



Child's Name: _____

Birthdate: _____ Age: _____ Sex: _____

School: _____ Grade in fall of 2017: _____

Parent/Guardian Information:

Parent/Guardian: _____ Relationship: _____

Email Address: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____

Parent/Guardian: _____ Relationship: _____

Email Address: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____

Authorized Pick Up: (Proper I.D. required at pick up)

Name: _____ Relationship: _____

Home/Work Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home/Work Phone: _____ Cell Phone: _____

Special Accommodations Needed: (in order to provide the best care and a safe environment for all children, we need to ensure that our resources match our student's needs)

History and Emergency Care Plan

Child's Name: _____

Allergies (please include any and all food allergies): _____

Please list any other conditions requiring special care: _____

Signs or symptoms to watch for: _____

Steps the staff should follow: _____

Medications (*if your child needs medication administered while in our care please complete the Authorization to Administer Medication Form*): _____

Additional information that may be helpful to us: _____

Doctor's Name: _____ Phone: _____

Alternative Emergency Contact:

Name: _____ Relationship _____

Home/Work Phone: _____ Cell Phone: _____

Name: _____ Relationship _____

Home/Work Phone: _____ Cell Phone: _____

I give the Connects Before and After School program permission to seek medical attention for my child in case of emergency.

Parent/Guardian Signature

Date

Child's Name:

Start Date:

School:

Grade 2017:

Teacher (if known):

My child will attend on these days and times: (Please "x" the boxes below to indicate your child's schedule.)

K5-5th Grade

Hours

AM Care

7am to start of school

PM Care

End of school to 6:00pm

AM and PM Care

Combo of Above

	M	T	W	TH	F
AM Care					
PM Care					
AM and PM Care					

K4 Wrap Around Care Program

Before AM K4

7am to start of school

After AM K4

End of AMK to 3:30pm

After AM K4 extended

End of AMK to 6:00pm

Before PM K4

7am to start of PMK

After PM K4

End of PMK to 6:00pm

	M	T	W	TH	F
Before AM K4					
After AM K4					
After AM K4 extended					
Before PM K4					
After PM K4					

(Please do not write in the blank space below – for office use)

I authorize the Whitefish Bay Recreation and Community Education Department to base my monthly fee off of the schedule I have submitted. If there are changes to my child's schedule, I am responsible to notify the Lydell office in writing 10 business days in advance of a permanent schedule change.

Parent/Guardian Signature

Date

I have read the policies of the Parent Handbook provided by the Connects Before and After School Program.

Parent/Guardian Signature

Date

(optional)

I give permission for my child to be photographed and/or videotaped during the program and I understand that photos or films may be used for local promotional purposes.

Parent/Guardian Signature

Date

Payment Agreement

Child's Name _____

E-Mail Address _____

Payment Options - Please choose **ONE** of the following methods of payment:

Auto-Debit on credit card

I hereby authorize the Whitefish Bay Recreation Department to make automatic debits from my credit card. Further, I understand that the debit will take place monthly on the 1st of each month, if this falls on the weekend or holiday the debit will take place on the next business day. It is my responsibility to inform the Recreation and Community Education Department of any discrepancies or report a change in credit card information including expiration date.

Card Number

Exp. Date

Cardholder Name

Signature

Date

Pay monthly fees by check

I understand that all payments must be made by the first of each month. Checks can be mailed or dropped off at the Whitefish Bay Recreation and Community Education Departments at: 5205 N. Lydell Avenue, Whitefish Bay, WI 53217.

This agreement will remain in effect until the program has ended. I approve this application, authorize payment by the above specified means and certify that the applicant is capable of participation in this program. I understand that by signing this form, I am responsible for all fees for the Connects Before and After School Program. I understand that the \$25 registration fee is non-transferable and non-refundable (\$50 family max). I understand that fees must be paid monthly in advance of service. I understand that failure to pay fees may result in a \$10 late fee per week. I understand that the fees for this program are established based on a schedule, not attendance. This is a flat monthly fee based on the school calendar (non-student attendance days are not included in tuition). Credits or refunds are not given for sick days, or other days when my child does not adhere to the schedule I have selected. I am required to give a 10 business day written notice for a permanent schedule change and/or withdrawal. No pro-rated refunds will be given after 1st of the month.

Parent/Guardian Signature

Date

Please read the following **Permission Slips** carefully, fill out if applicable, and sign at your discretion. Please return with Registration.

Walking Field Trips: There may be times that the Connects teachers plan a community walk close to the school (i.e. around the block), or walk to the park (Cahill for Cumberland and Klode Park for Richards) as part of your child's day. The community walks will be staffed with two or more teachers to ensure the safety of the children.

My child, _____, has permission to go on walking field trips.

Signature _____ Date _____

Permission to Walk Home: For your child's safety, he or she will NOT be permitted to walk or ride their bike home unattended unless you have written authorization on file with us.

My child, _____, HAS permission to walk home unattended, and may be dismissed at _____ (time).

Signature _____ Date _____

Extra Activity Notification: Your child may be involved in another school-sponsored activity (i.e. Lego Club, Scouts, Spanish club, etc.) and this is encouraged! Connects staff will make arrangements to escort students to and from that activity. Connects staff must be notified. Please fill out and sign, if applicable.

1. Activity _____

Dates _____ Time _____

Signature _____ Date _____

2. Activity _____

Dates _____ Time _____

Signature _____ Date _____

3. Activity _____

Dates _____ Time _____

Signature _____ Date _____

4. Activity _____

Dates _____ Time _____

Signature _____ Date _____

Medical Administration during Recreation and Community Education Programs

It is policy of the Shorewood/Whitefish Bay Health Department, and the Whitefish Bay School District, along with the recommendation of the state of Department of Public Instruction that *any and all medications which must be taken at Recreation and Community Education programs are to be administered by a Recreation and Community Education staff member.* The staff member must be over the age of 18 and have the proper training on administering prescription or non-prescription drugs.

The **Prescribed medication** should be brought to the staff member by the parent or other responsible adult. The bottle must be labeled with the following information: 1. Name and phone number of the pharmacy. 2. Student's name. 3. Name of Physician. 4. Name of the drug, frequency and dosage to be given.

Non-Prescription Drugs (i.e. Tylenol, Advil) should be brought to the staff member by the parent or other responsible adult. Non-prescription drugs must be brought in the bottle in which they were purchased.

A written statement is required from the parent authorizing the Recreation and Community Education staff to give this medication, and also, giving permission to contact the physician directly if more knowledge is needed to exercise prudent judgment for the safety and protection of the student on medication.

Name of child: _____

Prescription number: _____

Name of medication: _____

Amount of pills received: _____

Dosage and Frequency of Administration: _____

The Recreation and Community Education Staff member has my permission to administer the above medication as directed. I also give my permission to contact

Dr. _____ or Pharmacist _____ can be contacted if more knowledge is needed to exercise prudent judgment for the safety and protections of the student on medication.

Signature of Parent or Guardian: _____ Date: _____

Pursuant to the provisions in section 118.29 Stats. persons administering medication are immune from civil liability for any acts or omissions in administering a drug to a pupil in accordance with School Board Policy 4421 unless the act of omission constitutes a high degree of negligence.