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

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-$615/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

Automatic Payment Options*:

Select One:
☐ Monthly (Pulled on the 1st of the Month)
☐ Twice Per Month (Pulled on the 1st ond 15th of the Month)
☐ Check here if you receive Wisconsin County or State Funding

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____BEFORE SCHOOL ONLY-$50/WEEK

Monday -Friday
6:30 -8:30 AM
Added Benefits:
- 10% Discount for additional children in the Before & After School Program

Automatic Payments* are weekly

(Pulled every Monday)
☐ Check here if you receive Wisconsin County or State Funding

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____AFTER SCHOOL ONLY-$165/WEEK

Monday -Friday
12:30 -5:45 PM
Added Benefits:
- 10% Discount for additional children in the Before & After School Program

Automatic Payments* are weekly

(Pulled every Monday)
☐ Check here if you receive Wisconsin County or State Funding

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**All enrollment choices require automatic withdrawal for payment.*

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

2. Name (Last, First) _____
Relationship: _____ Phone Number: (___) _____
Email: _____
Place of Employment: _____
Phone Number: (___) _____
- This person can be notified in an emergency when Parent/ Guardian(s) cannot be reached. ☐ YES ☐ NO
- This person is authorized to pick up & drop off the child. ☐YES ☐ NO

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 www.theydc.org

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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: _____

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

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

☐ **Check here if you receive Wisconsin County or State Funding**

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