Y Kids Before & After School Care
Waupun Area School District 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 - $160/MONTH**
Monday – Friday
6:00 AM – 8:00 AM
3:00 PM – 5:45 PM
Added Benefits
- FREE School's Day Out Program
- FREE Family Membership to the YMCA of Dodge County
- WASD Non-District Boundary Student $300/ Month

☐ **BEFORE SCHOOL ONLY - $25/WEEK**
Monday – Friday
6:00 – 8:00 AM
- WASD Non-District Boundary Student $55/ Week

☐ **AFTER SCHOOL ONLY - $25/WEEK**
Monday – Friday
3:00 – 5:45 PM
- WASD NonDistrict Boundry Student $55/Week

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*)

Caregiver Print Name: _____

Caregiver Signature: _____

Date Signed :_____

General Information

1. Caregiver 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. Caregiver 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 caregiver(s) cannot be 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 caregiver(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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Alternate Release / Arrival Agreement

My child, _____, will arrive at _____ Elementary School from Y Kids Before and After School Care by way of walking at 8:00 a.m. on Monday, Tuesday, Wednesday, Thursday, and Friday.

My child, _____, will arrive at Y Kids Before and After School from _____ Elementary School by way of walking at 3:00 p.m. on Monday, Tuesday, Wednesday, Thursday, and Friday.

Additional Instructions: _____
_____
_____
_____

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

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): _____

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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