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 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.

EARLY RELEASE DAYS
Included in bi-weekly fees. Please check off the days you plan to attend and confirm attendance with Registrar.

☐ Wed. October 25 ☐ Thu. February 15 ☐ Fri. May 24

SCHOOL’S OUT FUN DAYS AT THE Y
On days when school is not in session, the Y will offer full day child care at the Waukesha Y. The tuition for the School’s Out Fun Day Program, $40 for YMCA Members or $50 for Program Participants, is in addition to the cost of Y BASE After School Care. To register for School’s Out Fun Days, please fill out and a separate registration form found on the website (gwcymca.org/Schools-Out-Fun-Days) or at the Business Office.

For current pricing, please see our 2023-2024 Enrollment & Tuition form.
**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

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 ________________________________________________________

Home Phone Number __________________________ Work 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 ________________________________________________________

Home Phone Number __________________________ Work 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 ____________

Phone Numbers: Home __________________________ Work __________________________

Daytime Address/Employer Name & Address ____________________________________________

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 ____________
   - □ 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 (r) or [a]. If you do not have an immunization record for this child, contact your doctor or local health department to obtain the records. 

<table>
<thead>
<tr>
<th>TYPE OF VACCINE</th>
<th>1st Dose M/D/Y</th>
<th>2nd Dose M/D/Y</th>
<th>3rd Dose M/D/Y</th>
<th>4th Dose M/D/Y</th>
<th>5th Dose M/D/Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria-Tetanus-Pertussis</td>
<td>□ DTP □ DTaP □ DT</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Polio</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hib (Haemophilus Influenzae Type B)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine (PCV)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Measles-Mumps-Rubella (MMR)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Varicella (chickenpox) vaccine</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Has child had Varicella (chickenpox) disease?</td>
<td>□ Yes □ No □ Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you do not have an immunization record for this child, contact your doctor or local health department to obtain the records. 

- □ 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 camp 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 apply insect repellent to my child. 
- □ I authorize the YMCA to allow my child to self-apply sunscreen. 
- □ I authorize the YMCA to allow my child to self-apply insect repellent. 
- □ My child may use sunscreen provided by the YMCA if theirs runs out or is missing (Generic SPF 30). 
- □ If no, only allow my child to use the sunscreen provided by parent: 

   Brand Name ___________________ Strength ___________________ 

- □ 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 ___________________