



# 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 1<sup>st</sup> of the Month*)

Twice Per Month  
 (*Pulled on the 1<sup>st</sup> and 15<sup>th</sup> of the Month*)

Weekly (*Pulled Every Monday*)

#### 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**

Caregiver Print Name: \_\_\_\_\_

Caregiver Signature: \_\_\_\_\_

Date Signed : \_\_\_\_\_



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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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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: \_\_\_\_\_

### 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 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