2026 Tiny Explorers Summer Preschool Registration

Ages 3 to 6

Child's Information

Child's Name_____ Birthdate_____ Today's Date_____

Familiar or Nickname_____ Age_____ Gender ○ Male ○ Female

Parent Email Address_____ YMCA Household/Single Parent Household Member ○ Yes ○ No

Days: Monday-Thursday **Time:** 9:00-11:15 **Fee:** Y Member* $75 General Public $100

	Date	Theme		Date	Theme
○ **Week 1**	June 8-11	**Sports of all Sorts**	○ Week 6	July 13-16	Wild West
○ Week 2	June 15-18	Down on the Farm	○ Week 7	July 20-23	Dinosaur Discovery
○ Week 3	June 22-25	To the Moon	○ Week 8	July 27-30	Outdoor Adventures
○ Week 4	June 29-July 2	**No Tiny Explorers**	○ Week 9	Aug 3-6	Wonders of Science
○ Week 5	July 6-9	Beach Bash	○ Week 10	Aug 10-13	Buggin' Out

Registration & Tuition Payment Agreement

* **A non-fundable registration fee of $25.00 is due at time of registration for Tiny Explorers.**
* **Payment Options: automatic weekly payment or pay in full at time of registration.**
* **You will be charged a $20 service fee for any returned payments.**
* ***To qualify for YMCA member tuition rates, child must be part of a Household or Single Parent Household membership effective from the date of registration through the program end date.**
* **Tuition will be auto drafted on Monday for 2 weeks prior to care.**

☐ $25 Tiny Explorers Registration Fee

☐ Pay in full for all weeks

☐ Check Enclosed ☐ Please Charge My: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express Amount: $ _____

*Card #: _____ Exp. Date: _____

Signature: _____ Total Amount Paid Today: $ _____

The card number listed above will be used for all payments at the time they are due. If a check was provided for deposits, information from check will be used for all payments at the time they are due.

Send payments and registration paperwork to Stevens Point Area YMCA 1000 Division St. Stevens Point, WI 54481

Stevens Point Area YMCA
- Child Care/Preschool/Before and After School Care/Vacation at the Y

PARENT/GUARDIAN CONSENT and WAIVER & RELEASE OF LIABILITY

_____ **Initial Section #1: REASONABLE ACCOMMODATIONS CLAUSE:** Children with special needs or challenges will be accepted provided that "reasonable accommodations" can be made for their participation in the program and/or the child's participation does not require an inordinate amount of staff time that would not allow for the safety and welfare of the other children in the program. I understand that if my child requires an unusual amount of one-on-one attention, whether due to special needs or behavior, my child may be removed from the program. (Does not apply to School District programs including 4 year old Kindergarten.)

_____ **Initial Section #2: MEDICAL RELEASE:** In the event I cannot be reached, I give consent for YMCA staff to act in my behalf in granting permission for my child to receive emergency treatment. I agree that I will be responsible for the payment of all medical services rendered.

_____ **Initial Section #3: RELEASE FROM LIABILITY:** I understand that all reasonable safety precautions are taken by the YMCA in the operation of its facility, equipment, and programs. However, participants and parents of children must recognize and accept that there are inherent risks when choosing to participate in any YMCA program; risks that could cause sickness, injury or death. I agree that my child's participation in the YMCA programs shall be undertaken at his/her sole risk, and that the YMCA, its directors, employees, volunteers, and agents shall not be liable for any claims, injuries, damages, losses, diseases, wrongful death, actions or causes of action whatsoever, to my child or his/her property, arising out of or connected to participation in this program or any other YMCA program. I agree to hold harmless and indemnify the YMCA, its directors, employees, volunteers, and agents from any and all liabilities and claims resulting from participation in this program.

_____ **Initial Section #4: MEDIA RELEASE:** I give my permission for my child to appear in media approved by the YMCA and for the YMCA to use photographs and video of my child for promotional purposes and social media.

_____ **Initial Section #5: FIELD TRIP PERMISSION:** I give permission for my child to participate in walking, parent driver, bus and YMCA Van field trips. I understand that details will be sent home in advance and that these trips are dependent on weather conditions.

_____ **Initial Section #6: SUNSCREEN:** I give permission for my child to use sunscreen I provide, and for my child to receive application assistance as needed.

_____ **Initial Section #7: PARENT HANDBOOK:** I have received the YMCA Child Care, Preschool, or Before and After School Care Parent Handbook, which includes necessary program information for my child and me. I have read the information and agree to abide by the policies and procedures therein. I also understand that a copy of the Policies Manual and DCF 251 licensing manual are available to me upon request.

_____ **Initial Section #8: PETS:** I have been informed of the pets in the center and their degree of contact with my child. I will be informed by the YMCA if pets are added prior to the pet's addition to the center.

_____ **Initial Section #9: RESPONSIBILITY STATEMENT:** I understand that the YMCA's responsibility for my child begins after s/he has entered the program area and has been signed in and ends when s/he leaves the program area and is signed out. **I understand that I and/or an authorized adult must sign my child in and out.**

_____ **Initial Section #10: PARTICIPANT ENROLLMENT ACCEPTANCE:** I hereby apply for a reservation for my child as a program participant. I agree to pay the total fee on or before the payment due date. Failure to pay by the due date may forfeit my application and deposit. Furthermore, if my child is forced to leave the program due to illness, injury, or inappropriate behavior a refund may not be available. Children must be picked up by the closing time 5:30PM. A late fee of $1 per minute will be charged after this time, minimum charge $5. Time will be determined by the clock in the room. YMCA membership must be valid at the time of registration and maintained through the program dates to receive member rates. (Does not apply to School District programs including 4 year old Kindergarten.)

_____ **Initial Section #11: SCHEDULE INFORMATION:** I understand that I am responsible for notifying the YMCA Child Development Office in writing of any changes in my child's schedule, and to inform the staff of any extracurricular activities that may affect my child's attendance. I understand that schedule cancellations, changes and transfers may result in fee charges (see current registration for details).

_____ **Initial Section #12: DAILY SHEET:** I give my permission to have my child's daily sheet information posted in the classroom and visible to others.

_____ **Initial Section #13: INFORMATION RELEASE:** I authorize the Stevens Point Area YMCA and my child's past and present school to exchange and share information related to my child including: YMCA reports, behavior plans, school psychological evaluations, social work reports, IEP's and related evaluations/reports.

_____ **Initial Section #14: ACCURATE/COMPLETE INFORMATION:** I hereby state that all information I have provided is accurate and complete. I understand that it is my responsibility and required by licensing to provide any changes/updates regarding emergency and health information to the YMCA.

I have carefully read and initialed each of the above parent/guardian consent sections. I fully understand that by signing this form I have given my parent/guardian consent for my child on all sections contained within.

_____ _____ _____/_____/_____

Child's Name – Please Print **Parent/Guardian Signature** **Date**

Form Rev. 12/23

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

http://dcf.wisconsin.gov

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child | Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip) | Home / Cell Phone No.

Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No.

b. Name and Relationship to Child | Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip) | Home / Cell Phone No.

Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child | Home / Cell Phone No.

Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No.

b. Name and Relationship to Child | Home / Cell Phone No.

Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.

☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child | Home / Cell Phone No.

Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name

Address (Street, City, State, Zip Code) | Telephone No.

AUTHORIZATIONS

☐ Yes ☐ No 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 child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.

☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.

☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian | Date Signed

Health History and Emergency Care Plan

Use of form: This form is voluntary and meets the requirements in DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. 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 may 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)	Birthdate (mm/dd/yyyy)	First Day of Attendance (mm/dd/yyyy)

Home Address (Street, City, State, Zip Code)

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

Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number
Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number

PHYSICIAN / MEDICAL FACILITY INFORMATION

Physician Name	Medical Facility Address	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 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months 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. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

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
   - ☐ Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism
   - ☐ Asthma
   - ☐ Cerebral palsy / motor disorder
   - ☐ Diabetes
   - ☐ Epilepsy / seizure disorder
   - ☐ Gastrointestinal or feeding concerns, including special diet and supplements

☐ 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 – Child Care Centers* 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: _____ _____ _____ _____ _____

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 required unless the health examination report is on an electronic printout from a licensed physician, physician assistant, or other EPSDT provider. Completion of this form meets the requirements of DCF 202.08 (4), DCF 250.04 (6) (a) 4. and DCF 251.04 (6) (a) 8. 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. Each child 2 years of age but who is not 5 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 other EPSDT provider to be completed, signed, and dated. The licensee / operator 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 includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

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

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

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

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

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

☐ Yes ☐ No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's 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 other EPSDT Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other EPSDT Provider	Date of Examination

Department of Health Services
Division of Public Health
F-44192 (03/2025)

State of Wisconsin
Wis. Stat. § 252.04

Child Care Immunization Record

Instructions: 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/phone 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. 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)					

History of varicella/chickenpox
In accordance with DHS 144.03(2)(g), I attest that this child has a reliable history of varicella disease and is not required to receive Varicella vaccine.

_____
Signature – Physician/PA/APNP Date Signed

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 two 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 four 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 two 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 four days or less before the first birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the fourth birthday (either the third, fourth or fifth) to be compliant (Note: a dose 4 days or less before the fourth 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 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 $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

Your Guide to Regulated Child Care
Your summary of the child care rules

A WORD ON WISCONSIN CHILD CARE REGULATIONS

Anyone providing care and supervision for 4 or more children under age 7 years for less than 24 hours a day must be licensed by the Department of Children and Families. Exceptions to this rule are:

- A parent, grandparent, great-grandparent, stepparent, brother, sister, first cousin, nephew, niece, uncle, or aunt of a child, whether by blood, marriage, or legal adoption, who provides care and supervision for the child.
- Public, parochial, or private schools.
- Care provided in the home of the child's parent for less than 24 hours per day.
- Counties, cities, towns, school districts, and libraries that provide programs for children primarily intended for social or recreational purposes.
- A program that operates not more than 4 hours per week.
- Group lessons to develop a talent or skill such as dance or music, social group meetings and activities, group athletics.
- A program where the parents are on the premises and are engaged in shopping, recreation, or other non-work activities.
- Seasonal programs of ten days or less duration in any 3-month period, including day camps, vacation bible school, and holiday child care programs.
- Emergency situations.
- Care and supervision for no more than 3 hours a day while the parent is employed on the premises.
- A program provided where the child of a recipient of temporary assistance to needy families, or Wisconsin Works (W-2), is involved in orientation, enrollment, or initial assessment or where parents are provided training or counseling.

Regulations set minimum health and safety standards for child care, but they cannot guarantee high quality care. That is why parent involvement is so crucial.

TYPES OF REGULATED CHILD CARE PROGRAMS

Licensed Family Child Care Centers

A program regulated under DCF 250 where a person provides care and supervision for less than 24 hours per day to between 4 and 8 children under 7 years of age.

Age groups may be mixed according to the following combinations. Additional allowed school-aged children in care for 3 or fewer hours per day are shown in parentheses.

Children Under Age 2		Children Age 2 and Older		School Age Children		Maximum Group Size
0	+	8	+	(0)	=	8
1	+	7	+	(0)	=	8
2	+	5	+	(1)	=	8
3	+	2	+	(3)	=	8
4	+	0	+	(2)	=	6

Licensed Group Child Care Centers

A program regulated under DCF 251 where a person for less than 24 hours per day provides care and supervision for 9 or more children.

Age of Children	Staff-To-Child Ratio*†	Maximum Group Size
Birth to 18 mos	1:4 or .25	8
18 mos to 2½ yrs	1:7 or .143	14
2½ yrs to 3 yrs	1:8 or .125	16
3 yrs	1:10 or .10	20
4 yrs	1:13 or .077	26
5 yrs and over	1:18 or .056	36

* These ratios are adjusted for mixed age groups

†These ratios are in effect until July 31, 2027. On August 1, 2027, the ratios revert to June 2025 ratios.

Licensed Day Camps for Children
A program regulated under DCF 252 that provides care and supervision to 4 or more children, 3 years of age and older, in a seasonal program oriented to the out-of-doors for periods less than 24 hours per day.

Age of Children	Counselor-to-Child Ratios*
3 years to 4 years	1:4 or .25
4 years to 5 years	1:6 or .167
5 years and 6 years	1:12 or .083
7 years and older	1:18 or .056

* These ratios are adjusted for mixed age groups

Certified Family Child Care
A program regulated under DCF 202 where a person provides care and supervision for less than 24 hours per day for no more than 3 children under age 7 with a maximum group size of 6, including the provider's own children under age 7. When three or more children present are under age 2, the maximum group size is reduced.

IF YOU HAVE QUESTIONS, CONCERNS, OR COMPLAINTS

First, talk to your child's caregiver and try to work out your differences. If those attempts fail, and you feel the caregiver is violating a state licensing regulation, contact the appropriate regional office. See https://dcf.wisconsin.gov/cclicensing/contacts or call 1-800-362-7353 for licensing contact information.

If you feel the caregiver is violating certification rules, contact the appropriate certifying agency. See https://dcf.wisconsin.gov/files/ccregulation/cccertification/certifiers.pdf or call 1-800-362-7353 for certification contact information.

WHAT IS QUALITY CHILD CARE?

That question has no easy, quick answer. Evaluating child care may seem an overwhelming task, especially if you are new to child care services. This checklist can help. For a thorough evaluation, go through the entire checklist section by section, or, if you prefer, focus on the parts that seem most important to you. YoungStar is a program of the Department of Children and Families created to improve the quality of child care for Wisconsin children. To search for safe, quality child care in Wisconsin, see the Regulated Child Care and YoungStar Public Search page http://childcarefinder.wisconsin.gov/Search/BasicSearch.aspx.

Caregivers

- ☐ Do they genuinely seem to enjoy working with young children?
- ☐ Do they seem to be warm, loving people?
- ☐ Do they talk with you openly and straightforwardly about their policies?
- ☐ What training and experience do they have? Do they receive regular, ongoing job-related training?
- ☐ Do they seem to get along well with each other?

Caregiver / child interaction

- ☐ Do they get down to eye level when talking to or listening to the children?
- ☐ Do they encourage the children to express their feelings verbally?
- ☐ Do they encourage children to work out negative feelings without hurting others?
- ☐ Do they respect individual differences among the children?
- ☐ Do the child guidance measures focus on what the child should do rather than what the child should not do?
- ☐ Do they set reasonable limits and allow children to make choices when appropriate?
- ☐ Do they provide guidance with words, tone of voice, and actions that show respect for children? Note: See licensing and certification rules for prohibited actions.
- ☐ Do they show patience by letting children do things for themselves and exert their independence?
- ☐ Do the children seem comfortable when talking to the caregivers?
- ☐ Do the children seem happily occupied and relaxed?
- ☐ Does the ratio of children to caregivers meet state requirements?

Physical environment

- ☐ Are the play areas clean and large enough so children can move freely and safely?
- ☐ Is the playground safe and supervised by an adult?
- ☐ Is play equipment sturdy and in good repair?
- ☐ Are games, toys, etc. stored where the children can get to them?
- ☐ Are wall displays placed at child's eye level?
- ☐ Are unused electrical sockets covered with safety caps?
- ☐ Are cleaning fluids, medications, poisons, sharp tools, matches, etc. stored away from children?
- ☐ Is the area free of other hazards: peeling paint, exposed electrical wires, uncovered hot water pipes, unprotected hot radiators or heaters?
- ☐ Are fire safety and tornado drills practiced?
- ☐ Are emergency telephone numbers posted by the telephones?
- ☐ Is there adequate heat, ventilation, and lighting?
- ☐ Are bathrooms clean and sanitary?
- ☐ Are step stools in the bathrooms to help young children reach toilets and sinks?

Program / Activities

- ☐ Is there a regular daily schedule? Is it organized without being rigid?
- ☐ Are activities geared for different age and developmental levels?
- ☐ Are there indoor and outdoor activities?
- ☐ Is time provided for physical activity and quiet play?
- ☐ Is there a nap or rest period?
- ☐ Are there structured activities as well as free play when children can choose what to do?
- ☐ Are there opportunities for different types of interactions—large group play, small group play, alone time?
- ☐ Are there materials for different types of play—drama, music, creative movement, language skills, gross and fine motor skills, art projects, sand and water play?
- ☐ Are there living plants for children to observe and care for?
- ☐ Are there pets in areas of the center accessible to children? Have pets been appropriately vaccinated? Are pets tolerant of children? Is close supervision provided?
- ☐ Are the children taken out into the community for activities—parks, libraries, museums, field trips? Is there adequate supervision?

Transportation

- ☐ Are vehicles used to transport children insured, and does the center's policy address insurance coverage for transportation?
- ☐ Are vehicles in safe operating condition?
- ☐ Are appropriate individual child car safety seats and booster seats used?
- ☐ Does the center have a procedure to ensure that no child is left unattended in a vehicle?
- ☐ Do vehicles with a seating capacity of 6 or more passengers in addition to the driver have a vehicle alarm installed to ensure no child is left unattended in a vehicle?

General things to look for

- ☐ Is the license / certificate posted?
- ☐ Are visits by the parents, whether announced or unannounced, welcome at any time?
- ☐ Are there opportunities for parent / caregiver communication?
- ☐ Is this the kind of place you would enjoy spending your day?
- ☐ Are the results of the most recent licensing visit posted?
- ☐ Do staff and children wash their hands before meals and after toileting or diapering?
- ☐ Are meals and snacks well balanced and wholesome?
- ☐ Is the food preparation area clean and sanitary?
- ☐ Are menus posted in licensed programs?

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
HOUSEHOLD LETTER (Non-Pricing Programs)

For Group Child Care & Outside of School Hours Centers
FFY 2026, Rev. 6/25

Dear Parent or Guardian:

Stevens Point Area YMCA is enrolled in the CACFP, a USDA program which
(Name of Agency)
provides federal assistance dollars to eligible child care centers for serving more nutritious meals. The amount of money our agency receives from this program is based on the income levels of our families. **In order to continue providing a quality meal service without additional charge, we request every family of our enrolled children to complete new a Household Size-Income Statement form (HSIS) each year. Please complete and return the attached HSIS form to our office. This information will be kept strictly confidential in our files.** Only one completed HSIS is required for all children in your household. Once we have properly approved your HSIS as eligible, our agency will receive the higher *("Free" or "Reduced-price")* meal reimbursement rates for your enrolled children, for 12 months from the *Effective Month of Determination* regardless of any change in your household size and/or income or termination from Benefits Programs.

- You are not required to complete this HSIS if no one in your household receives benefits from FoodShare (Supplemental Nutrition Assistance Program (SNAP)), FDPIR (Food Distribution Program on Indian Reservations), Wisconsin Works Programs and your household income is higher than the amount shown for your household size within the table below. In this case, however, we would appreciate you returning the HSIS to us with "N/A" written on it along with your signature and date.

Determining Eligibility based on Participation in Benefits Programs → *Complete Part 1 and Part 3 of HSIS form*

Our agency receives the Free meal reimbursement rate for children in households receiving benefits from FoodShare WI, FDPIR, or Wisconsin Works (W-2) Programs. W-2 Programs is Wisconsin's Temporary Assistance for Needy Families (TANF) program. It provides employment preparation services, case management, and cash assistance to eligible families with the following programs: Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), Case Management, W-2 Transitions (W-2T), Custodial Parent of an Infant (CMC), and At-Risk Pregnancy (ARP). **W-2 Programs IS NOT the WI Child Care Subsidy Program.**

You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare, FDPIR, W-2 Works Programs:

(a) The names of your enrolled children;
(b) Checked box for the benefit your household receives and its case number; &
(c) The signature of an adult member in the household & signature date

- DO NOT list case numbers for:
- Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
- DO NOT list 16-digit Quest Card number *(starts with 5077)* for FoodShare

Determining Eligibility by Household Size and Income → *Complete Part 2 and Part 3 of HSIS form*

Household-Size Income Scale (Effective July 1, 2025 to June 30, 2026)

Household Size	Annual Income Level (at or below)
1	$ 28,953
2	$ 39,128
3	$ 49,303
4	$ 59,478
5	$ 69,653
6	$ 79,828
7	$ 90,003
8	$ 100,178
For each additional Household Member, add:	+$ 10,175

If your household earns a total income that is less than or equal to the income levels listed within this table, we will receive higher meal reimbursement rates *("Free" or "Reduced-price" meal rate)* for your children. **For determining eligibility based on your household size and income, you must include the following information on the HSIS (a-e):**

(a) Full names of all household members who share income and expenses, including children, parents, and non-related persons;
(b) Income received by each household member identified by source of income and its pay frequency;
(c) Total number of household members;
(d) The signature of an adult member of the household and signature date; and
(e) The last four digits of the social security number of the adult household member signing the HSIS or an indication he/she does not have a social security number.

- Disclosure of United States citizenship or immigration status is not required and is not a condition of eligibility for higher meal reimbursement rates.

Eligibilities of Foster, Runaway, Homeless, and Migrant Children, and Children enrolled in Head Start: Our agency will receive the Free meal reimbursement rates for foster, runaway, homeless, and migrant children and children enrolled in Head Start who reside in your household, when you provide the respective documentation listed below. **The respective documentation is required for these children to be eligible for Free Meals: These children's eligibility for Free meals does not extend to other children in your household.**

- **Foster children:** Your completed HSIS with the 'Foster Child' box checked next to your foster children's names. When including them on your HSIS completed for your non-foster children, any income reported for your foster children must only be for their personal use. Your foster children will then be eligible at the "Free" meal rate. Your non-foster children's eligibilities will be based on the benefits or income information provided on your household's completed HSIS form.
- **Children Enrolled In Head Start:** Written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.
- **Runaway, Homeless, and Migrant Children:** Written certification of the child's status from an official of the appropriate Runaway and Homeless Youth Program, Migrant Education Program, or school official.

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You are not required to provide this information, but if you do not, our agency cannot receive higher reimbursement rates for meals served to your children. You must include the last four digits of the social security number of the household member signing the form unless: the HSIS is only for your foster child(ren); you list a case number for receiving benefits from FoodShare WI, WI Works Cash Programs, or FDPIR; or when the household member signing the HSIS checks "None" for not having a SS#.

Sharing Eligibility Information: Children's eligibility information may be shared in accordance with disclosure protection requirements without prior notification, with education, health, and nutrition programs to assess their eligibility for benefits. The law allows us to share your children's eligibility information with programs such as Medicaid or BadgerCare for ensuring their access to free or low cost health insurance, **unless you tell us not to.** This information may only be used for determining eligibility for their programs; if your children are eligible, they may contact you to offer their enrollment options. Filling out this HSIS does not automatically enroll your children in these programs. **If you do not want your information to be shared with these programs, notify us in writing. This notification will not change whether your children's meals are eligible for meal reimbursement.** Your eligibility information provided on the HSIS may also be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

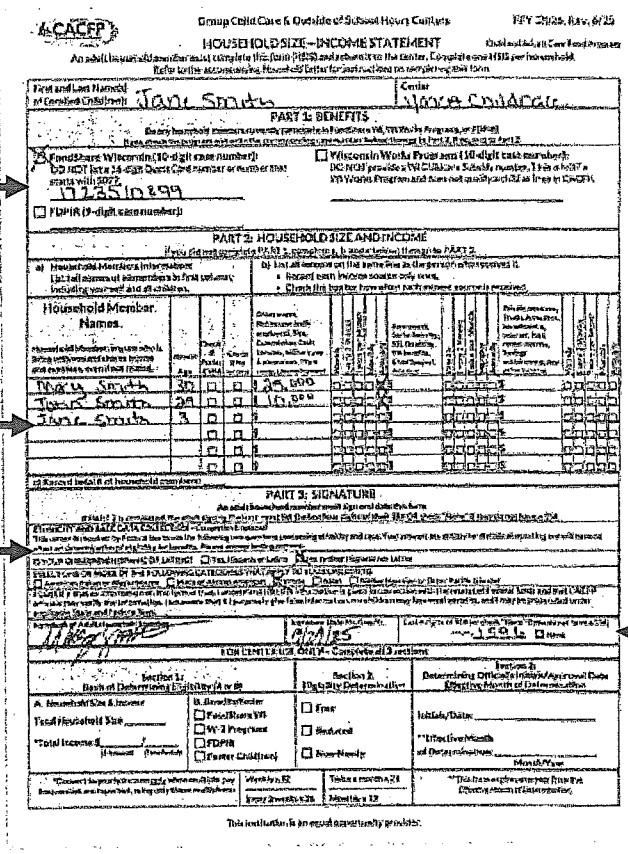
Refer to the USDA Non-Discrimination Statement and Complaint Filing Procedure (https://dpi.wi.gov/nutrition#discrimination).
This institution is an equal opportunity provider.

Signature of Agency Representative

If you are enrolled in FoodShare or Wisconsin Works Program, please indicate the 10-digit case number. This is NOT the 16-digit Quest card or WI Childcare Subsidy number.

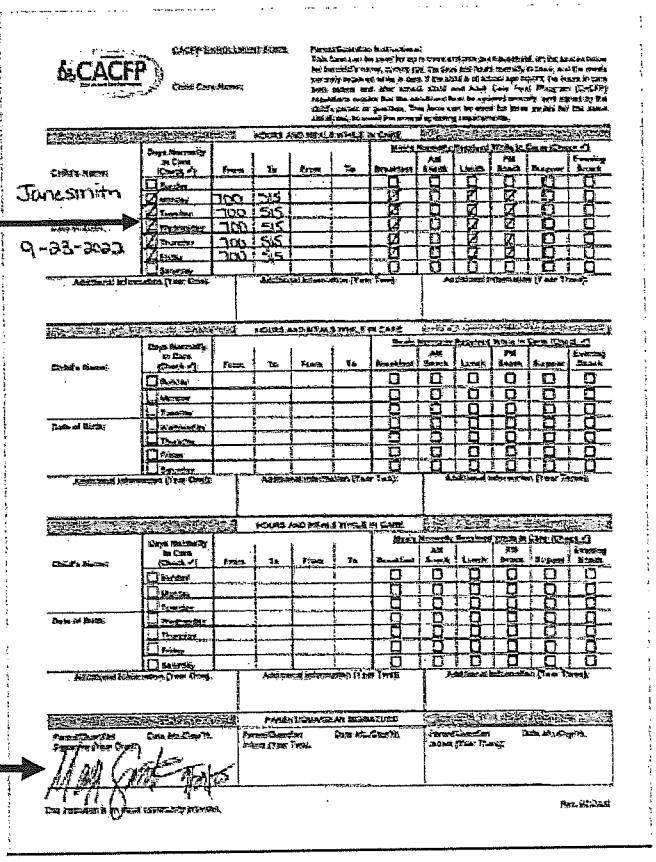
Please list all family members, including your enrolled child

Please check the boxes in the Ethnicity and Data section.



Please sign, date, and include the last 4-digits of your SSN.

Please check the boxes for Breakfast, Lunch, and Snack. Please provide an estimated time that you child will arrive and leave childcare.



Please sign and date.

If you have any questions about filling out these forms, please reach out to Julie Treml at jtreml@spymca.org

CACFP ENROLLMENT FORM

Child Care Name:

Parent/Guardian Instructions:
This form can be used for up to three children per household. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. **This form can be used for three years for the same child(ren), to meet the annual updating requirements.**

HOURS AND MEALS WHILE IN CARE

Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Meals Normally Received While in Care (Check ✓)

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

HOURS AND MEALS WHILE IN CARE

Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Meals Normally Received While in Care (Check ✓)

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

HOURS AND MEALS WHILE IN CARE

Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Meals Normally Received While in Care (Check ✓)

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

PARENT/GUARDIAN SIGNATURE

Parent/Guardian Signature (Year One):	Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Two):*	Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Three):*	Date *Mo./Day/Yr.*

CACFP

Group Child Care & Outside of School Hours Centers

FFY 2026, Rev. 6/25

HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

An adult household member must complete this form (HSIS) and return it to the center. Complete one HSIS per household.

Refer to the accompanying *Household Letter* for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren):	Center

PART 1: BENEFITS

Do any household members currently participate in FoodShare WI, WI Works Programs, or FDPIR?

If yes, check the program and write the corresponding case number below; then go to Part 3. If no, skip to Part 2.

☐ **FoodShare Wisconsin (10-digit case number):** DO NOT list a 16-digit Quest Card number or number that starts with 5077.

____

☐ **Wisconsin Works Programs (10-digit case number):** DO NOT provide a WI Childcare Subsidy number. This is NOT a WI Works Program and does not qualify a child as free in CACFP.

____

☐ **FDPIR (9-digit case number):**

____

PART 2: HOUSEHOLD SIZE AND INCOME

If you did not complete PART 1, complete a, b, and c below; then go to PART 3.

a) Household Members Information: List full names of all members in first column, including yourself and all children.

b) List all income on the same line as the person who receives it.

- Record each income source only once.
- Check the box for how often each income source is received.

Household Member Names Household Member: anyone who is living with you and shares income and expenses, even if not related.	(Optional) Age	Check if Foster Child	Check if No Income	Gross wages, Net Income (self-employed), Tips, Commission, Cash bonuses, Military pay & allowances, Work comp, Unemployment	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Retirement, Social Security, SSI, Disability, VA benefits, Child Support, Alimony	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Private pensions, Trusts, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐

c) Record total # of household members: ______

PART 3: SIGNATURE

An adult household member must sign and date this form

If PART 2 is completed, the adult signing the form must list the last four digits of their SS# OR check "None" if they do not have a SS#.

ETHNICITY AND RACE DATA COLLECTION – *Completion is optional*

This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. **Please answer both questions.**

IS YOUR CHILD(REN) HISPANIC OR LATINO? ☐ Yes, Hispanic or Latino ☐ No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):

☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

I CERTIFY that all information on this form is true. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Signature of Adult Household Member	Signature Date *Mo./Day/Yr.*	Last 4 digits of SS# (or check "None" if you do not have a SS#) ***-**-_ _ _ _ ☐ None

FOR CENTER USE ONLY – Complete all 3 sections

Section 1: Basis of Determining Eligibility (*A or B*)		Section 2: Eligibility Determination	Section 3: Determining Official's Initials/Approval Date Effective Month of Determination
A. *Household Size & Income* Total Household Size ______ *Total Income $______/______ ($ Amount) (Time Period)	B. *Benefits/Foster* ☐ FoodShare WI ☐ W-2 Programs ☐ FDPIR ☐ Foster Child(ren)	☐ Free ☐ Reduced ☐ Non-Needy	Initials/Date: ______ **Effective Month of Determination: ______ Month/Year

*Convert to yearly income only when multiple pay frequencies are reported, using only these multipliers:	Weekly x 52 Every 2 weeks x 26	Twice a month x 24 Monthly x 12	**This form expires one year from the *Effective Month of Determination.*

This institution is an equal opportunity provider.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

DRAFT AGREEMENT
SPYMCA CHILD DEVELOPMENT OFFICE

BANK DRAFT INFORMATION:

Child's Name:_____

Name on Account:_____

Program: ❍Child Care ❍ Before and After School Care ❍Preschool ❍Camp

Account Type: ❍ Checking ❍ Savings ❍ Credit/Debit Card

Card Number:_____ Expiration Date:_____

Billing Zip Code:_____ Card Type:_____ CVV:_____

Bank Name:_____

Account #:_____Routing #_____

Date	Draft Amount	1rst Draft Date	Last Draft Date	Parent Initials

IF USING BANK ACCOUNT, MUST ATTACH VOIDED CHECK HERE:

The YMCA guarantees satisfaction with the quality of its services. This authorization will remain in effect until revoked by me in writing and until you actually receive such notice, I agree that you shall be fully protected in honoring any such charge. I agree that your treatment of each such charge and your rights in respect to it, shall be the same as if it were signed by me and that if any such charge be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of services.

If at anytime the amount in my account is insufficient to cover the amount to be deducted, the bank is not obligated to pay and is not responsible for these insufficient funds. Nor shall the bank be liable for any errors by the Stevens Point Area YMCA in handling the terms of this authorization.

I will use an electronic funds transfer to pay for services and I agree that if for any reason I wish to terminate or change the status of services, I must give the **YMCA WRITTEN NOTICE 15 DAYS IN ADVANCE** of my automatic withdrawal date. A $20.00 service fee will be charged on any returned bank draft.

SIGNATURE _____ **DATE**___/_____/_____

Stevens Point Area YMCA

School Age/Day Camp – Health History and Care Form

FULLY COMPLETE ALL SECTIONS of this REQUIRED Health and Care Form and return to:
Stevens Point Area YMCA, Child Development Office, 1000 Division Street, Stevens Point, WI 54481 (715) 342-2999

First Day of Attendance: _____

Participant Name _____ Birth Date _____ Age _____ ❑ M ❑ F

Street Address _____
Street City State Zip

Home Phone _____ School _____ Grade_____ Height _____ Weight_____

Parent/Guardian Name _____ **Parent/Guardian Name**_____

Home Address _____ Home Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Place of Employment and Phone # _____ Place of Employment and Phone # _____

_____ _____

Cell Ph._____ Home Ph. _____ Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____ Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care: Email Where Reachable While Child is in Care:

_____ _____

Please Indicate any Custody Issues _____

Emergency Contacts (other than Parent/Guardian) and Persons Authorized to Pick Up Child.

Emergency Contact Name _____ **Emergency Contact Name**_____

Relationship to Child _____ Relationship to Child _____

Place of Employment and Phone # _____ Place of Employment and Phone # _____

_____ _____

Cell Ph._____ Home Ph. _____ Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____ Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care: Email Where Reachable While Child is in Care:

_____ _____

Participant Physician _____ Phone _____
Dr. Name/Facility Office Address

Participant Dentist _____ Phone _____
Dr. Name/Facility Office Address

Insurance Information: Is Participant covered by family medical/hospital insurance? ☐ YES ☐ NO

Carrier or Plan Name _____ Member ID # _____ Group # _____

Carrier Address & Phone # _____

Name of Insured _____ Relationship to Participant _____

Emergency Treatment Authorization: In the event I cannot be reached in an emergency, I authorize the YMCA staff to transport to and/or secure from any licensed hospital, physician and/or medical personnel any emergency care or treatment deemed necessary for my child. I agree that I will be responsible for the payment of any and all medical services rendered.

Signature of Parent/Guardian _____ **Date** _____

OVER

Participant Name _____ **Birth Date** _____ **Age** _____ ☐ M ☐ F

HEALTH CONDITIONS: (Check any that apply to the participant and explain below, include severity.)

❑ Sleepwalking	❑ Frequent Ear Infections	❑ Skin Problems	❑ Cerebral Palsy/Motor
❑ Bed-wetting	❑ Heart Defect/Disease	❑ Joint/Bone Problems	❑ Picky Eater
❑ Athlete's Foot	❑ High Blood Pressure	❑ Head/Neck/Back Injuries	❑ Vegetarian
❑ Warts	❑ Diabetes	❑ Epilepsy/Convulsions/Seizures	❑ Allergies
❑ Eating Disorder	❑ Frequent Headaches	❑ Visual Impairment/Glasses…	❑ Asthma
❑ Diarrhea/Constipation	❑ Indigestion	❑ Hearing Impairment/Aids…	❑ Other _____
❑ Abnormal Menstruation	❑ Sinus Trouble	❑ Speech Impairment	❑ Other _____
❑ Homesickness	❑ Frequent Nose Bleeds	❑ Learning Disability	
❑ Doesn't Swim (describe)	❑ Bleeding Clotting Disorder	❑ ADD or ADHD	❑ Does participant have a School IEP? If yes please provide a copy.
❑ Nightmares	❑ Fainting/Dizziness	❑ Cognitive Disability	
❑ Exercise Induced Difficulties	❑ Emotional/Behavior Disorder	❑ Chronic Illness/Condition	

Give details including triggers, signs/symptoms, care procedures and when to call parent and/or 911 for any conditions checked above: _____

_____

_____

Identify any YMCA staff that you have given specialized instructions/training to: _____

ALLERGIES Describe reaction/symptoms, management instructions and when to call parent or 911.

Medications (list)

_____ _____

_____ _____

Foods (list)

_____ _____

_____ _____

Insects, Animals, Plants…

_____ _____

_____ _____

MEDICATIONS (Please name and describe reason for taking.)

Medication Name	Dosage (tabs & mg)	Times Taken	Reason for Taking
1. _____	_____		
2. _____	_____		
3. _____	_____		
4. _____	_____		

Will participant medication need to be taken during this program? ____ Yes ____ No ____ Maybe *If yes or maybe a* Authorization to Administer Medication form must be completed. All Medications are required to be in original containers and be clearly labeled.

List and describe any other participant Health Conditions/Disorders/Impairments/Diseases/Illnesses/Major Surgeries/ Special Needs and indicate if there are any Restrictions: _____

_____

_____

*** A copy of participant's immunization records or provided form must be attached.**

I hereby state that the information I have provided is accurate and complete. I understand that it is my responsibility to provide any changes/updates regarding emergency and health information to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize my child's participation in this program.

_____ _____ _____

Participant Name - Please Print | Signature of Parent/Guardian | Date

Review dates: _____ _____ _____ _____ _____