



Whitefish Bay
RECREATION
Bringing Community Together

2023-24 Connects Enrollment Form

Child's Name: _____

Birthdate: _____ Age: _____ Identify as: Male Female

School: _____ Grade in Fall of 2023: _____

Requested Start Date: _____

Parent/Guardian Information:

***Primary Emergency Contact**

Parent/Guardian: _____ Relationship: _____

Email Address: _____

Street Address: _____ City: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Employer: _____

Occupation: _____

***Secondary Emergency Contact**

Parent/Guardian: _____ Relationship: _____

Email Address: _____

Street Address: _____ City: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Employer: _____

Occupation: _____

History and Emergency Care Plan

Child's Name: _____

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)

Allergies (food, environmental, etc.): _____

Please list any other conditions requiring special care: _____

Signs/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:

Doctor's Name: _____ Phone: _____

Alternative Emergency Contacts: (this is someone other than the primary and secondary parent/guardian)

Name: _____ Relationship: _____

Cell Phone: _____ Other Phone: _____

Name: _____ Relationship: _____

Cell Phone: _____ Other Phone: _____

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

Parent/Guardian Signature

Date

Please read the following **Permission Slips** carefully.

Fill out, if applicable, and sign at the bottom of the page 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 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.

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 or bicycle home unattended and may be dismissed at _____ (time).

DOES NOT have permission to walk or bicycle home.

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.

I do not give my child permission to be photographed and/or videotaped.

Authorized Pick Up: The following people have your permission to pick up your child(ren):

***Proper I.D. required at pick-up**

Name: _____ Relationship: _____

Cell Phone: _____ Other Phone: _____

Name: _____ Relationship: _____

Cell Phone: _____ Other Phone: _____

Parent/Guardian Signature

Date

Medical Administration during Recreation and Community Education Programs

It is the policy of the Shorewood/Whitefish Bay Health Department, and the Whitefish Bay School District, along with the recommendation of the state Department of Public Instruction that *any and all medications that 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 in administering prescription or non-prescription drugs.

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 the 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 protection 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.

Child's Name: _____ School: _____

Grade 2023/2024: _____ Teacher (if known): _____ Requested Start Date: _____

My K5 – 5th-grade child needs care on these days and times (please 'x' the box/es to indicate need):

K5 – 5 th Grade	Hours	M	T	W	TH	F
AM Care	7:00am to start of school					
PM Care	End of school to 6:00pm					
Both AM and PM Care	All of the above					

My 4K AM child needs care on these days and times (please 'x' the box/es to indicate need):

AM K4	Hours	M	T	W	TH	F
Early Morning Care	7:00am to the start of AMK4					
Wrap Around Care	End of AMK4 until 3:15					
Extended Care	End of AMK4 until 6:00pm					

My 4K PM child needs care on these days and times (please 'x' the box/es to indicate need):

PM K4	Hours	M	T	W	TH	F
Early Morning Care	7:00am to 8:00am					
Wrap Around Care	8:00am to the start of PMK4					
Extended Care	End of PMK4 until 6:00pm					

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

I authorize the Whitefish Bay Recreation and Community Education Department to base my monthly fee on the schedule I have submitted. If there are permanent schedule changes or program withdrawals, I am responsible to notify the office (in writing) 10 business days in advance.

Parent/Guardian Signature

Date

I have read the policies in the handbook provided by the Connects Before and After School Program.

Parent/Guardian Signature

Date

Payment Agreement Child's Name _____

1. **Auto-Debit on the credit card (all card brands)**

Use this credit card for the non-refundable enrollment fee.

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 the 1st of the month falls on a 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 changes in credit card information, including the expiration date.

Card Number _____ Exp. Date _____ CVV _____

Cardholder Name _____ Billing Zip Code _____

Signature _____ Date _____

***Additional card information if tuition should be split between two credit cards.**

2. **Auto-Debit on the credit card (all card brands)**

Use this credit card for the non-refundable enrollment fee.

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 the 1st of the month falls on a 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 changes in credit card information, including the expiration date.

Card Number _____ Exp. Date _____ CVV _____

Cardholder Name _____ Billing Zip Code _____

Signature _____ Date _____

3. **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 Lydell School and Community Center 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 110-business-day written notice for a permanent schedule change and/or withdrawal. No pro-rated refunds will be given after the 1st of the month.

Parent/Guardian Signature _____ Date _____