Y Summer Program @ Columbus Park June 16th – July 25th 2025

2003 54th St. Kenosha, WI 53140 • 262-359-7609 • awamboldt@kenoshaymca.org

✍ **Please fill out in Blue or Black Ink ONLY!** ✍

Student's Full Name	**Gender** (choose) ○M ○F ○Non-Conforming ○Other	**Today's Date:**
Address / City / Zip	**Telephone**	**Birth Date**

Current Grade Level: ○Kindergarten ○1st ○2nd ○3rd ○4th ○5th **Grade Entering in Fall:** ○1st ○2nd ○3rd ○4th ○5th

Is the Student Hispanic or Latino?
○Yes, Hispanic or Latino
○No, neither Hispanic nor Latino

Select one or more of the following categories that apply to the student:
☐American Indian or Alaska Native ☐Black or African American ☐White ☐Asian
☐Native Hawaiian or Other Pacific Islander ☐Other _____

Parent or Guardian (provide the information requested for EACH parent or guardian.)
****NOTE: All parents/guardians will be permitted to visit during center hours unless access is prohibited or restricted by a court order****

Legal Guardian #1 First and Last Name	Home Address / City / Zip	Home Phone #	Cell Phone #
Work Name & Address	Work #	Email Address	
Legal Guardian #2 First and Last Name	Home Address / City / Zip	Home Phone #	Cell Phone #
Work Name & Address	Work #	Email Address	

Student lives with: (choose) ○Both Parents ○Mother ○Father ○Grandparent(s) ○Guardian

Special Custody Concerns: **This Section MUST be signed even if there are NO concerns**

Are there any custody concerns regarding this student that we need to be aware of while the student is in our care? **Please Attach any documentation (court order, etc.) to back up all custody concerns.**

○Yes ○No If YES, please explain Attach a copy of your current court order

_____

_____

_____

✖ _____
Signature of Parent or Guardian Date

Physician & Medical Facility Information

Physician Name	Address	Phone #

Preferred Medical Facility - Please circle one or write other:

○**Aurora Medical – 10400 75th St.** ○**Center Kenosha Hospital – 6308 8th Ave.** ○**St. Catherine's – 9916 75th St.** ○**Other:**_____

I hereby give my consent for emergency medical care or treatment, to be used ONLY if I cannot be immediately reached.

✖ _____
Signature of Parent or Guardian Date

AUTHORIZED PEOPLE TO CALL & EMERGENCY CONTACT FOR YOUR STUDENT.
****Provide additional names & information for people authorized to: Contact when parent/guardian cannot be reached who can receive information on your student and authorized as a pick-up person that staff can release your student into his/her care****

Contact #1 First and Last Name	Home Phone #	Cell Phone #	Work #
Home Address / City / Zip	Relationship to Child		
Contact #2 First and Last Name	Home Phone #	Cell Phone #	Work #
Home Address / City / Zip	Relationship to Child		

I give permission for my student to participate in Field Trips and other activities during operating hours.
Walking – ☐YES ☐NO Transported* – ☐YES ☐NO

*Transported Field Trips always require an additional permission slip. This slip will include all details of the field trip.

✖ _____
Signature of Parent or Guardian Date

HEALTH HISTORY & EMERGENCY CARE PLAN

1. Check any special medical condition that your student may have:

   ☐ **None** ☐ Physical Handicaps ☐ Epilepsy / Seizure Disorder ☐ Asthma ☐ Diabetes

   ☐ Cerebral Palsy / Motor Disorder ☐ Emotional / Behavior Disorder including ADD, ADHD or ODD *(Please Circle)*

   ☐ Gastrointestinal or Feeding Concerns Including Special Diet and Supplements

   ☐ Other condition(s) requiring special care (Specify):_____

2. Does your student have any allergies?

   ☐ Food Allergies - ☐ **No** ☐ Yes--Specify food(s):_____

   ☐ Non-Food Allergies - ☐ **No** ☐ Yes--Specify:_____

   If Yes, Fill out a - e. Attach additional information if needed. If No, skip to #8.

   a. Triggers that may cause problems - Specify:_____

   b. Signs or Symptoms to watch for - Specify:_____

   c. Steps the child care provider should follow:_____

   _____

   d. When to call parents regarding symptoms or failure to respond to treatment: _____

   e. When to consider that the condition requires emergency medical care or reassessment: _____

   _____

3. Is there additional information that may be helpful to the child care provider? ☐ **None** ☐ Yes

   Specify: _____

4. Does your student take any medication (this information is needed whether they take medicine while in the program or at another time of the day, in case of emergency).

   ☐ Yes ☐ No If yes, what is the medication? _____

INSURANCE INFORMATION

5. Insurance Company:_____ Policy # _____

6. Name of person holding insurance policy:_____Group # _____

MEDIA RELEASE

7. I understand that my child's/ward's picture/video may be taken by any YMCA staff, volunteer, sponsor or any other YMCA program colleague for media, promotional and/or public relations purposes including, without limitation, use on sponsor owned and operated websites, social media sites, and print and digital media, and allow for these images, videos, representations and other media to be used for promotional, media and/or public relations purposes unless I submit a statement to the contrary to appropriate YMCA staff.

   ☐ YES, I grant the Kenosha YMCA permission to use photos/videos of my child. I understand the photos may be shared on the Kenosha YMCA website, in print and on Kenosha YMCA social media pages.

   ☐ NO, please do not take or use any photos/videos of my child.

_____

Signature of Parent or Guardian Date