



# SCHOOL-AGE CHILD CARE (SACC) 2025 SUMMER REGISTRATION

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

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

## Child(ren's) Information

1. Name (Last, First) \_\_\_\_\_ Age as of 6/10/25 \_\_\_\_\_ School \_\_\_\_\_ Grade Sept. 2025 \_\_\_\_\_ Birth Date \_\_\_\_\_

2. Name (Last, First) \_\_\_\_\_ Age as of 6/10/25 \_\_\_\_\_ School \_\_\_\_\_ Grade Sept. 2025 \_\_\_\_\_ Birth Date \_\_\_\_\_

## Check Location

Calvary Lutheran  Ferguson Family YMCA  Langlade School  Meadowbrook School  West Side YMCA  East Side YMCA

## Check the weeks your child(ren) will be attending Child's start date: \_\_\_\_\_

Week 1  June 10 - June 13 (4 days)      Week 4  June 30 - July 3 (4 days)      Week 7  July 21 - July 25      Week 10  Aug 11 - 15

Week 2  June 16 - June 20      Week 5  July 7 - July 11      Week 8  July 28 - Aug 1      Week 11  Aug 18 - 22

Week 3  June 23 - June 27      Week 6  July 14 - July 18      Week 9  Aug 4 - Aug 8      (Note: Langlade end date is Aug. 20)

**(If you are enrolling your child in 7 weeks or less of School-Age Child Care, skip this Day Camp section)**

### Check the following day camp information if interested in attending 1 or 2 weeks of camp as part of your child's summer experience.

All children (ages 5-12) attending at least 8 weeks of SACC are able to attend one week of day camp (2-week maximum). For an additional (\$20 Kids Camp) or (\$40 Camp Wabansi) plus your weekly summer rate, your child can experience one week of day camp. If you choose to attend a second week of day camp, you will be charged the regular day camp rate (See Optional Day Camp Section in brochure). Please fill out all pertinent information as it relates to the camp(s) of your choice. All camp weeks will be assigned and announced in your confirmation letter. It is not always possible to honor all weeks of camp requested especially if wanting more than one.

My Child:  is  is not interested in attending either day camp.

My Child would like to attend **KIDS CAMP** (ages 5-10)  Yes  No If yes,  1 Week  2 Weeks

Please list & prioritize which weeks (1-11) you would like your child to attend. 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

There is no bus transportation to and from Kids Camp. You will need to drop off and pick up at Kids Camp.

While at Kids Camp, my child would like to be in a group with: \_\_\_\_\_

My Child would like to attend **CAMP WABANSI** (ages 7-12)  Yes  No If yes,  1 Week  2 Weeks

Please list & prioritize which week(s) (2-10) you would like your child to attend. 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

My child's bus stop for Wabansi will be:  West Side YMCA  East Side YMCA  Langlade (There is no bus stop at Ferguson Family YMCA, Meadowbrook, or Calvary)

While at Wabansi, my child would like to be in a group with: \_\_\_\_\_

If you register your child(ren) for any other YMCA programs throughout the summer, please call the SACC office with the details (Overnight Camp, Swim Lessons, etc.)

Upon registering, you **MUST** pay the following: (\$30 registration fee per child AND first FULL week of care.)

Total fee enclosed: \$ \_\_\_\_\_ (Make checks payable to YMCA) Financial Assistance Requested  Yes  No

Office Use Only: Paid \_\_\_\_\_ Immun.  Kids Camp \_\_\_\_\_ Wabansi \_\_\_\_\_ Uni \_\_\_\_\_ TAP \_\_\_\_\_

Draft  \_\_\_\_\_ Computer    3rd Party  \_\_\_\_\_ AC  \_\_\_\_\_ BC  Site Copies  Confirmation  Sp. Concern



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Did your child(ren) participate in the: **2024 SUMMER PROGRAM**  Yes  No If yes, which site? \_\_\_\_\_ **OR** **2024-25 BEFORE/AFTER SCHOOL 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) \_\_\_\_\_



# 2025 SUMMER SACC

## School-Age Child Care (SACC) Summer Medical Registration

**First Child's Name:** \_\_\_\_\_

### Medication

Will your child require any medication while at the summer program? Yes  No

If yes, please list medication: \_\_\_\_\_ (You will be required 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).

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

### 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 Summer 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 if I withdraw from the program prior to May 10 and written notice is provided, I will receive my first week's payment in return. If written notice is provided after May 10, my first week's payment and registration fee per child is forfeited.
- \_\_\_\_\_ I understand that if I withdraw from the program in June or thereafter, a two-week written notice must be provided to the SACC office and payment for additional weeks may be required.
- \_\_\_\_\_ I understand the information in this brochure as it relates to cancelling a week of care at my child's summer location.

X Parent or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# 2025 SUMMER SACC

## School-Age Child Care (SACC) Summer Medical Registration

Second Child's Name: \_\_\_\_\_

### Medication

Yes  No

Will your child require any medication while at the summer program?

If yes, please list medication: \_\_\_\_\_ (You will be required 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).

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

### 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.

# 2025 SUMMER SACC/TAP

## YMCA Bank Draft or Credit Card Draft Agreement

Upon registration, payment will be made for your first week of the summer program (SACC or TAP). Draft amounts will occur for the remaining summer weeks you have registered for. This does not include any week(s) of Camp U-Nah-Li-Ya. Camp will bill you directly.

Weekly drafts will be drafted on the Monday of the current week attending (Example: If attending week 2 (June 16-20) your draft for this week will occur on Monday, June 16).

Monthly drafts will be drafted on the 1<sup>st</sup> or 15<sup>th</sup> of the month per your request for the weeks of care occurring within that month.

(Example: Weeks of June 10, 16, 23, 30 will be drafted in June. Weeks of July 7, 14, 21, 28 will be drafted in July. Weeks of August 4, 11, 18 will be drafted in August.)

**Please fill out the information below and return this form to the SACC/TAP office upon registration.**

Child(ren)'s Name: \_\_\_\_\_ Summer Site: \_\_\_\_\_

Frequency of Draft: \_\_\_\_\_ Weekly OR \_\_\_\_\_ Monthly ( \_\_\_\_\_ 1<sup>st</sup> or \_\_\_\_\_ 15<sup>th</sup>)

### 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:

\_\_\_\_\_ Discover Card \_\_\_\_\_ Master Card \_\_\_\_\_ Visa Name as it appears on the card: \_\_\_\_\_

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: \_\_\_\_\_ 3 Digit CVV Code: \_\_\_\_\_

### Authorization:

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

- I understand my payment will continue until my scheduled payments are completed.
- 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 25<sup>th</sup> of the month prior. Notification for accounts drafting on the 15<sup>th</sup> must be in by the 10<sup>th</sup> of the month.
- 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:

- Atwo-week advance written notice must be given prior to withdrawing from a program.**
- Following one month of insufficient funds or declined credit card, the YMCA will send a letter and statement to be paid within 15 days.
- 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.
- If you do not comply with the arrangements, you 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.

Parent/Payee Signature: \_\_\_\_\_

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

**PLEASE RETURN THIS DRAFT AGREEMENT ALONG WITH YOUR COMPLETED SUMMER SACC/TAP REGISTRATION FORM.**

