Y Kids Before & After School Care
Prairie View 4K Wrap 2023-2024

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Enrollment Contract

Child's Name: _____ DOB: _____
Address: _____
Phone Number: _____ Email: _____
First Day of Attendance: _____ School: _____

I would like my child enrolled in:

____BEFORE & AFTER SCHOOL - $550/MONTH
Monday – Friday
6:30 AM – 8:30 AM
12:30 PM – 5:45 PM
Added Benefits
- 10% Discount for additional children in the Before & After School Program
- FREE School's Day Out Program
- FREE Family Membership to the YMCA of Dodge County

____BEFORE SCHOOL ONLY - $45/WEEK
Monday – Friday
6:30 – 8:30 AM
Added Benefits
- 10% Discount for additional children in the Before & After School Program

____AFTER SCHOOL ONLY - $150/WEEK
Monday – Friday
12:30 – 5:45 PM
Added Benefits
- 10% Discount for additional children in the Before & After School Program

All enrollment choices require automatic withdrawal for payment.

Automatic Payment Options
Select One:
- ❑ Monthly (*Pulled on the 1st of the Month*)
- ❑ Twice Per Month
  - ❑ (*Pulled on the 1st and 15th of the Month*)
- ❑ Weekly (*Pulled Every Monday*)

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____

Date Signed :_____

General Information
1. Parent/Guardian Name (Last, First MI):

_____
Relationship: _____ Phone Number: (___) _____
Email: _____
Address (Street, City, State, Zip): _____
Does the child reside at this residence? **YES** **NO**
Place of Employment: _____ Phone Number: (___) _____

2. Parent/Guardian Name (Last, First MI):

_____
Relationship: _____ Phone Number: (___) _____
Email: _____
Address (Street, City, State, Zip): _____
Does the child reside at this residence? **YES** **NO**
Place of Employment: _____ Phone Number: (___) _____

Emergency/Authorized Contacts
1. Name & Relationship to Child (Last, First): _____

_____
Phone Number: (___) _____ Email: _____
Place of Employment: _____ Phone Number: (___) _____
- This person can be notified in an emergency when Parent/Guardian(s)can notbe reached. **YES** **NO**
- This person is authorized to pick up & drop off the child. **YES** **NO**

2. Name & Relationship to Child (Last, First): _____

_____
Phone Number: (___) _____ Email: _____
Place of Employment: _____ Phone Number: (___) _____
- This person can be notified in an emergency when Parent/Guardi an (s) cannot be reached. **YES** **NO**
- This person is authorized to pick up & drop off the child. **YES** **NO**

Physician / Medical Facility
Name: _____ Phone Number: (___) _____
Address (Street, City, State, Zip): _____

Authorizations
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 program and a summary of the Wisconsin State Licensing Rules. **YES** **NO**

I give permission for my child to participate in transported and walking field trips and other activities during operating hours. **YES** **NO**

I have been informed of the number of pets in the program and their degree of contact with my child. **YES** **NO**

YMCA OF DODGE COUNTY
220 Corporate Drive, Beaver Dam WI 53916
P 920 887 8811 F 920 887 9298 W theYdc.org
facebook.com/theYdc twitter.com/theYdodgecounty

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Authorization to Draw EFT or Credit Card for Y Kids Before & After School Program in the BDUSD.

Name on EFT Account / Credit Care: _____

Billing Address: _____

Billing City: _____ Billing State: _____

Billing Zip Code: _____

Please choose ONE of the following forms of Payment to use for your draft:

Credit Card

Credit Card Number: _____

Expiration Date: _____

☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER** ☐ **AMERICAN EXPRESS**

EFT Account

Bank Name: _____

Bank City: _____

Bank Routing Number: _____

Account Number: _____

☐ CHECKING ☐ SAVINGS

Health History & Emergency Care Plan

If available, attach any health care plan information from the child's medical professional.

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

☐ NO SPECIFIC MEDICAL CONDITION
☐ Asthma
☐ Cerebral Palsy/Motor Disorder
☐ Diabetes
☐ Epilepsy /Seizure Disorder
☐ Gastrointestinal Concerns
☐ CD/LD
☐ ADD/ADHD
☐ Autism
☐ Milk Allergy
☐ Food Allergy (Please specify): _____
☐ Non-Food Allergy (Please specify): _____
☐ Other condition(s) requiring special care – Specify:

_____

For the next questions, if they do not apply to your child, please write "N/A" on the line.

2. Triggers that may cause problems: _____

3. Signs or Symptoms to watch for: _____

4. Steps the provider should follow: _____

5. Identify any 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 program:

_____

I understand that I must provide all the information requested on this page and it must be up to date and accurate for my child to be enrolled in this program. If any changes are made during my child's enrollment, I will notify the program as soon as possible.

Print Name: _____

Signature: _____

Today's Date: _____

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