



STATELINE FAMILY YMCA

WISCONSIN AFTER SCHOOL 2026-2027

PARTICIPANT INFORMATION

Use full legal names for all parties.

Child's First Name: _____ MI _____ Last Name: _____
 Birth Date: _____ Gender: _____
 Address: _____
 Phone: _____ Email: _____

PUT AN "X" IN EACH APPLICABLE BOX:

REGISTRATION LOCATION.		
GARDEN PRAIRIE 3 RD -5 TH GRADE	[]	ANY SCHEDULE NOTES:
POWERS 4K-5 TH GRADE	[]	ANY SCHEDULE NOTES:
THE LINCOLN ACADEMY @ IRONWORKS YMCA 4K-5 TH GRADE	[]	ANY SCHEDULE NOTES:

A \$50 non-refundable registration fee is required per child at time of enrollment. To receive the member rate, the child must be a Stateline Family YMCA member at time of registration and during program time.

MONTHLY FEE (Draft occurs on the 1 st of each month, excluding Aug)	SEPTEMBER-MAY FEE (Excluding December)		DECEMBER FEE	
	YMCA Member	Non Member	YMCA Member	Non Member
PM CARE	\$112	\$156	\$84	\$117
REGISTRATION (One Time Fee)	\$50			

BEFORE/AFTER SCHOOL DISCOUNTS

- 2nd Child Discount available for each additional child enrolled in Stateline Family YMCA before/after school programs. \$10 Per month for each additional child.
- Financial Assistance is available for before/after school programs, you are required to complete the financial assistance application, and provide additional documentation as stated on the FA application.

QUESTIONS- CONTACT CARLEY

CBarger@StatelineYMCA.org

CHECK & SIGN BELOW

- I understand that the non-refundable \$50 registration fee will draft at time of enrollment.
- I understand that all schedule/payment changes need to be made by the 15th of the month prior to the change request and that I must notify Ruthie at RLeavy@statelineymca.org of the requested change.
- I understand that I am responsible for all program fees, even if my child does not attend.
- I understand that my before/after school care fee will draft on the 1st of each month (September-May).
- I understand that the YMCA will pro-rate the fee the month of December ONLY.
- I understand that my child will automatically be withdrawn from the 26/27 after school programs at the end of the 26/27 school year, and that I will need to register for the following school year if my child needs care.
- I understand that if school cancels or releases early, YMCA before/after school care programs will be closed.
- I understand that I will be charged an additional fee if I arrive late for child pick-up:
 \$15/child if I arrive after 6PM \$30/child if I arrive after 6:15PM
 \$45/child if I arrive after 6:30PM \$60/child if I arrive after 6:45PM
- I understand that if late pick-up occurs more than 2x my child could be removed from program.
- I understand that if the YMCA can not reach any of the authorized individuals listed on my enrollment paperwork after 6:15PM, the police will be called for child abandonment.
- I authorize the Stateline Family YMCA to auto draft my after school program fees.
 - Uses banking information on file (last 4#'s) _____
 - I will notify and update my banking information for the auto-draft (in-person/phone)
- I understand that my account will be charged a \$25 processing fee for each returned payment.

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date



DID YOU KNOW...

United Way Blackhawk Region provides grant funding that enables the Stateline Family YMCA to reduce after-school care fees by 50%, removing barriers and helping keep child care affordable.

Help us **SHARE** how reducing after school care fees helps your family:

How Do Reduced Fees:

- Affect your ability to work?
- Help your child?
- What barriers are removed?

PARTICIPANT INFORMATION

Child's First Name: _____ MI _____ Last Name: _____
 Birth Date: _____
 Child's Grade Level: _____ School Attending: _____
 Swim Level: _____

(1) Parent/Guardian Information:

First Name: _____ MI _____ Last Name: _____
 DOB _____ Gender _____ Relationship to Child _____
 Phone: Cell _____ Work _____ Employer _____
 Address _____ City _____ State _____ Zip Code _____
 Email Address _____

(2) Parent/Guardian Information:

First Name: _____ MI _____ Last Name: _____
 DOB _____ Gender _____ Relationship to Child _____
 Phone: Cell _____ Work _____ Employer _____
 Address _____ City _____ State _____ Zip Code _____
 Email Address _____

Medical and Behavior Information				Additional Information (Specific Allergies, Dietary Needs, Triggers)
Has your child been diagnosed or treated for the following: (Mark all that apply)				
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Allergies:	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Food	
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Environmental	
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Insect	
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Dietary Needs	
<input type="checkbox"/>		<input type="checkbox"/>	ADD/ADHS	
<input type="checkbox"/>		<input type="checkbox"/>	ODD	
<input type="checkbox"/>		<input type="checkbox"/>	Autism Spectrum	
<input type="checkbox"/>		<input type="checkbox"/>	Other:	
Physician's Name				
Physician's Phone				
Hospital of Choice				
Emergency Contact (In the event that parent/guardian can not be reached)		Name	Phone	
Secondary Emergency Contact		Name	Phone	

ADDITIONAL AUTHORIZED INDIVIDUALS FOR PICK-UP (outside those listed above)			
A- Name and Relationship to Camper	Contact Phone #	Email	Place of Employment and Work Phone #
B- Name and Relationship to Camper:	Contact Phone #	Email	Place of Employment and Work Phone #

TYPICAL TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Pick Up (PM ONLY)					

Additional Information.
Social and Emotional Needs

Fears or Phobias (e.g, spiders, heights, darkness): _____ _____ _____ _____	Behavioral Triggers (situations, sounds, environments): _____ _____ _____ _____	Coping Strategies (techniques to calm down): _____ _____ _____ _____	Social Skills (e.g., shy, outgoing): _____ _____ _____ _____
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Developmental Considerations

Developmental Delays (any known concerns):

Special Interests or Hobbies:

Behavioral Information

Behavioral Concerns (specific behaviors to monitor):

Reward Systems (ways to encourage positive behavior):

Parental Insights

Parent Concerns:

Preferred Communication
(best way to communicate w/
you):

Cultural or Family
Traditions (any relevant
practices):

Additional Notes (additional information to help Y staff):

Parent/Guardian Signature	Date
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DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER. State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus <i>Influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

- Yes year _____ (Vaccine is not required)
 No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³ 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³ 2 Varicella

¹If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4 **IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR**

IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

- Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.

- For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

Physician's Signature Required

- For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

- For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5 To the best of my knowledge this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian

Date Signed