SCHOOL-AGE CHILD CARE (SACC) 2024-25 BEFORE AND/OR AFTER SCHOOL REGISTRATION FORM

(Complete all forms in black ink)

All registration information must be completely filled out before your child is registered (ALL child care forms).

Current YMCA Membership? ☐ **Yes** ☐ **No** **If yes,** ☐ **Family Membership** ☐ **Youth Membership**

BEFORE SCHOOL

Child's Name: _____ Sex ____ Age as of Sept., 2024 ____ Grade as of Sept., 2024 ____ Birth Date: _____

Child's Name: _____ Sex ____ Age as of Sept., 2024 ____ Grade as of Sept., 2024 ____ Birth Date: _____

School: _____ Site Desired _____

Circle Desired Days M T W Th F Child(ren)'s Starting Date: _____

AFTER SCHOOL

Child's Name: _____ Sex ____ Age as of Sept., 2024 ____ Grade as of Sept., 2024 ____ Birth Date: _____

Child's Name: _____ Sex ____ Age as of Sept., 2024 ____ Grade as of Sept., 2024 ____ Birth Date: _____

School: _____ Site Desired _____

Circle Desired Days M T W Th F Child(ren)'s Starting Date: _____

Registration fee for all participants is $25 per child for Before and/or After School and must be submitted with registration form.

Total fee enclosed: $ _____ **(make checks payable to YMCA)** **Financial Assistance Requested** ☐ Yes ☐ No

AC ☐ _____

Br Cty ☐ _____

3rd Party ☐ _____

Office Use Only: Paid _____ Draft _____ Immun. ☐ Confirmation ☐ Handbook ☐ Site File ☐ KDO ☐ Bussing ☐ Sp. Concern ☐

S	O	N	D	J	F	M	A	M	J

SCHOOL-AGE CHILD CARE (SACC) 2024-25 BEFORE AND/OR AFTER SCHOOL REGISTRATION FORM

(Complete all forms in black ink)

All registration information must be completely filled out before your child is registered **(all child care forms in black ink).**

Did your child(ren) participate in the 2023-24 Before/After School Program? ☐ Yes ☐ No If yes, which site? _____

OR 2024 Summer Program? ☐ Yes ☐ No If yes, which site? _____

Child(ren) Information

Name (Last, First)	Sex	Home Address (Street, City, State)	Zip Code	Telephone
1.				
2.				

Please list your main email address to receive School-Age correspondence.

_____

Parent or Guardian Information

Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Home Phone	Cell Phone	Work Name & Address	Work Phone

Emergency Contact (List information of person to contact when mother, father or guardian cannot be reached.)

Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Home Phone	Cell Phone	Work Name & Address	Work Phone

Persons Authorized to Pick Up Child(ren) – Include Parents

Relationship to Child	Name (Last, First)	Home Address (if not listed above)	Home Phone	Cell Phone	Work Name & Address (if not listed above)	Work Phone

Parent's Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Spouse Deceased

Note any custody arrangements or restrictions (Attach court order if applicable) _____

the YMCA SCHOOL-AGE CHILD CARE (SACC) 2024-25 REGISTRATION FORM

First Child's Name: _____

MEDICATION

Will your child require any medication while at the Before/After School program? Yes ☐ No ☐

If yes, please list medication: _____
(You will be asked to complete a "Medication Authorization Form")

HEALTH HISTORY

Check any special medical condition(s) that your child may have (you must check at least one box in this section).

☐ No Medical Condition
☐ Sensitivity to the sun
☐ Asthma
☐ Epilepsy/Seizure Disorder
☐ Heart Problems
☐ Diabetes
☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD or Autism (please circle which disorder)
☐ Cerebral Palsy/Motor Disorder
☐ Non-Food Allergies, please specify _____
☐ Food Allergies, specify food(s) _____
☐ Milk Allergy (attach a statement from the Doctor indicating the acceptable alternative)
☐ Gastrointestinal or feeding concerns including special diet
☐ Other Condition(s) requiring special care, please specify
_____
_____
_____

EMERGENCY CARE PLAN

If you checked any condition listed above, please answer the following questions. If something does not apply, write NA.

1. Triggers that may cause problems - specify.
2. Signs or symptoms to watch for - specify.
3. Action steps the YMCA staff should follow.
4. Identify any staff to whom you have given specialized training/instructions to help treat symptoms.
5. When to call parents regarding symptoms or failure to respond to treatment.
6. When to consider that the condition requires medical care or reassessment.
7. Any additional information that may be helpful to staff.

PARENT CONSENT AUTHORIZATION

Please initial each line & provide signature at bottom of page stating you have read and understand each item.

_____ I am aware that a copy of the YMCA Licensing Policies and Wisconsin Licensing Rules for Day Care are available at the program for review at any time.

_____ I authorize the YMCA to take my child on all field trips via bus or walking during any of the YMCA Before/After School program days my child is enrolled.

_____ I ☐ **GIVE** or ☐ **DO NOT GIVE** permission for promotional photographs to be taken of my child(ren). Please check one box.

_____ In the event of an emergency, I authorize any medical treatment that may be needed. I understand that in the event of an injury, I will be contacted first and this waiver will only be necessary if I or my emergency contact cannot be reached.

_____ I understand that all above said information is confidential and is only used as a guide in understanding my child(ren).

_____ I understand that my $25 registration fee per child is non-refundable and if I drop from the program but do not provide written notice to the SACC office two weeks prior to my scheduled starting date, I am required to pay for these two weeks.

Parent or Guardian's Signature: _____ Date: _____

the YMCA SCHOOL-AGE CHILD CARE (SACC) 2024-25 REGISTRATION FORM

Second Child's Name: _____

MEDICATION

Will your child require any medication while at the Before/After School program? Yes ☐ No ☐
If yes, please list medication: _____
(You will be asked to complete a "Medication Authorization Form")

HEALTH HISTORY

Check any special medical condition(s) that your child may have (you must check at least one box in this section).

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☐ Sensitivity to the sun
☐ Asthma
☐ Epilepsy/Seizure Disorder
☐ Heart Problems
☐ Diabetes
☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD or Autism (please circle which disorder)
☐ Cerebral Palsy/Motor Disorder
☐ Non-Food Allergies, please specify _____
☐ Food Allergies, specify food(s) _____
☐ Milk Allergy (attach a statement from the Doctor indicating the acceptable alternative)
☐ Gastrointestinal or feeding concerns including special diet
☐ Other Condition(s) requiring special care, please specify
_____
_____
_____

EMERGENCY CARE PLAN

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5. When to call parents regarding symptoms or failure to respond to treatment.

6. When to consider that the condition requires medical care or reassessment.

7. Any additional information that may be helpful to staff.

2024-25 SCHOOL YEAR BANK DRAFT OR CREDIT CARD DRAFT AGREEMENT

Draft amounts will occur for all Before and/or After School Child Care weeks throughout the school year. All drafts will be drafted monthly on the 1st or 15th of the month per your request for the weeks of care occurring within that month. (Example: Weeks of Sept. 2, Sept. 9, Sept. 16, Sept. 23 & Sept 30 will be drafted in September). A draft guideline for the 2024-25 school year will be included inside your parent handbook.

Child(ren)'s Name: _____ Child Care Site: _____

Your draft will occur on the 1st or 15th of each month. Please select your monthly draft date: ☐ 1st or ☐15th

Please select how you would like to receive your monthly receipts for payments made: ☐ email (confirm your email address on registration form) or ☐ at childcare site

If checking or savings draft, please supply the following information: Type of Account: ☐ Checking or ☐ Savings

Bank Name: _____ Account Holder's Name: _____

Bank Routing No: _____ Account Number: _____

If credit card draft, please supply the following information: Name as it appears on the card: _____

☐ Discover Card ☐ Master Card ☐ Visa

A 3% fee will be applied to all debit/credit card transactions. This fee does not apply to cash, check, or ACH/EFT payments.

Card Number: _____ Expiration Date: _____ CVV Code: _____

AUTHORIZATION:

I hereby authorize my financial institution to withdraw the amount based on my payment schedule from the account listed above.

A. I understand my payment will continue until my scheduled payments are completed.

B. It is my responsibility to notify the YMCA immediately of any account change or closing and to provide the YMCA with current account information. To make changes for drafts on the first of the month you must notify the YMCA by the 25th of the month prior. Notification for accounts drafting on the 15th must be in by the 10th of the month.

C. The YMCA reserves the right to refuse entrance into the facility or programs if payments are delinquent. Full payment of delinquent payments will be required for reinstatement into programs.

CANCELLATION:

A. A two-week advance written notice must be given prior to withdrawing from a program.

B. Following one month of insufficient funds or declined credit card, the YMCA will contact payee and send a statement to be paid within 15 days.

C. Following a second month of insufficient funds or declined credit card, you will be contacted by the program director so that you can make arrangements to pay your balance due.

D. If you do not comply with the arrangements, your child will be terminated from the program. Your account will be frozen and you must pay any past due amount before participating in any YMCA program or membership in the future.

WOULD YOU BE INTERESTED IN GIVING MORE CHILDREN THE OPPORTUNITY TO EXPERIENCE THIS PROGRAM BY MAKING A DONATION TO THE YMCA'S ANNUAL CAMPAIGN?

☐ Yes - I'd like to make a 1 time donation of $ _____ ☐ Yes - I'd like to add $_____to monthly draft for the 2024-25 school year

Parent/Payee Signature: _____ Date: _____

RETURN THIS DRAFT AGREEMENT ALONG WITH YOUR COMPLETED SCHOOL YEAR REGISTRATION FORM.