The McKenzie Family Boys & Girls Club
PRESCHOOL REGISTRATION

MEMBER INFORMATION

Member General Information

Name: ______________________________

Member Birthdate: ______________________________

ATTENDANCE

Hours of Operation: 7:00 am - 6:00 pm
Holidays: Labor Day, Thanksgiving, Day After Thanksgiving, Christmas Eve, Christmas, New Year's Eve, MLK Jr., Memorial Day, Independence Day
Professional Development: TBD

ARRIVAL AND DEPARTURE

	Anticipated Time for Drop Off	Anticipated Time for Pick Up
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		

THE MCKENZIE FAMILY BOYS & GIRLS CLUB

A BRANCH OF BOYS & GIRLS CLUBS OF DANE COUNTY

The McKenzie Family Boys & Girls Club

PRESCHOOL APPLICATION

This form is for members ages 2.5 (30 months) to 5 years.
*5 year olds not enrolled in school.

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 GENERAL INFORMATION

Name: ______________________________

Home Address: ______________________________

City & State: ____________________ Zip: ____________

Member Birthdate: ______________________________

Member School: ______________________________

Member School District: ______________________________

Member Grade: ______________________________

Anticipated First Date of Attendance: ____________________

Member Gender:

☐ Female ☐ Male ☐ Transgender ☐ Other

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 ☐ Unknow

Member Lives with:
Mark only one square.

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

Member Disabilities/Other Health Needs:

☐ Yes, member has documented disabilities/other health needs and may require accomodations to participate in the program.

☐ No, member does not have disabilities/other health needs and does not require accomodations to participate in the program.

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
☐ 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 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-$84,999
☐ $85,000 or more
☐ I am currently unemployed

FAMILY INFORMATION *Continued*

How 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)
☐ WIC
☐ WI Works (W2)
☐ Medicaid or BadgerCare
☐ Reduced/Free Lunch
☐ I do not receive any benefits at this time
☐ Other

AUTHORIZED PICK UPS

Must be 18 years of age.

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

____

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

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

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

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

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

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

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

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

Member Emergency Contact
(In addition to parental guardian, must complete at least 1 contact)
(List First & Last Name, Relation to Member, Phone Number, and Address)

Name: ______________________

Relationship: ______________________

Best Contact Phone: ______________________

Address: ______________________

____

Member Emergency Contact 2 (Optional)
(List First & Last Name, Relation to Member, Phone Number, and Address)

Name: ______________________

Relationship: ______________________

Best Contact Phone: ______________________

Address: ______________________

____

Member Emergency Contact 3 (Optional)
(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 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
- ☐ Cognative Disability
- ☐ Learning Disability
- ☐ ADHD/ADD
- ☐ Autisim 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:* ____________________

Must complete the following if special medical condition(s) were indicated.

Specify triggers that may cause problems.

____

____

____

Specify signs of symptoms to watch for.

____

____

____

Specify Steps the child care provider should follow.

____

____

____

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. Must be completed and filed at the center prior to the Club administering medication.

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, my child does not have any special medical condition(s)

When to call parents regarding symptoms or failure to respond to treatment.

____

____

When to consider that the condition requires emergency medical care of reassessment.

____

____

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.

- ☐ 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

HEALTH EXAMS

State Law requires each child 2-4 years of age to complete an initial health examination prior to enrollment and at least every two years thereafter. *Child Health Report forms are available in the Membership Services Area.

I will provide an Child Health Report by:

- ☐ Faxing to: (608) 257-7570
- ☐ In Person

PRESCHOOL INTAKE

By providing complete information about your child, you will be assisting staff in creating a positive experience for them while in care.

Sleep

Current sleep schedule:

Falls asleep easily

☐ Yes ☐ No

Mood upon awakening - Describe:

Takes favorite toy(s) to bed

☐ Yes ☐ No

If "Yes", list toy(s):

Notes:

Diapering / Toileting

Diaper type:

☐ Cloth ☐ Disposable ☐ N/A

Highly sensitive skin

☐ Yes ☐ No

Lotions, powders or salves used

☐ Yes ☐ No

If "Yes", list product name(s):

Toilet training attempted

☐ Yes ☐ No

If "Yes", describe routine:

Type of toilet seat used at home

☐ Potty chair ☐ Special toilet seat ☐ Regular toilet seat

Verbal Communication

Family's prefered language:

☐ English ☐ Spanish ☐ Other

If "Other", specify:

Age when child began talking:

Child speaks in:

☐ Words ☐ Sentences

Notes:

Miscellaneous

Child's favorite indoor toys and activities:

Childs favorite outdoor toys and activities:

List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff while caring for your child.

Comforting

Does your child have a fussy time?

☐ Yes ☐ No

If "Yes", specify time:

How is fussy time handled?

Child like to be:

☐ Held ☐ Sung to ☐ Rocked ☐ Read to ☐ Other:

Special things you say or do to comfort child:

Self Expression

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, etc.?

Additional comments:

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

Emergency Contact Information:

Name: ____

Best Contact Phone: ____

Work Phone Number: ____

Email Address: ____

Home Address: ____

City & State: ______________________ Zip: ______________

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

Authorized Destinations

Mark all that apply.

☐ Club Field Trips

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 childcare 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 Clubs 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 Clubs and its agents for public relations and/or program evaluations purposes on behalf of the Boys & Girls Clubs.**

__________ *(Please Initial)* **Boys & Girls Clubs 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, SPASD and other school districts.**

PAYMENT

Memberships are not complete without payment. Please answer the following questions to determine your membership rate.

The Boys & Girls Clubs asks our families to partner with us in covering the cost of care. Fees are based on a sliding income scale. ***Fees are billed in advance of the care provided.***

Payment Options are:
Monthly: No later than the 5th of the month
Weekly: 1 week in advance of the care provided

Type of Program	Age 2.5-3	Age 3-5
Rate	$265 week	$245 week
Income Categories	**Scholarship Rate**	**Scholarship Rate**
24,999 and under	$190	$190
25,000-49,999	$195	$195
50,000-74,999	$200	$200
75,000-84,999	$210	$205
85,000 and up	$225	$215

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

McKenzie Family Club: 011

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 Wisconsn Shares Child Care Subsidy, I am requesting a Boys & Girls Club Scholarship. I will provide the following in addition to documentation that supports I do not qualify for Wisconsin Shares:
Check only one square.

- ☐ Pay Stub that documents my annual income
- ☐ Taxes that document my annual income
- ☐ SSI/Disability Check
- ☐ Unemployment Check
- ☐ Other documents that verifty annual income
- ☐ NA, I am using WI Shares

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 or an emergency contact 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

Beneficiary Self-Certification Form – 2018

(For use beginning April 1, 2018)

Program Name: ______________________ **Program Dates:** ______________________

This program has received assistance from Dane County through funds that were provided in part by the U.S. Department of Housing and Urban Development (HUD) which requires that the following information be completed. This information will be kept confidential.

Name: ______________________

Home Address: ______________________

City & State: ______________ Zip: ______________

Date of Birth: ______________________

Head of Household? ☐ Yes ☐ No

Disabled? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female

Family Size: __________ people

Source(s) of Income: ______________________

Are You currently a W2 Recipeint? ☐ Yes ☐ No

Race: ______________________

Ethnicity: ☐ Hispanic ☐ Non Hispanic

In the chart below, find your family size, then circle the income level for your family's current annual income. Total family income includes income from all sources (wages, unemployment, social security, public assistance, interest and dividends, worker's comp, etc.) for all members of your family who are at least 18 years of age.

Household Size	Extremely Low Income Limits (30%)	Very Low Income Limits (50%)	Low Income Limits (80%)
1 Person	$19,250 or less	$19,251 – 32,100	$32,101 – 50,350
2 People	$22,000 or less	$22,001 – 36,700	$36,701 – 57,550
3 People	$24,750 or less	$24,751 – 41,300	$41,301 – 64,750
4 People	$27,500 or less	$27,501 – 45,850	$45,851 – 71,900
5 People	$29,700 or less	$29,701 – 49,550	$49,551 – 77,700
6 People	$33,740 or less	$33,741 – 53,200	$53,201 – 83,450
7 People	$38,060 or less	$38,061 – 56,900	$56,901 – 89,200
8 People	$42,380 or less	$42,381 – 60,550	$60,551 – 94,950

☐ My family income is higher than the amounts listed above for my family size. (Check the box only if it applies)
My family income is: $__________________

I attest that the information provided is true and correct to my knowledge. I understand that the information listed on this form may be subject to verification by Dane County and/or by the U.S.

Department of Housing and Urban Development (HUD), the Office of the Inspector General, or their authorized representatives.

____

Beneficiary Signature *Date*

WARNING: Title 18, Section 1001 of the U.S. Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.