STATELINE FAMILY YMCA – SUNSHINE SUMMER CAMP 2022

Child Information

Child's Name: _____ Birthdate: _____

Address: _____ Age: _____

City State Zip Code: _____ Grade in Fall 2022: _____

Home Phone: _____ ☐ Male ☐ Female

Parent/Guardian Information

Parent/Guardian #1	Parent/Guardian #2
Last Name: _____	Last Name: _____
First Name: _____	First Name: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Employer: _____	Employer: _____
E-Mail: _____	E-Mail: _____

Medical and Behavior Questions – (these help us provide the best care possible)

Has your child been diagnosed or treated for the following?

☐ Asthma ☐ Allergies ☐ Dietary Needs

☐ Diabetes ☐ Seizures ☐ Allergy to Insect Stings

☐ ADD/ADHD ☐ Other _____

Physician's Name: _____

Physician's Phone: _____

Preferred Hospital: _____

Parent's Statement of Understanding

I understand that my child must be physically signed in/out by authorized adults	☐ Yes	☐ No
I understand that the YMCA is not responsible for lost, stolen, or damaged personal articles	☐ Yes	☐ No
I understand that my weekly balance is due by the Wednesday prior to the week attending	☐ Yes	☐ No

I give permission to the Stateline Family YMCA to:

Seek medical treatment for my child, in my absence, in the event of an emergency	☐ Yes	☐ No
Use photos or videos taken of my child for any and all promotional purposes	☐ Yes	☐ No
To transport my child as necessary for all activities: Bussing, Swimming, Field Trips	☐ Yes	☐ No
Allow my child to go on short walks with the group leader under Y staff supervision	☐ Yes	☐ No
Allow my child to participate in field trips	☐ Yes	☐ No
To apply sunscreen/bug repellent that I supplied to my child	☐ Yes	☐ No

Parent/Guardian Signature: _____ Date: _____

YMCA Sunshine Camp Registration

Weeks & Dates	Camp Theme	Camp Days (no camp on Fridays)
Week 1: June 6-9	Seuss-A-Palooza	☐ Monday-Thursday
Week 2: June 13-16	Little Gardners	☐ Monday-Thursday
Week 3: June 20-23	Barnyard Boogie	☐ Monday-Thursday
Week 4: June 27-July 30	Little Artists	☐ Monday-Thursday
Week 5: July 4-7	NO CAMP	
Week 6: July 11-14	Space Adventures	☐ Monday-Thursday
Week 7: July 18-21	Under the Sea	☐ Monday-Thursday
Week 8: July 25-28	Dino Diggers	☐ Monday-Thursday
Week 9: August 1-4	Animal Planet	☐ Monday-Thursday
Week 10: August 8-11	Little Scientists	☐ Monday-Thursday
Week 11: August 15-18	Ahoy Matey	☐ Monday-Thursday

Camp Information

Ages: 3-4
Time: 8:30-11:30 a.m.
Days: Mon.-Thurs.
Location: Ironworks
Payment Options: Self-Pay, YMCA Financial Assistance (if qualified), or Wisconsin W2

Camp Cost

Member: $68/week

Non-Member: $92/week

Deposit (non-refundable)

$25 per weekly

Payment Due Date

Due in full Monday prior to the week of attending camp.

STATELINE FAMILY YMCA EMERGENCY CARD

General Information

Child's Name: _____ D.O.B.: _____

Home Address: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Child's Medical Information

Allergies: _____ Current Medication: _____

Preferred Hospital (if needed): _____

Physician & Phone: _____

Parent/Guardian Signature Authorizing Emergency Care:

_____ Date: _____

In addition to the parent(s)/guardian(s) listed on the front of this card, the following people have permission to pick up my child:

1) _____ Phone _____

2) _____ Phone _____

3) _____ Phone _____

4) _____ Phone _____

5) _____ Phone _____

6) _____ Phone _____

Parent/Guardian Signature: _____ Date: _____

Other Information that may be helpful: _____

_____

_____

My child has permission to be photographed by the Y: ☐ Yes or ☐ No

STATELINE FAMILY YMCA BANK OR CREDIT CARD DRAFT AUTHORIZATION

Name (please print) _____
Last First Middle Initial

Address _____
Street City State Zip Code

Please Select Draft Option Below:

Sunshine Camp **Child's Name:** _____
(Drafted on Monday prior to the week attending camp)

Check Weeks Authorizing Draft:

☐ Week 1 ☐ Week 2 ☐ Week 3 ☐ Week 4 ☐ Week 5 ☐ Week 6
☐ Week 7 ☐ Week 8 ☐ Week 9 ☐ Week 10 ☐ Week 11

Weekly Draft – Member $68 Non-Member $92

Draft Option:

Checking Account **Bank Name:** _____
Account #: _____ **Routing #:** _____

Savings Account **Bank Name:** _____
Account #: _____ **Routing #:** _____

Credit Card **Name of Card:** _____ **Card Type** _____
Card #: _____ **Exp:** _____ **CID#:** _____

- This authorization continues indefinitely and automatically until cancelled by the person signing this authorization. Draft cancellation needs 15-day notice.
- Amount of draft will be determined by elected program and the fee and adjustments defined by the program policy. The draft may be adjusted based on increased fee rates or adjustments as defined by the
- program policy.
- Each program requires separate authorization forms.
- All drafts are non-refundable
- A fee of $25 will be charged for all returned drafts because of non-sufficient funds, account closing, or payment stopped. Two charges of this type will result in expulsion from the program.

I authorize the Stateline Family YMCA to draft the above-named bank or credit card account for payment of membership or program fees. Any change in fees may constitute a change in the draft amount. I understand that the Stateline Family YMCA may initiate a preauthorization to validate the account number and bank transit number listed. I also understand that I am liable for the entire balance plus the processing fee for returned drafts.

_____
Authorized Signature Date

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/2017)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

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

STEP 1 PERSONAL DATA PLEASE PRINT

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)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) 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 *Influenzae* 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)

STEP 3 REQUIREMENTS

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 child care entrance. Children who reach a new age/grade level while attending this child 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

[1]If 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).

[2]If 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.

[3]MMR 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).

[4]Children 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).

STEP 4 COMPLIANCE DATA AND WAIVERS

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

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child 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 child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child 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):

STEP 5 SIGNATURE

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

_____ _____

SIGNATURE - Parent, Guardian or Legal Custodian | Date Signed

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child.		
☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.		

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition

☐ Asthma ☐ Diabetes ☐ Gastrointestinal or feeding concerns including special diet and supplements

☐ Cerebral palsy / motor disorder ☐ Epilepsy / seizure disorder ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism

☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care 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 child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____