



BOYS & GIRLS CLUBS
OF DANE COUNTY

Boys & Girls Club 2019 SUMMER CAMP REGISTRATION

Hours of Operation: 7:30am - 5:30pm

CAMPER INFORMATION

Member General Information

Name: _____

Member Birthdate: _____

Member Age: _____

Member Gender:

Female Male Transgender Other

Camp Site

Mark only one square.

Allied Club - 4619 Jenewein Road
 Taft Club - 2001 Taft Street

My Child

Mark only one square.

Is a non-swimmer
 Has taken swimming lessons

Skill level: _____

ATTENDANCE

Day Camp

9am - 5:30pm

Week 1 (June 17- June 21)
 Week 2 (June 24- June 28)
 Week 3 (July 1-July 5)

*Closed July 4th

Week 4 (July 8-July 12)
 Week 5 (July 15-July 19)
 Week 6 (July 22-July 26)
 Week 7 (July 29-August 2)
 Week 8 (August 5-August 9)
 Week 9 (August 12-August 16)
 Week 10 (August 19-August 23)

Before Care

7:30am - 9am

Week 1
 Week 2
 Week 3
 Week 4
 Week 5
 Week 6
 Week 7
 Week 8
 Week 9
 Week 10

PAYMENT

Fee Structure Policy: All summer registration fees are non-refundable due to any circumstances.

We Accept WI Shares!

Fees are due no later than the 5th of the Month or Weekly in Advance of the Care Provided. See payment schedule below.

Scholarships Available!

Summer Camp (M-F)

Day Camp (9am-5:30pm)
Before Care (7:30am-9am)

Rates

\$180/Week (Day Camp)
\$50/Week additional (Before Care)

BGDC Scholarship

Day Camp \$25
Before Care and Day Camp \$35

If payment(s) are not received, space is no longer reserved for the camper. We accept cash, money orders and credit card transactions. To receive a scholarship, additional documentation required

Payment Schedule - Due by 5:30pm

Week 1 Upon Enrollment
Week 2 June 17th
Week 3 June 24th
Week 4 July 1st
Week 5 July 8th
Week 6 July 15th
Week 7 July 22
Week 8 July 29
Week 9 August 5th
Week 10 August 12th



BOYS & GIRLS CLUBS OF DANE COUNTY

Boys & Girls Club MEMBERSHIP APPLICATION

This form is for members ages 5*-13.
*5 year olds must be enrolled in Kindergarten.

Membership Materials take 24-48 hours to process and must be complete. You will receive a confirmation phone call/email to notify you when your child may begin attending.

For your child's well-being, the information you provide must be complete and accurate. This information is necessary for compliance with WI Administrative Code for Group Child Care Centers and Boys & Girls Club records.

MEMBER INFORMATION

Member General Information

Name: _____

Home Address: _____

City & State: _____ Zip: _____

Member Birthdate: _____

Member School: _____

Member School District: _____

Member Grade: _____

Anticipated First Date of Attendance: _____

Member Race/Ethnicity

Mark only one square.

- American Indian/Alaska Native
- Asian
- Black/African American
- Latino
- Multi-Racial
- Native Hawaiian/Pacific Islander
- White/Caucasian
- Other

Member School Lunch Eligibility

Mark only one square.

- Free
- Reduced
- Non-Needy
- Unknown

Member Gender:

- Female
- Male
- Transgender
- Other

Member Lives with:

Mark only one square.

- Both Parents
- Mother Only
- Father Only
- Foster Care
- Guardian
- Group Home
- Other

Member previous attendance

Mark only one square.

- Yes
- No

If Member has previous attendance which Club location did they attend?

Member will arrive at the Club from:

- School Provided Transportation
- Parent/Guardian Drop Off
- BGCDC Provided Transportation (separate application)
- Walking
- Public Transportation

FAMILY INFORMATION

Parent/Guardian 1

Name: _____

Best Contact Phone: _____

Work Phone Number: _____

Email Address: _____

Home Address: _____

City & State: _____ Zip: _____

Parent/Guardian 2

Name: _____

Best Contact Phone: _____

Work Phone Number: _____

Email Address: _____

Home Address: _____

City & State: _____ Zip: _____

List Your Annual Household Income

Mark only one square.

- Less than \$9,999
- \$10,00-\$14,999
- \$15,00-\$22,999
- \$23,000-\$33,999
- \$34,000-\$49,999
- \$50,000-\$74,999
- \$75,000 or more
- I am currently unemployed

FAMILY INFORMATION *Continued*

Home Many Members Are in Your Household Including Yourself?

Mark only one square.

2 3 4 5 6 7 8 9 10 More than 10

Are You or Any Member of Your Family on Active Duty?

Mark only one square.

Yes No

Are You or Any Member of Your Family a Club Alumni?

Mark only one square.

Yes No

List Any Benefits You Receive

- SSI/Disability
 FoodShare
 WI Shares (Child Care Subsidy)
 Medicaid or BadgerCare
 Reduced/Free Lunch
 I do not receive any benefits at this time
 Other

AUTHORIZED PICK UPS Person(s) picking up club member must be at least 18 years old.

Member may be picked up by:

(List First & Last Name, Phone Number and Address)

Name: _____

Best Contact Phone: _____

Address: _____

Member may be picked up by:

(List First & Last Name, Phone Number and Address)

Name: _____

Best Contact Phone: _____

Address: _____

Member may be picked up by:

(List First & Last Name, Phone Number and Address)

Name: _____

Best Contact Phone: _____

Address: _____

Member may be picked up by:

(List First & Last Name, Phone Number and Address)

Name: _____

Best Contact Phone: _____

Address: _____

HEALTH HISTORY & EMERGENCY PLAN

Name of Medical Facility:

Address of Medical Facility

Address: _____

City & State: _____ Zip: _____

Telephone: _____

Name of Physician

(Please Initial) **I authorize the BG CDC to apply sunscreen to my child.**
(Brand: No-Ad Kids SPF 50)

(Please Initial) **I authorize my child to self-apply sunscreen.**
(Brand: No-Ad Kids SPF 50)

(Please Initial) **I authorize the BG CDC to apply repellent to my child.**
(Brand: OFF! Family Care 5% Picardin)

(Please Initial) **I authorize my child to self-apply repellent.**
(Brand: OFF! Family Care 5% Picardin)

(Please Initial) **I authorize the BG CDC to apply lotion to my child.**
(Brand: Vaseline Intensive Care Coco Radiant)

(Please Initial) **I authorize my child to self-apply lotion.**
(Brand: Vaseline Intensive Care Coco Radiant)

(Please Initial) **I authorize the BG CDC to apply petroleum jelly to my child.**
(Brand: Vaseline 100% Pure)

(Please Initial) **I authorize my child to self-apply petroleum jelly.**
(Brand: Vaseline 100% Pure)

Member Emergency Contact For contact purposes only. (In addition to parent/guardian) (Must Complete)

(List First & Last Name, Relation to Member, Phone Number, and Address)

Name: _____

Relationship: _____

Best Contact Phone: _____

Address: _____

Member Emergency Contact

(List First & Last Name, Relation to Member, Phone Number, and Address)

Name: _____

Relationship: _____

Best Contact Phone: _____

Address: _____

Member Emergency Contact

(List First & Last Name, Relation to Member, Phone Number, and Address)

Name: _____

Relationship: _____

Best Contact Phone: _____

Address: _____

HEALTH HISTORY & EMERGENCY PLAN *Continued*

Check any special medical condition(s) that your child may have. If available, provide any health care plan information from the child's physician, therapist, etc.

Check all that apply.

- No Specific Medical Condition
- Asthma: Controlled Medication Required
- Cerebral Palsy/Motor Disorder
- Diabetes
- Food Allergies *Specify:* _____
- Non - Food Allergies *Specify:* _____
- Gastrointestinal or Feeding Concerns Including Special Diet and Supplements
- Epilepsy/Seizure Disorder
- Cognitive Disability
- Learning Disability
- ADHD/ADD
- Autism Spectrum Disorder
- Milk Allergy If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative
- Other Conditions *Specify:* _____

If you indicated Any Special Medical Condition(s): Specify triggers that may cause problems.

Write NA if Not Applicable.

If you indicated Any Special Medical Condition(s): Specify signs of symptoms to watch for.

Write NA if Not Applicable

If you indicated Any Special Medical Condition(s): Specify Steps the child care provider should follow.

Write NA if Not Applicable

Will your child take any medication(s) while in care?

Mark only one square.

- Yes No

If yes, a copy of the form Authorization to Administer Medication should be attached to this form.

If you indicated Any Special Medical Condition(s): Identify any child care staff to whom you have given specialized training/instructions to help treat symptoms.

Check all that apply.

- Club Director/Assistant Club Director
- Membership Services Associate
- Group Leader/Teacher
- Other Management
- NA

If you indicated Any Special Medical Condition(s): When to call parents regarding symptoms or failure to respond to treatment. Write NA if Not Applicable.

If you indicated Any Special Medical Condition(s): When to consider that the condition requires emergency medical care of reassessment. Write NA if Not Applicable.

Additional information that may be helpful to the child care provider:

Signature and Date

Signature and Date

IMMUNIZATIONS

State Law requires all children in child care centers to present evidence of immunization against certain diseases.

I will provide an immunization record by:

Check all that apply.

- Emailing: registration@bgcdc.org
- Faxing to: (608) 257-7570
- In Person
- By Printing and Completing the Child Care Immunization Record Form
- My child is not immunized *must print and complete Child Care Immunization Record Form

CHILD CARE IMMUNIZATION RECORD

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.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (X) except to indicate whether the child has had chickenpox. 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 <i>Influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

- Yes year _____ (Vaccine is not required)
- No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 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

¹If the child began the Hib series at 12-14 months of age, only 2 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 4 days or less before the first birthday is also acceptable).

²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th 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 up to \$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

TRANSPORTATION PERMISSION-CHILD CARE CENTERS

Completion of this form meets compliance with DCF 251.

Member Name

Name: _____

Does the child have any special health care needs?

Mark only one square. Mark "Yes" if a health condition is listed on the Health History & Emergency Plan.

Yes No

Transportation Emergency Contact (in addition to parent/guardian)

Name: _____

Best Contact Phone: _____

Work Phone Number: _____

Email Address: _____

Home Address: _____

City & State: _____ Zip: _____

In the event an authorized adult is not at destination to receive child or the child is unable to enter the building: I give permission to first contact the parent/guardian, then emergency contact (for contact purposes only). If no adult can be reached, the child will be returned to the Club location. The child will need to be picked up from the Club.

Signature & Date

Signature and Date

Authorized Destinations

Mark all that apply.

Allied Club 4619 Jenewein Road Fitchburg to
Taft Club 2001 Taft Street Madison

Taft Club 2001 Taft Street to
Allied Club 4619 Jenewein Road Fitchburg

School/Summer School to Allied or Taft Club

Club Field Trips

Summer School Name and Address

(Only if BGDCDC Picks Child Up)

School Name: _____

Address: _____

City & State: _____ Zip: _____

(Please Initial) **I hereby give my consent for emergency medical treatment to be given.**

(Please Initial) **I hereby give permission for my school-aged child to enter a building unescorted.**

ALTERNATIVE ARRIVAL AND RELEASE AGREEMENT

This form gives Boys & Girls Club permission to accept your child at the Club

My child will arrive at the Club from:

Check all that apply.

- School Provided Transportation (School Year or Summer School)
- Myself or other Authorized Adult
- Walking (including entering the Club without an adult)
- Community Activity: _____
- Other: _____

Name of School/Activity my child will arrive from:

Time of Arrival

Indicate time of arrival next to each day.

Days:

Check all that apply.

- Monday _____ :
- Tuesday _____ :
- Wednesday _____ :
- Thursday _____ :
- Friday _____ :

My child will leave from the Club to go Home by:

Check all that apply.

- Myself of other Authorized Adult *Must be 18 Years or Older
- School Provided Transportation (Taxi, Badger Bus)
- Walking (including leaving the Club to an adult in a car)
- Community Activity: _____
- Other: _____

Time of Dismissal

Indicate time of departure next to each day.

Days:

Check all that apply.

- Monday _____ :
- Tuesday _____ :
- Wednesday _____ :
- Thursday _____ :
- Friday _____ :

Signature & Date

Signature and Date

AUTHORIZATIONS

(Please Initial) I understand that it is my responsibility to monitor my child's participation in Club activities based on any physical or medical limitations that my child has that would inhibit his/her participation.

(Please Initial) In the event of injury or should emergency medical care be required, I authorize Club staff to arrange for emergency medical attention for my child.

(Please Initial) I give permission for my child to participate in transported and walking field trips and other activities during operating hours.

(Please Initial) I am aware of the center's policies regarding pets.

(Please Initial) I acknowledge I have had an opportunity to review the child care policies of this center and a summary of the WI Rules for Group Child Care Centers.

(Please Initial) I understand my child may receive noninvasive physical exams and/or other types of assessments as a benefit of his/her membership.

(Please Initial) I give permission for my child to participate in surveys, discussion groups or other activities that help determine the success of Club programs.

(Please Initial) I authorize release of information from school about my child so the Clubs can best serve its members.

(Please Initial) I authorize Boys & Girls Club to obtain or share data related to my child for the purpose of program assessment.

(Please Initial) I grant permission for photographs, audiotapes and records of my child to be used by the Club and its agents for public relations and/or program evaluations purposes on behalf of the Boys & Girls Club.

(Please Initial) Boys & Girls Club has permission to receive and share information (for use of identifying program and opportunity needs (within agencies serving our members such as: Health Department, other Health Agencies, MMSD, VASD, SPASD and other school districts.

PAYMENT

Memberships are not complete with out payment. Please answer the following questions to determine your membership rate.

The Boys & Girls Club asks our families to partner with us in covering the cost of care.

Fees are billed in advance of the care provided.

Payment Options are:

Monthly: No later than the 5th of the month

Weekly: No later than 5:30pm on Monday of the week prior

Payment Schedule Due by 5:30pm		Summer Camp (M-F) Day Camp (9am-5:30pm) Before Care (7:30am-9am)
Week 1	Upon Enrollment	Rates \$180/Week (Day Camp) \$50/Week additional (Before Care)
Week 2	June 17th	
Week 3	June 24th	BGCDC Scholarship Day Camp \$25 Before Care and Day Camp \$35
Week 4	July 1st	
Week 5	July 8th	
Week 6	July 15th	
Week 7	July 22	
Week 8	July 29	
Week 9	August 5th	
Week 10	August 12th	

We Accept WI Shares!

Scholarships Available! * With Appropriate Documentation

2019 FPL Table for Financial Eligibility in the Wisconsin Shares Child Care Subsidy Program

Group Size	Annual 185% FPL	Monthly 185% FPL
2	\$31,284	\$2,607
3	\$39,461	\$3,288
4	\$47,638	\$3,970
5	\$55,815	\$4,651
6	\$63,992	\$5,333
7	\$72,169	\$6,014
8	\$80,346	\$6,695
9	\$88,523	\$7,377
10	\$96,700	\$8,058
Each Additional Person Add	\$8,177	\$681

If your income falls within the limits, please apply for WI Shares by calling 1-888-794-5556 or www.access.wisconsin.gov

Provider Number: 1000586911

Allied: 001

Taft: 002

Go online to ACCESS and click on "Am I Eligible" to see if you might qualify. <https://access.wisconsin.gov/>

I do not qualify for Wisconsin Shares Child Care Subsidy Program. I am requesting a scholarship. I will provide the following: Check only one square.

- Pay Stub that shows I am over the income limit
- Taxes that show I am over the income limit
- SSI/Disability Check
- Unemployment Check
- Copy of my work schedule that shows my work hours are not when my child is in care
- Denial Letter from Department of Children and Families
- Other
- NA

LATE FEES

A late fee of \$5 for every 15 minutes after the hours of operation will be charged. This fee must be paid in full before the member's next day of attendance.

I agree to pay any late fees as applicable.

(Please Initial)

(Please Date)

If the member uses Boys & Girls Club provided transportation and the member is unable to enter his/her destination and a parent/guardian cannot be reached a late fee of \$5 for every 15 minutes after the member arrives at the Club will be charged. This fee must be paid in full before the member's next transportation usage.

I agree to pay any late fees as applicable

(Please Initial)

(Please Date)

SIGNATURE

I hereby certify that the information provided in this application is correct to the best of my knowledge.

Printed Name (First & Last)

Signature and Date