Waukesha YMCA 3-5 Year Old Preschool Options
Please select the Preschool class and days per week you wish to register for: (For current pricing, see our rate sheet.)

☐ Preschool & Full-Day Extended Care Plus | 7:00 AM – 6:00 PM  ☐ 5 Days (M–F)  ☐ 3 Days (M/W/F)  ☐ 2 Days (T/Th)
☐ Preschool & Half-Day Extended Care Plus | 7:00 AM – 2:30 PM  ☐ 5 Days (M–F)  ☐ 3 Days (M/W/F)  ☐ 2 Days (T/Th)
☐ Preschool Only | 9:00 AM – 11:30 AM  ☐ 5 Days (M–F)  ☐ 3 Days (M/W/F)  ☐ 2 Days (T/Th)

CHILD’S SWIM ABILITY  □ Beginner  □ Intermediate  □ Advanced

□ I RECEIVE CHILD CARE BENEFITS (WISCONSIN SHARES)
I understand I am responsible for payments that are not covered (co-pays) and must set up an Auto Payment for any Co-pays required of me. An authorization letter must be submitted with this registration form. Please email us at registrar@gwcymca.org for Provider & Location Number.

□ I RECEIVE YMCA FINANCIAL ASSISTANCE
I understand I am responsible for any payment balance not covered by financial assistance and must set up an automatic payment for any co-pays required of me.

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

☐ I authorize the Y to charge the payment method on file for the $50 registration fee.

PAYMENT INFORMATION
Registration will not be processed unless it is accompanied by a non-refundable $50 registration fee 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 Signature  Date

CONTACT US
WAUKESHA YMCA
320 E Broadway, Waukesha 53186
262-542-2557
registrar@gwcymca.org
CHILD INFORMATION
Child’s First Name ___________________________ Middle Initial ___ Last Name ___________________________ Gender □ M □ F □ Other
Birth date _____/_____/_______ Age (as of June 12, 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) ___________________________ Phone Numbers: Home ___________________________ E-Mail ___________________________
Preferred method of contact ___________________________ 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) ___________________________ Phone Numbers: Home ___________________________ E-Mail ___________________________
Preferred method of contact ___________________________ 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 ___________________________