MCDONELL AREA CATHOLIC SCHOOLS
Est. 1882
1316 Bel Air Blvd., Chippewa Falls, Wi 54729 • Tel 715.723.0538 • Fax 715.723.1501 • www.macs.k12.wi.us

# St. Charles Early Childhood Center

## Registration Form

**Child's Full Name:**_____ **Age:**_____ **D.O.B.:**_____

**Child's Full Name:**_____ **Age:**_____ **D.O.B.:**_____

**Child's Full Name:**_____ **Age:**_____ **D.O.B.:**_____

**Child's Home Address:**_____

**Child(ren) live with:** _____**Both Parents** _____ **Mother** _____ **Father** _____ **Other**

**CHECK A BOX BELOW**

❑ **Current St. Charles Early Childhood Family** (Fill out Parent Information if anything has changed)

❑ **New St. Charles Early Childhood Family** (Fill out Parent Information)

**Parent/Guardian Information**

**Parent/Guardian Name:** _____

**Parent D.O.B:** _____ **SSN:** _____

**Address:** _____

**Parent/Guardian Work Phone:**_____ **Ext.**_____ **Cell or Home Phone:** _____

**Email address:** _____

**Place of Employment:** _____

**Catholic: Yes:** _____ **No:** _____ **If so, which parish:** _____

**Parent/Guardian Name:** _____

**Parent D.O.B:** _____ **SSN:** _____

**Address:** _____

**Parent/Guardian Work Phone:**_____ **Ext.**_____ **Cell or Home Phone:** _____

**Email address:** _____

**Place of Employment:** _____

**Catholic: Yes:** _____ **No:** _____ **If so, which parish:** _____

**Emergency Contact Information**

**Name:** _____ **BEST Phone #:**_____

**Relationship to child:**_____

| | | |
|---|---|---|
| **Parent/Guardian Print Name** | **Parent/Guardian Signature** | **Date** |

| | | |
|---|---|---|
| **Parent/Guardian Print Name** | **Parent/Guardian Signature** | **Date** |

**DEPARTMENT OF CHILDREN AND FAMILIES**
Division of Early Care and Education

**http://dcf.wisconsin.gov**

# CHILD CARE ENROLLMENT

**Use of form:** Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

## CHILD INFORMATION

| Name (Last, First, MI) | Birthdate (mm/dd/yyyy) | First Day of Attendance |
|---|---|---|
| | | |

**PARENT OR GUARDIAN** – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

| a. Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care |
|---|---|---|
| | | |

| Home Address (Street, City, State, Zip) | Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No. |
|---|---|---|
| | | |

| b. Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care |
|---|---|---|
| | | |

| Home Address (Street, City, State, Zip) | Does child reside at this location? ☐ Yes ☐ No | Place of Employment and Work Phone No. |
|---|---|---|
| | | |

**AUTHORIZED PERSONS** – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

| a. Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No. |
|---|---|---|---|
| | | | |
| b. Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No. |
| | | | |

**EMERGENCY CONTACT** – The person to be notified in an emergency when parents / guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up the child.

| Name and Relationship to Child | Home / Cell Phone No. | Email Address Where Reachable While Child is in Care | Place of Employment and Work Phone No. |
|---|---|---|---|
| | | | |

## PHYSICIAN OR MEDICAL FACILITY

| Name | Address (Street, City, State, Zip Code) | Telephone Number |
|---|---|---|
| | | |

## AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

| **SIGNATURE** – Parent or Guardian | Date Signed |
|---|---|
| | |

# HEALTH HISTORY AND EMERGENCY CARE PLAN

**Use of form:** This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

## CHILD INFORMATION

| Name (Last, First, MI) | Address – Home (Street, City, State, Zip Code) | |
|---|---|---|
| Telephone Number | Birthdate (mm/dd/yyyy) | Date – First Day of Attendance (mm/dd/yyyy) |

## PARENT / GUARDIAN INFORMATION

Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

| Name | Telephone Number – Home | Telephone Number – Work | Telephone Number – Cellular |
|---|---|---|---|
| Name | Telephone Number – Home | Telephone Number – Work | Telephone Number – Cellular |

## PHYSICIAN / MEDICAL FACILITY INFORMATION

| Name – Physician | Address – Medical Facility | Telephone Number |
|---|---|---|

## SUNSCREEN / INSECT REPELLENT AUTHORIZATION

If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

| | Brand Name | Ingredient Strength |
|---|---|---|
| ☐ Yes ☐ No I authorize the center to apply sunscreen to my child.<br>☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen. | | |
| ☐ Yes ☐ No I authorize the center to apply repellent to my child.<br>☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent. | Brand Name | Ingredient Strength |

## HEALTH HISTORY AND EMERGENCY CARE PLAN

If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition
☐ Asthma
☐ Diabetes
☐ Gastrointestinal or feeding concerns including special diet and supplements
☐ Cerebral palsy / motor disorder
☐ Epilepsy / seizure disorder
☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

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 the child care provider.

| **SIGNATURE** – Parent or Guardian | Date Signed (mm/dd/yyyy) |
|---|---|
| | |

**Review dates:** _____ _____ _____ _____ _____

Diocese of La Crosse
Child Comprehensive Medical Release and Permission Form

Catholic School or School System
August 2020

Name of Catholic School/Catholic School System – Name and City:

_____

## Contact Information

Male ☐ Female ☐

Student Name:_____Date of Birth: _____

Address:_____City:_____State:_____Zip: _____

Phone #:_____(Home) E-mail Address: _____

Mother's name:_____Phone: (H)_____(W)_____(C)_____

Father's name:_____Phone: (H)_____(W)_____(C)_____

Emergency Contact:_____Relationship: _____

Phone: (H)_____(W)_____(C)_____

Physician:_____Clinic/Hospital:_____Office Phone: _____

Medical Insurance Company:_____Policy #: _____

## Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which the student is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken. The Catholic School/Catholic School system will take reasonable care to see that the following information will be held in confidence. Some classes, field trips, and activities may be physically strenuous. If you desire to limit the student's participation in any way, please submit your wishes.

1. Is the student in good health and able to participate in normal activities? Yes ☐ No ☐
   If not, please submit a statement indicating limitations and/or restrictions.
2. Please give the date of the student's most recent physical examination: _____
3. Immunization History (Please give dates)
   Date of last Tetanus Shot: _____
   *Please fill in below only for foreign mission trips:*
   DPT_____DPT Booster_____Polio Booster_____Polio Series _____
   Other: _____
   *Note: You are responsible for consulting your doctor about immunizations necessary for foreign missions.
4. Allergies
   Pollens ☐ Medications ☐ Food ☐ Insect Bites ☐
   Please note specifics: _____
5. Has the student ever suffered from or been treated for any of the following:
   Asthma ☐ Epilepsy/seizure disorder ☐ Heart trouble ☐
   Diabetes ☐ Frequently upset stomach ☐ Physical handicap ☐
   Depression ☐ Emotional/Mental Disorder ☐ Other _____
6. Operations, serious injuries, or major illnesses in the past year:
   _____ Dates: _____
7. Is the student subject to emotional reactions to new situations (example - fainting)? _____
8. Has the student recently been exposed to contagious disease or conditions, such as mumps, COVID-19, measles, chickenpox, etc.? If so, list date and disease or condition: _____
9. Does the student have a medically prescribed diet? Y ☐ N ☐

## Medical Treatment

*Emergency Medical Treatment*: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment at my expense. I wish to be advised prior to any further treatment by the hospital or doctor. In the event that you are unable to reach me, such treatment may be administered if deemed necessary. In the event of an emergency, if you are unable to reach me at the numbers given above, please contact the emergency contact listed above.

Initials of Parent Guardian:_____Date: _____

*Other Medical Treatment*: In the event it comes to the attention of the Catholic School/Catholic School System, its administrators, teachers, support staff, coaches, field trip chaperones, or representatives associated with an event or activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Initials of Parent Guardian:_____Date: _____

*Medications*: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: _____

Initials of Parent Guardian:_____Date: _____

## Parental/Guardian Consent and Liability for Minors

I,_____, grant permission for my child,_____to participate in Catholic School/Catholic School
Parent or guardian's name Child's name
System events that require transportation to a location away from the Catholic School. Activities will take place under the guidance and direction of Catholic School/Catholic School System from_____.
Name of Catholic School/Catholic School System

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("student"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend _____, its officers, directors, employees and agents, and the Diocese of La Crosse, its employees
Name of Catholic School/Catholic School System
and agents, chaperones, or representatives associated with events or activities, from any claim arising from or in connection with my child attending the events or activities or in connection therewith, and I agree to compensate the Catholic School/Catholic School System, its officers, directors and agents, and the Diocese of La Crosse, its employees and agents and chaperones, or representative associated with the events or activities for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the Catholic School/Catholic School System/Diocese of La Crosse.

Initials of Parent Guardian:_____Date: _____

## Code of Conduct

We expect each student to conform to these rules of conduct:

No possession or use of alcohol, drugs, tobacco, or pornography.
No fighting, weapons, fireworks, lighters, or explosives.
No offensive or immodest clothing.
Student may not drive to events or activities.
No males in female sleeping quarters, and no females in male sleeping quarters.
Active participation is expected.
Respect property.
Respect one another, administrators, teachers, support staff, coaches, volunteers, event or activity officials and leaders.
Respect and comply with schedules and with any other specific event rules established.

**Students who fail to comply with these expectations may be sent home at their parents' expense.**

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in school activities. I agree to abide by the stated personal limitations and code of conduct.

Initials of Student:_____Date:_____

Initials of Parent Guardian:_____Date: _____

## Permission to Use Participant Photos

You have my permission to use said student's photos for communication, educational, and public relation purposes

Initials of Student:_____Date: _____

Initials of Parent Guardian:_____Date: _____

## Statement of Truth and Accuracy

I hereby certify that all of these statements are true and accurate to the best of my knowledge.

Signature of Parent/Guardian:_____Date: _____

Signature of Student:_____Date: _____

# Student Pick- Up / Release Authorization Form

Name of Student(s):

_____

Mother/Guardian Name:

_____

Father/Guardian Name:

_____

## Authorized to Pick-Up Student

Please list below all persons, besides parents/guardians, who are authorized to pick up your child from school.
Note: For your child's safety, authorized persons may be asked for photo identification. Please inform the person on the list in advance on this precautionary measure. **Persons may be added to the list or removed at any time, just inform the office staff of any changes to this form.**

| Name | Relation | Phone # |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

---

**EMERGENCY CONTACT** - The person to be notified in an emergency when parents/guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up my child.

| Name and relationship to Child | Home/Cell Phone No. | Email Address | Place of Employment & Phone No. |
|---|---|---|---|
| | | | |

# Getting to know your child

(Age 12 months and Up)

Child's Name: _____

Parent/Guardian's Name: _____

Parent/Guardian Email: _____

---

What does your child prefer to be called: _____

Has your child been in childcare before? _____

Favorite activities: _____

Favorite food(s): _____

Least favorite food(s): _____

Favorite color: _____

Other favorites: _____

Fears: _____

Allergies: _____

How does your child go to sleep? (Does not apply to SUPERS Kids): _____

_____

Are there any special dolls or items that he/she will need in order to fall asleep? _____

_____

What is the usual time and length of naps taken each day? _____

Anything else that you feel we should know about your child? _____

_____