is authorized to secure emergency medical treatment. Prudent attempts will be made to contact the parents immediately.
- The YMCA is not responsible for lost, stolen or damaged personal articles.
- I authorize the YMCA to have and use photographs and videos of the person named in this application as may be needed for its public relations programs, including social media.
- I agree to waive any claims against the YMCA and its members and volunteers for injuries or damages that may result from the conduct of other persons including participants in YMCA programs.
- I understand that there are no pets on location.
- I understand if my child requires alternate arrival or release, I will complete a separate form with updated information on it.
- I understand that current immunization information (page 1 of Registration Form) must be completed at the time of registration.
- I understand failure to complete all mandatory forms will result in a forfeited spot in ELP Wrap Care and my child will be taken off rosters. No exceptions.

_____
Parent/Guardian Signature Date

For Office Use Only: _____
DATE RECEIVED TIME RECEIVED STAFF INITIALS

2023–2024 REGISTRATION FORM, HEALTH HISTORY & EMERGENCY CARE PLAN

YMCA of Greater Waukesha County One form per child. A new form must be filled out each year.

(ALL SECTIONS MUST BE FILLED OUT. IF SOMETHING DOES NOT APPLY, PLEASE USE N/A)

CHILD INFORMATION

Child's First Name _____ Middle Initial ____ Last Name _____ Gender ☐ M ☐ F ☐ Other _____

Birth date ____/____/____ Age (as of Sept. 1, 2023) _____ Child resides with ☐ Parent/Guardian #1 ☐ Parent/Guardian #2 ☐ Both

Are you a Y Member? ☐ Yes ☐ No If yes, Y Member Number _____ Home Branch _____

Parent/Guardian Information – Both parents must be listed. Use N/A if not applicable.

#1 Parent/Guardian First Name _____ Middle Initial ____ Last Name _____ Gender ☐ M ☐ F ☐ Other Birth date ____/____/____

Home Address (Street, City, State, Zip) _____

Preferred method of contact _____ E-Mail _____

Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____

Daytime Address/Employer Name & Address _____

#2 Parent/Guardian First Name _____ Middle Initial ____ Last Name _____ Gender ☐ M ☐ F ☐ Other Birth date ____/____/____

Home Address (Street, City, State, Zip) _____

Preferred method of contact _____ E-Mail _____

Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____

Daytime Address/Employer Name & Address _____

Emergency Contacts/Others Authorized to Pick Child Up One contact that is NOT a parent/guardian is required. Can add more on an Alternate Arrival/Release Form.

#1 First Name _____ Last Name _____ Relationship to child _____

Home Address (Street, City, State, Zip) _____

Phone Numbers: Home _____ Work _____ Cell _____

#2 First Name _____ Last Name _____ Relationship to child _____

Home Address (Street, City, State, Zip) _____

Phone Numbers: Home _____ Work _____ Cell _____

MEDICAL AND BEHAVIOR QUESTIONS

These questions help us to provide the best care for your child. All information is confidential to Y Staff.
(ALL SECTIONS MUST BE FILLED OUT. IF SOMETHING DOES NOT APPLY, PLEASE USE N/A)

1. Has your child had any of the following? ☐ NONE

☐ Asthma ☐ Autism ☐ Diabetes

☐ ADD/ADHD ☐ Epilepsy/Seizures ☐ Cerebral Palsy/Motor Disorder

☐ Cognitively Disabled ☐ Dietary Restrictions _____

☐ Food/Milk Allergies _____

If child is allergic to milk, attach a statement from a medical professional indicating an acceptable alternative.

☐ Gastrointestinal or feeding concerns, including special diet and supplement

_____

☐ Non-Food Allergies _____

☐ Special accommodations at school (IEP, 504, ARD)

☐ Sensory Concerns _____

☐ Status of Vision, Hearing & Speech _____

☐ Other Conditions requiring Special Care _____

2. Triggers that may cause any of the above problems (specify) _____

_____

3. Signs or symptoms to watch for _____

_____

_____

4. Steps the childcare provider should follow _____

_____

5. Identify any staff to whom you gave specialized training/ instructions

_____

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. Language(s) spoken at home _____

9. Additional Information that may be helpful to us _____

_____

10. Emergency Numbers Complete contact information required.

Physician Name _____ Phone _____

Location Address _____

11. List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE a (✓) or (×). If you do not have an immunization record for this child, contact your doctor or local health department to obtain the records.

TYPE OF VACCINE	1st Dose M/D/Y	2nd Dose M/D/Y	3rd Dose M/D/Y	4th Dose M/D/Y	5th Dose M/D/Y
Diphtheria-Tetanus-Pertussis Specify ☐ DTP ☐ DTaP ☐ DT					
Polio					
Hib (Haemophilus Influenzae Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)			Has child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known. ☐ Yes, Year _____ ☐ No or Unsure (Vaccine is required)		
Varicella (chickenpox) vaccine Vaccine is required only of the child has not had chickenpox disease.					

☐ My child does not meet all immunization requirements. These requirements can only be waived if a properly signed health, religious, or personal conviction waiver is filed with the YMCA. Forms available at gwcymca.org.

12. Is your child currently taking any medications? ☐ Yes ☐ No

If yes, what kind and purpose _____

_____

Does Y Staff need to administer medications? ☐ Yes ☐ No

☐ I understand that if medication needs to be administered during YMCA programming, an Authorization to Administer Medication Form MUST be completed and medication must be brought to school on your child's first day. Form is available at gwcymca.org.

13. Sunscreen/Insect Repellent (If provided by a parent, each bottle must be labeled.)

☐ I authorize the YMCA to apply **sunscreen** to my child.

☐ I authorize the YMCA to allow my child to self-apply **sunscreen.**

☐ My child may use **sunscreen** provided by the YMCA if theirs runs out or is missing (Generic SPF 30).

☐ If no, will only allow my child to use the sunscreen provided by parent:

Brand Name _____ Strength _____

☐ I authorize the YMCA to apply **insect repellent** to my child.

☐ I authorize the YMCA to allow my child to self-apply **insect repellent.**

☐ My child may use **insect repellent** provided by the YMCA if theirs runs out or is missing (Generic 25% Deet).

☐ If no, I will only allow my child to use the repellent provided by parent:

Brand Name _____ Strength _____