



# A PLACE TO RECONNECT & LEARN



**YMCA Extended Care Academy for Ages 4-17, Begins September 21**

YMCA Extended Care Academy is an in-person program that supports students, ages 4-17, who are e-learning through their school district. To help children stay on task, avoid backslides during school virtual learning, and support their academic, physical, and mental health, the Y has created a fun, safe and controlled environment in which children can continue their educational journey with the support of a great team.

## **Your child will benefit from:**

- Lower group size (1:10 ratio) than a traditional classroom setting at school to ensure the health and safety of our children and families
- Coordination with your school district for synchronous and asynchronous instruction via Zoom, Google Hangouts, and similar apps with a certified teacher
- Peer-to-peer interaction
- An infusion of physical activities and fun brain breaks every day to support the body, mind, and spirit

## **YMCA Extended Care Academy will be offered at the following location:**

- Children's Wisconsin, Milwaukee campus - Curative Building - 1000 N. 92nd Street, Wauwatosa, WI

## **Daily schedule:**

- Drop off - 6:00 - 8:30 a.m. / Program - 8:30 a.m. - 3:00 p.m. / Pick Up - 3:00 - 7:30 p.m.

## **Fees, safety protocols and additional information:**

- Fee is \$36/per day. Register for one day or up to five days per week.
- Wisconsin Shares are accepted. The YMCA provider number is 1000558721.
- Please note, while a snack will be provided, children should bring their own lunch.
- To view our COVID-19 safety protocols, please visit our website [ymcamke.org](https://ymcamke.org).

**REGISTER TODAY!**

To register visit [ymcamke.org](https://ymcamke.org). For questions call Anjye Camfield at 414-274-0756 or email [acamfield@ymcamke.org](mailto:acamfield@ymcamke.org). Completed registration forms can be emailed to [daycamp@ymcamke.org](mailto:daycamp@ymcamke.org).

# E-LEARNING ACADEMY A DISTINCTLY WHOLE- STUDENT APPROACH



*“We know that children learn more in school than just reading, writing and arithmetic. They get social and emotional skills, healthy meals and exercise, mental health support, and other things you just can’t get with online learning.”*

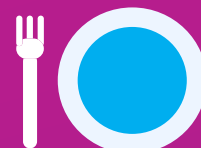
– Dr Sally Goza, President of The American Academy of Pediatrics

## YMCA Extended Care Academy has been created with an intentional whole-student approach that includes:

- On-site education support and tutoring (Students bring their own assignments, materials, and technology; WiFi and in-person academic support is provided by the Y.)
- Peer connection and social-emotional development including **CircleUp** check-ins for students to share how they’re doing
- A choice of **Y Selectives**: arts, hobbies, fitness activities, athletic training, leadership development, and more

## CONVENIENT AND SAFE

- Convenient, flexible program hours
- Strict safety and cleaning protocols based on guidelines from the Center for Disease Control and Department of Health and Human Services
- 1:10 staff-to-student ratio, social distancing, and masks for students and staff when indoors (and when social distancing is not possible outdoors)
- Afternoon snack provided



**Child Information**

Child's First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Gender  M  F Birth date \_\_\_ / \_\_\_ / \_\_\_

This will be my child's \_\_\_ year at YMCA School Age Age (at start of program) \_\_\_ Child resides with  Mother  Father  Both  Other \_\_\_\_\_

**Parent/Guardian Information – Both parents must be listed or use N/A if not applicable.**

#1 Parent/Guardian First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Gender  M  F Birth date \_\_\_ / \_\_\_ / \_\_\_

Address-Home (Street, City, State, Zip) \_\_\_\_\_

My address changed since last school year. Home Phone Number: \_\_\_\_\_ E-Mail \_\_\_\_\_

Where can we reach you while your child is at YMCA School Age programs? Work Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Daytime Address \_\_\_\_\_

My preferred method of communication  Cell  E-Mail

#2 Parent/Guardian First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Gender  M  F Birth date \_\_\_ / \_\_\_ / \_\_\_

Address-Home (Street, City, State, Zip) \_\_\_\_\_

My address changed since last school year. Home Phone Number: \_\_\_\_\_ E-Mail \_\_\_\_\_

Where can we reach you while your child is at YMCA School Age programs? Work Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Daytime Address \_\_\_\_\_

My preferred method of communication  Cell  E-Mail

**Emergency Contacts/Others Authorized to Pick Child Up – Must put one person other than parent or guardian. \*Can add more on a separate sheet of paper.**

#1 Contact First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address-Home (Street, City, State, Zip) \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

#2 Contact First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Address-Home (Street, City, State, Zip) \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**12 Medical and Behavior Questions to help us provide the best care possible  
(ALL lines MUST be filled out. If something does not apply, please use N/A)**

**1. Has your child had any of the following, if so, please explain**

- Asthma  Autism  Diabetes
- ADD/ADHD  Epilepsy/Seizures  Cerebral Palsy/Motor Disorder
- Cognitively or Learning Disabled  NONE (QUESTIONS 1-8)
- Dietary restrictions \_\_\_\_\_
- Food/milk allergies \_\_\_\_\_

If child is allergic to milk, attach a statement from a medical professional indicating an acceptable alternative.

Gastrointestinal or feeding concerns, including special diet and supplement \_\_\_\_\_

Non-food allergies \_\_\_\_\_

Status of vision, hearing and speech \_\_\_\_\_

Other conditions requiring special care \_\_\_\_\_

**2. Triggers that may cause any of the above problems (specify) \_\_\_\_\_**

**3. Signs or symptoms to watch for \_\_\_\_\_**

**4. Steps the childcare provider should follow \_\_\_\_\_**

**5. Identify any staff to whom you gave specialized training/instructions \_\_\_\_\_**

**6. When to call parents regarding symptoms or failure to respond to treatment \_\_\_\_\_**

**7. When to consider that the condition requires emergency medical care or reassessment \_\_\_\_\_**

**8. Additional information that may be helpful to us \_\_\_\_\_**

**9. Emergency Numbers**

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**10. List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE a (√) or (x). If you do not have an immunization record for this child, contact your doctor or local health department to obtain the records.**

TYPE OF VACCINE	1st Dose M/D/Y	2nd Dose M/D/Y	3rd Dose M/D/Y	4th Dose M/D/Y	5th Dose M/D/Y
Diphtheria-Tetanus-Pertussis Specify DTP, DTaP, or DT					
Polio					
Hib (Haemophilus Influenzae 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					Has child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known. <input type="checkbox"/> Yes; year _____ <input type="checkbox"/> No or Unsure (Vaccine is required)

My child does not meet all immunization requirements. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the day camp. Visit ymcamke.org for forms.

**11. Is the child currently taking any medications?  Yes  No**

If yes, what kind and why \_\_\_\_\_

If medication needs to be administered during YMCA School Age programming, a Medication Permission Form MUST be completed. Visit ymcamke.org for forms.

**12. Sunscreen/Insect repellent (if provided by a parent), and each bottle must be labeled.**

- I authorize staff to apply sunscreen to my child
- I authorize staff to allow my child to self-apply sunscreen
- My child may use any sunscreen provided by YMCA School Age programs (NO-AD Brand SPF 30) if theirs runs out or is missing.

If no, will only allow my child to use the sunscreen provided by parent:

Brand Name \_\_\_\_\_ Strength \_\_\_\_\_

- I authorize the staff to apply repellent to my child
- I authorize the staff to allow my child to self-apply repellent

My child may use any repellent provided by YMCA School Age programs (Off Brand 25% DEET) if theirs runs out or is missing.

If no, I will only allow my child to use the repellent provided by parent:

Brand Name \_\_\_\_\_ Strength \_\_\_\_\_

Child's Name \_\_\_\_\_

School Location \_\_\_\_\_

**Parent/Guardian Authorization**

**Yes**  **No** I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately. I authorize the YMCA staff/volunteers to administer first-aid. Prudent attempts will be made to contact the parent/guardian immediately. I understand that in signing this form, I agree to release the YMCA of Metropolitan Milwaukee from any liability for the risk of illness, accidents or injury.

**Yes**  **No** I have had an opportunity to review the policies of this School Age program and a summary of the Wisconsin Rules for Licensing Child Care Centers. A Parent Handbook and Licensing Rules are available on site at your request and at [www.ymcamke.org](http://www.ymcamke.org).

**Yes**  **No** I give permission for my child to participate in field trips and other activities during program hours.

**Transported**  **Walking** I give permission for my child to walk to his/her classroom from program at morning bell and/or from classroom to program at afternoon bell.

If pets are added to the program, parents will be notified prior to the pet's addition to the program.

For my child's participation in activities sponsored by or any matters related to the YMCA of Metropolitan Milwaukee, I hereby give my permission and consent, now and for all time (without any further compensation, claim or demand by me) to the YMCA of Metropolitan Milwaukee, and to any advertising agency, entities and third parties collaborating with YMCA of Metropolitan Milwaukee and their representative, if any (the "Organizations") to make, reproduce, edit, broadcast or rebroadcast any video film, footage and other sound track recordings, or photo reproductions of me, and my narrative account of my experience with YMCA activities ("Materials") for publication, display, sale or exhibition thereof in promotions, advertising and legitimate business uses without any further compensation to me.

I understand the YMCA of Metropolitan Milwaukee reserves the right to withdraw a child from the program if, at the YMCA's discretion, the enrollment of the child negatively affects the integrity of the program and/or the YMCA's legal obligations through and under the Division of Children and Family Services (DCF-251).

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**Payment Options**

**Private Pay and MY WI Child Care/3rd Party Pay must select one of the following forms of payment in order for registration to be completed:**

I would like the YMCA to charge my credit card \$\_\_\_\_\_ on the first of each month.

**Credit/Debit Card Account Information**

Print your name as it appears on card \_\_\_\_\_

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ Zip Code \_\_\_\_\_

**-OR-**

I would like a monthly bank draft from my checking/savings account in the amount of \$\_\_\_\_\_ to be taken out on the first of each month.

**Bank Draft Account Information** (Please attach a voided check for verification and processing.)

Print your name as it appears on your banking account \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

Checking  Savings

**MyWICChildCare Agreement**

\_\_\_\_\_ I Receive MYWICChildCare Benefit. I will initiate MYWICChildCare EBT Edge payment on the first of each month.

\_\_\_\_\_ I understand that I am responsible for payments not covered (parent share). I have selected a payment option of either debit/credit card or automatic draft payment and provided the necessary information (above) to cover any additional costs not covered by MYWICChildCare Benefit or other 3rd party benefit.

**Credit/Debit Card Authorization Agreement** (Please initialize that you agree to each point listed)

\_\_\_\_\_ I hereby authorize the YMCA of Metropolitan Milwaukee to charge the credit/debit card named above or initiate automatic drafts from my account at the financial institution named above.

\_\_\_\_\_ I understand that the charge to my card/draft from my account will take place on or about the first of each month.

\_\_\_\_\_ I understand it is my responsibility to check my credit card/bank statement and report any discrepancies to the School Age Office within 10 days of the draft in question.

\_\_\_\_\_ I understand that I am financially responsible for all payments. Should my payment not be honored by my financial institution for any reason, I agree to be responsible for that payment plus a \$30 service charge assessed by the YMCA. If full payment is not made, I agree to pay for all extra fees incurred for the collection of funds.

\_\_\_\_\_ I understand that it is my responsibility to notify the YMCA of Metropolitan Milwaukee any change in my bank account or credit card information, including the expiration date. Changes must be submitted in writing at least 10 days in advance of the billing date.

\_\_\_\_\_ I understand that my credit/debit card or account draft will be processed on or about the first of each month.

This agreement will remain in effect until the program has ended, the YMCA of Metropolitan Milwaukee receives a written notice of cancellation from me at least four weeks before cancellation from program, or until I submit a new bank draft permission form to the YMCA of Metropolitan Milwaukee.

Provider and location numbers can be found listed on information/registration form or call our School Age Office (414-274-0759) for these numbers.

I approve this application, authorize payment by 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 YMCA School Age Program. I understand that the registration fee is non-transferable and non-refundable. I understand School Age Program fees must be paid monthly and in advance of the service. I understand that failure to pay fees may result in a late fee of \$10 per week. I understand fees are established based on schedule, not attendance. **This is a flat monthly fee with no credit for time off, holidays, vacations, absences due to illness or behavior.** I am required to give a four-week notice for a permanent schedule change and/or withdrawal which affects the number of days my child will attend the YMCA School Age Program. Adjustments to the monthly rate will be made four weeks after initial date of notice to customer service. I understand that any schedule change must be made in writing to the email or mailing address listed in this brochure. A confirmation email or phone call from YMCA customer service agent will follow request.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

## Y Extended Learning Academy at Children's Hospital

\_\_\_ September 21  
\_\_\_ September 22  
\_\_\_ September 23  
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Closed November 27

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Closed December 24  
Closed December 2

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Closed December 31  
Closed January 1