

# Mukwonago Y At Washington-Caldwell Elementary 4K Wrap Care Registration Form



Child's Name \_\_\_\_\_

Child Start Date \_\_\_\_\_ School District Child Resides In \_\_\_\_\_

## MUKWONAGO YMCA AT WASHINGTON-CALDWELL ELEMENTARY 4K WRAP CARE OPTIONS

Please select the Wrap Care option and days per week you wish to register for. For current pricing, see our rate sheet. Care is available between 11:30 AM - 3:40 PM. If care is needed beyond traditional Wrap Care, please see info on our Y BASE program.

Half Day |  5 Days per Week  3 Days per Week  2 Days per Week

<input type="checkbox"/> MONDAYS	<input type="checkbox"/> TUESDAY	<input type="checkbox"/> WEDNESDAYS	<input type="checkbox"/> THURSDAYS	<input type="checkbox"/> FRIDAYS
<b>HOURS NEEDED</b>	<b>HOURS NEEDED</b>	<b>HOURS NEEDED</b>	<b>HOURS NEEDED</b>	<b>HOURS NEEDED</b>
<input type="checkbox"/> 11:30 AM - 3:40 PM	<input type="checkbox"/> 11:30 AM - 3:40 PM	<input type="checkbox"/> 11:30 AM - 3:40 PM	<input type="checkbox"/> 11:30 AM - 3:40 PM	<input type="checkbox"/> 11:30 AM - 3:40 PM
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

### 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.

## CONTACT US

**MUKWONAGO YMCA**  
 245 E Wolf Run, Mukwonago 53149  
 262-363-7950

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 Business Desk in writing by the 10th of the prior month to terminate your monthly payment plan or to change your payment information. A \$10 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 \$10 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.

- 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 Business Desk 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 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 Wrap Care and my child will be taken off rosters. No exceptions.

\_\_\_\_\_ Initial

\_\_\_\_\_ Parent/Guardian Signature

\_\_\_\_\_ Date

For Office Use Only:

DATE RECEIVED

TIME RECEIVED

STAFF INITIALS



**2020-2021 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 September 1, 2020) \_\_\_\_\_ 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/Work 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/Work Address \_\_\_\_\_

**Emergency Contacts/Others Authorized to Pick Child Up** Must put one person other than parent or guardian. Can add more on 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. Additional Information that may be helpful to us** \_\_\_\_\_  
 \_\_\_\_\_

**9. Emergency Numbers**

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Location Address \_\_\_\_\_

**10. List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE a (✓) or (x). 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 <input type="checkbox"/> DTP <input type="checkbox"/> DTaP <input type="checkbox"/> DT					
Polio					
Hib (Haemophilus Influenzae Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only of the child has not had chickenpox disease.					Has child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known. <input type="checkbox"/> Yes, Year _____ <input type="checkbox"/> No or Unsure (Vaccine is required)

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](http://gwcymca.org).

**11. 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. Visit [gwcymca.org](http://gwcymca.org) for forms.

**12. 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 NO-AD 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 OFF 25% Deet).  
 If no, I will only allow my child to use the repellent provided by parent:  
 Brand Name \_\_\_\_\_ Strength \_\_\_\_\_