Whitefish Bay School District

Child's Name:_____

Birthdate: _____**Age**:_____**Sex:**_____

School: _____**Grade in fall of 2018**:_____

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 2018/2019:

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**	**M**	**T**	**W**	**TH**	**F**
AM Care	7am to start of school					
PM Care	End of school to 6:00pm					
AM and PM Care	Combo of Above					

K4 Wrap Around Care Program		**M**	**T**	**W**	**TH**	**F**
Before AM K4 & Early AM-PM K4	7am to start of school					
After AM K4	End of AMK to 3:15pm					
After AM K4 extended	End of AMK to 6:00pm					
Before PM K4	Start of school to start of PMK					
After PM K4	End of PMK to 6:00pm					

(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 or program withdrawal.

_____

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

Payment Agreement

Child's Name_____

E-Mail Address _____

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

☐ **Auto-Debit on credit card (Visa, Master Card or Discover)**

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_____

Photo Permission: 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 program promotion and on district approved social media and web pages.

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.