



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

LEARN
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**3 Year Old Preschool &
4K Wrap Around Care
Enrollment Packet 2019-20**

GENEVA LAKES FAMILY YMCA

203 S. Wells St.

Lake Geneva, WI 53147

262.248.6211



FOR YOUTH DEVELOPMENT®
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Welcome to the **GENEVA LAKES FAMILY YMCA's Wrap Around Care Program!**

We are looking forward to an exciting school year. The Wrap Around Care program is based on the standards and the four core values of the YMCA. We are committed to helping instill in your child, the values of Caring, Honesty, Respect, and Responsibility. Our qualified, experienced staff will provide a safe and caring environment where your child will make new friends, enjoy new experiences and have fun. We offer a healthy snack, homework time, arts and crafts, active games, and much more!

All of the forms below must be completed and turned in at the time of registration:

- Early Childhood Care Registration Form: 2019-20**
- EFT Draft Agreement Form**
- Child Care Enrollment Form**
- Health History & Emergency Care Plan Form**
- Day Care Immunization Record Form**
- Alternate Arrival/Release Form**
- Signed Parent Handbook Agreement Form**
- Paid \$25 Registration Fee**

Child's Name: _____ DOB: _____

If you have any questions, please contact:

GENEVA LAKES FAMILY YMCA
203 S. Wells St.
Lake Geneva, WI 53147 262.248.6211

Jami Golz jami.golz@glymca.org
Youth & Family Director 262.248.6211 ext.26



Wrap Around Care Payment Information

Child's Name: _____

School Site: (circle one): Star Center Central Dension

Wrap Around Care weekly fees will be charged to your bank account via a weekly draft on the **Monday** prior to the week attending and will occur for all weeks throughout the school year.

Checking Account Information

Name (as it appears on account): _____

Banking Institution _____

Routing # _____ Account # _____

Address: _____

Zip Code: _____

Signature: _____ Date: _____

I hereby authorize my financial institution to withdraw the amount based on my payment schedule from the account listed above. I authorize the YMCA to use the following account to withdraw my weekly rate on the Monday prior to the week attending. (Please initial)

____ I understand my payment will be drafted from my account every August 26, 2019 – May 25, 2020.

____ I understand that I will pay for the scheduled time slot I have reserved, regardless if my child attends the entire scheduled time slot or does not attend.

____ I understand I have reserved this time slot for my child, therefore it is my responsibility to pay for each scheduled time slot until I notify in writing my intention to discontinue enrollment or change my child's enrollment and schedule.

____ It is my responsibility to notify the YMCA with a two-week notice of any change in or closing of the account to be drafted and to provide the YMCA with current account information to make changes for the EFT draft.

____ If payments are delinquent, the YMCA reserves the right to discontinue entrance and care services in the Early Childhood Care program. Full payment of delinquent accounts are required for reinstatement into the Wrap Around Care program.

Cancellation:

A 2- week advance written notice must be given prior to withdrawing from a program. Your account will be charged for all care services reserved during the 2-week period.

Signature: _____ Date: _____

***Note: You will need to provide your banking information at the time of registration.**

WRAP AROUND CARE REGISTRATION FORM 2019-2020

Current YMCA Member? Yes No

Child's Name	DOB	AGE	<input type="checkbox"/> M <input type="checkbox"/> F
School	Start Date	Grade	
Billable Parent's Name	DOB	Phone #	
Address	City	State & Zip	

A \$25 Registration Fee is due at the time of registration, along with all required forms (see page 2).

Please select your child care scheduling needs below:

	3 Days Per Week	4 Days Per Week	5 Days Per Week		
Full Day – 6 or more hours per day (Includes free YMCA Youth Membership) Any time between 6:30 am—6 pm	\$120 Circle Days: M T W TH F Time: _____ AM/PM to _____ AM/PM	\$160 Circle Days: M T W TH F Time: _____ AM/PM to _____ AM/PM	\$180 Days: Monday-Friday Time: _____ AM/PM to _____ AM/PM		
Half Day – Less than 6 hours per day (Includes free YMCA Youth Membership) Any time between 6:30 am—6 pm	\$90 Circle Days: M T W TH F Time: _____ AM/PM to _____ AM/PM	\$120 Circle Days: M T W TH F Time: _____ AM/PM to _____ AM/PM	\$130 Days: Monday-Friday Time: _____ AM/PM to _____ AM/PM		
Hourly: \$5.25 per child Minimum of 6 hours per week	Monday Care Time: _____ AM/PM to _____ AM/PM	Tuesday Care Time: _____ AM/PM to _____ AM/PM	Wednesday Care Time: _____ AM/PM to _____ AM/PM	Thursday Care Time: _____ AM/PM to _____ AM/PM	Friday Care Time: _____ AM/PM to _____ AM/PM

Parent Consent/Authorization (Please initial and sign)

_____ I understand if my child is absent, I am still responsible for the payment on the days that I have selected.
 _____ Parents with varied schedules will inform staff which days your child will attend by no later than Monday prior to the week of care.

_____ When school is cancelled due to weather-related circumstances, YMCA Wrap Around Care programs are CANCELLED.

_____ I do or do not give permission for promotional photographs to be taken of my children.

Signature: _____ **Date:** _____

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance
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PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
-----------------------------------	-----------------------	--

Home Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
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b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
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Home Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
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AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.

Yes No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
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PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number
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AUTHORIZATIONS

- Yes No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
- Yes No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
- Yes No I give permission for my child to participate in Transported Walking field trips and other activities during operating hours.
- Yes No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed
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HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number
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SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child. <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child. <input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

- | | | |
|---|--|--|
| <input type="checkbox"/> No specific medical condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastrointestinal or feeding concerns including special diet and supplements |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy / seizure disorder | <input type="checkbox"/> Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism |
| <input type="checkbox"/> Cerebral palsy / motor disorder | | |
| <input type="checkbox"/> Other condition(s) requiring special care – Specify. | | |

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

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 prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

- a.
- b.
- c.

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 the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates: _____

DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER. State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center**. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus <i>Influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

Yes year _____ (Vaccine is not required)

No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³ 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³ 2 Varicella

¹If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4 **IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR**

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.

For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

Physician's Signature Required

For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5 To the best of my knowledge this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian	Date Signed
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ALTERNATE ARRIVAL / RELEASE AGREEMENT – CHILD CARE CENTERS

Use of form: This form is voluntary. However, this completed form, when on file in the child's record, meets the requirements of DCF 250.04(6)(a)3. and DCF 251.04(6)(a)5. and 251.095(4)(a)2. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Complete this form for placement in the child's file when the child will arrive at the center from school, home or other activities, or depart from the center to go to school, home or other activities, and the child will not be accompanied by a parent or other previously authorized person or transported by the center. This form should be updated as information changes. Periodic review with the parent / guardian is recommended to ensure safety. If the center transports the child, the department's form "Transportation Permission – Child Care Centers" may be used to obtain parental authorization.

ARRIVAL INSTRUCTIONS

My child _____
(Child's name)

will arrive at _____
(Name of center)

from _____
(School, home or other activity)

by way of _____
(Walking, bicycle, bus, car pool, etc. Be as specific as possible.)

at _____ A.M. OR P.M.
(Time of arrival)

on Sunday Monday Tuesday Wednesday Thursday Friday Saturday
(Days of the week)

My child will arrive from this destination with OR without center supervision.

RELEASE INSTRUCTIONS

My child _____
(Child's name)

will leave _____
(Name of center)

by way of _____
(Walking, bicycle, bus, car pool, etc. Be as specific as possible.)

to go to _____
(School, home or other activity)

at _____ A.M. OR P.M.
(Time of departure)

on Sunday Monday Tuesday Wednesday Thursday Friday Saturday
(Days of the week)

My child will travel to this destination with OR without center supervision.

ADDITIONAL INSTRUCTIONS

I understand that I am responsible for notifying the center of any changes in this schedule such as vacation, school conference days, etc.

SIGNATURE – Parent

_____ gned (mm/dd/yyyy)

WRAP AROUND CARE CHANGE/CANCELLATION FORM

Staff initial: _____

Date: _____

Use this form only if child is already registered (please use a separate form for each child).

All changes must be completed 2 WEEKS PRIOR to the start of a two week session.

Select purpose of form: CANCEL CARE CHANGE ATTENDANCE

Student's Name _____ Parent/Guardian's Name _____

Parents/Guardian's Contact Information: Email _____ Phone _____

Dates of Session _____ School _____

CANCEL CARE: (Requires 2 week Notice)

Current Registered Schedule: _____

Reason for Cancellation: _____

Parent/Guardian Signature: _____

CHANGE ATTENDANCE: (NEW SCHEDULE)

	Monday	Tuesday	Wednesday	Thursday	Friday
Start Time					
End Time					

Is this a one-time change or a permanent change?: _____

Parent/Guardian Signature: _____

Bank Draft Account Change Form:

New Account Information: Name of Financial Institution _____

Routing Number _____ Account Number _____

*Must attach voided check of new account.

Please scan and email your changes to jami.golz@glymca.org, or you may drop off your change form at the Geneva Lakes Family YMCA, located at 203 S. Wells Street Lake Geneva, WI. 53147. Change forms can also be given to your child's YBASE site supervisor.

Please allow 3-5 business days for processing request. You will be notified via phone or email.