

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-\$325/MONTH - (\$185 – parent portion, \$140 – Waupun School District Subsidy)

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 \$325/Month

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)
- ☐ Check here if you receive Wisconsin County or State Funding

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

BEFORE SCHOOL ONLY-\$60/WEEK - (\$30 – parent portion, \$30 – Waupun School District Subsidy)

Monday -Friday 6:00 -8:00 AM

Added Benefits:

- WASD Non-District Boundary Student \$60/Week

Automatic Payments* are weekly

(Pulled every Monday)

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

AFTER SCHOOL ONLY-\$60/WEEK - (\$30 – parent portion, \$30 – Waupun School District Subsidy)

Monday -Friday 3:00 -5:45 PM

Added Benefits:

- WASD Non-District Boundary Student \$60/Week

Automatic Payments* are weekly

(Pulled every Monday)

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

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

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____

Date Signed: _____

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.

Name on EFT Account / Credit Card: _____
 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**

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: _____