Peters Family CAMP GLACIER HOLLOW STEVENS POINT AREA YMCA

Camp Glacier Hollow 2025 Camp Registration

Participant Name _____ Birth Date _____

	DAY CAMP (AGES 7-12)	DATES	OPTIONAL OVERNIGHT	MEMBER COST	NON MEMBER COST
	SUMMER KICKSTART	JUNE 2-6		$200	$240
	EMERGENCY SERVICES	JUNE 9-13		$200	$240
	PIRATES OF LAKE ELAINE	JUNE 16-20		$200	$240
	MYTHS AND LEGENDS	JUNE 23-27	JUNE 26 ☐	$200	$240
	STARS AND STRIPES	JUNE 30-JULY 2		$145	$180
	ECO ADVENTURE	JULY 7-11	JULY 10 ☐	$200	$240
	WACKY WATERS	JULY 14-18		$200	$240
	WILD, WILD WEST	JULY 21-25	JULY 24 ☐	$200	$240
	RAIDERS OF THE LOST ARTIFACT	JULY 28- AUG 1		$200	$240
	GLACIER HOLLOW OLYMPICS	AUG 4-8		$200	$240
	GAME SHOW MANIA	AUG 11-15	AUG 14 ☐	$200	$240
	SURVIVOR: CAMP EDITION	AUG 18-22	AUG 21 ☐	$200	$240
	MESSTIVAL	AUG 25-29		$200	$240

	OVERNIGHT CAMP (AGES 7-14)	DATES	TIER A	TIER B	TIER C
	BEGINNING EXPLORER 1 (ages 7-10)	JUNE 8-11	$440	$390	$305
	ECO ADVENTURE	JUNE 15-20	$595	$540	$465
	HOOFBEATS	JUNE 22-27	$630	$575	$500
	BEGINNING EXPLORER 2 (ages 7-10)	JUNE 29-JULY 2	$440	$390	$305
	FISHIN'. HUNTIN', CAMPIN'	JULY 6-11	$585	$530	$455
	ADVENTURE CAMP	JULY 13-18	$595	$540	$465
	SPORTSAPALOOZA	JULY 20-25	$630	$575	$500
	WILD WATERS	JULY 27-AUG 1	$585	$530	$455
	WISE SPIRITS	AUG 3-8	$585	$530	$455
	STRONG SPIRITS	AUG 10-15	$585	$530	$455
	TWILIGHT TAMERS	AUG 17-22	$585	$530	$455

	ADVENTURE TRIPS (AGES 12-17)	DATES	TIER A	TIER B	TIER C
	SYLVANIA WILDERNESS CANOE AND LAKE SHORE	JUNE 21-28	$625	$570	$500
	PICTURED ROCKS NATIONAL LAKESHORE	AUG 2-9	$625	$570	$500

TIERED PRICING FOR OVERNIGHT CAMP

OFFERING MORE OPPORTUNITIES TO MORE CAMPERS!

In our continuing efforts to offer the Camp Glacier Hollow experience to everyone, we understand that different families have differing abilities to pay. Our tiered pricing allows us to accommodate all financial situations. Please consider selecting the highest tier you can afford, allowing Camp Glacier Hollow to stretch our funding to continue improving the quality of our camp experience. Price B and Price C are subsidized by the YMCA through fundraising, special events, and contributions, requiring that you completing a subsidy survey that will be sent to the email address provided above.

- **Price C** is our historically subsidized rate, which does not represent the true cost of camp.
- **Price B** is a partially subsidized rate, but more clearly reflects the actual cost of camp.
- **Price A** most accurately reflects the actual cost of YMCA Camp Glacier Hollow.

OVERNIGHT CAMP REGISTRATION INFORMATION

1. Complete both sides and return this form along with a $100 non-refundable, non-transferable deposit or full payment for each session. If program is full, your deposit will be returned and you will be placed on a waiting list. Balance is due at least (4) four weeks prior to each camp session. An unpaid balance may result in forfeiture of your reserved spot. Invoices will not be mailed.
2. As your camp session gets closer, you will receive an email with specific details about your camp session.
3. Your child's completed health history profile and immunization information MUST be submitted with this registration form. The registration process will not begin until all completed forms are received. Parents are responsible for any changes to the profile including emergency contact and authorized pick up information.
4. We will return all fees except your deposit if written cancellation is made four weeks prior to session. After four weeks, refunds may not be available.
5. All Stevens Point Area YMCA Family and Single Parent Family members are eligible for a $25 Member Discount for "LIT Training."

DAY CAMP REGISTRATION INFORMATION

1. Fully complete both sides of the Day Camp Registration and submit, with $30 (per week) deposit. If the requested program is full, your deposit will be returned and you will be placed on a waiting list. Deposits will not be returned due to changes or cancellations initiated by camper families. **Incomplete registrations will not be processed.**
2. A one-time, non-refundable $25 Camp Registration fee is also required. This fee only needs to be paid once, regardless of the number of weeks your camper is registered.
3. Your child's completed health history profile and immunization information MUST be submitted with this registration form. The registration process will not begin until all completed forms are received. Parents are responsible for any changes to the profile including emergency contact and authorized pick up information.
4. Balance is due at least (2) two weeks prior to each camp week. An unpaid balance may result in forfeiture of your child's registration. All balances will be auto drafted from the debit/credit card provided for weekly balances. Invoices will not be mailed. You will be charged a $20 service fee to transfer between weeks or programs.
5. Approximately one week prior to each camp, you will receive an email with general camp information, arrival and departure times, and a list of things to bring.
6. We will return all fees except your Registration Fee and Deposit if written cancellation is made two weeks prior to each session. After two weeks, refunds

DAY CAMP

❒ Participant is SPYMCA Family or Single Parent Family Member

❒ $25 Summer Camp Registration Fee

❒ $30 Deposit (per week) or payment

TOTAL DUE: $_____

OVERNIGHT

Tier Price: A B or C

$_____

Y Member Discount (-$25):

$_____

$100 Dep. Required. Total Paid Now:

$ _____

❒ Check Enclosed ❒ Charge My Card:

Amount: $ _____

❒ Visa ❒ Master Card ❒ Discover ❒ American Express

Card #: _____ Exp Date:_____

Name on Card: _____

The YMCA guarantees satisfaction with the quality of its services. This authorization will remain in effect until revoked by me in writing and until you actually receive such notice, I agree that you shall be fully protected in honoring any such charge. I agree that your treatment of each such charge and your rights in respect to it, shall be the same as if it were signed by me and that if any such charge be dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of services.

If at anytime the amount in my account is insufficient to cover the amount to be deducted, the bank is not obligated to pay and is not responsible for these insufficient funds. Nor shall the bank be liable for any errors by the Stevens Point Area YMCA in handling the terms of this authorization.

I will use an electronic funds transfer to pay for services and I agree that if for any reason I wish to terminate or change the status of services, I must give the **YMCA WRITTEN NOTICE 15 DAYS IN ADVANCE** of my automatic withdrawal date. A $20.00 service fee will be charged on any returned bank draft.

_____

Initial Here

YMCA CAMP GLACIER HOLLOW
2025 CAMP Registration

Participant Name _____ Birth Date _____ Age at Camp _____

Gender _____ Grade Next Year _____

Are there any medical, custodial, physical, behavioral conditions or special needs that we should be aware of now?

_____

_____

Have you attended an overnight camp before? _____I am a returning camper. This is my _____ year at camp.

Parent 1 Contact Information:	Parent Contact Information:
Name: _____	Name: _____
Phone Number: _____	Phone Number: _____
Email: _____	Email: _____
Emergency Contact:	How did you hear about YMCA Camp Glacier Hollow?
Name: _____	☐ YMCA Center
Phone Number: _____	☐ Internet
Email: _____	☐ Social Media
	Other: _____

I understand that all reasonable safety precautions are taken by the YMCA in the operation of its facility, equipment and programs. I am aware of and accept all the risks inherent in the program. I agree that my or my child's voluntary participation in Day Camo, Resident Camp, Teen Leadership Programs, and/or Outdoor Adventure Trips shall be undertaken at my or his/her sole risk, and that the YMCA and Camp Glacier Hollow, its directors, employees, volunteers and agents shall not be liable for any claims, injuries, damages, losses, diseases, wrongful death, actions or cause of action whatsoever, to me, my child and his/her property, arising out of or connected to participation in Resident Camp, Teen Leadership Programs, and/or Outdoor Adventure Trips including but not limited to transportation services, camping, canoeing/kayaking, rafting, hiking, swimming, biking, rock climbing, fishing, horseback riding/grooming, and other camp activities. In the event that I cannot be reached in an emergency, I authorize the YMCA staff to transport to or secure emergency services for me or my child, and I give my consent for the YMCA staff to act on my behalf in granting permission for me or my child to receive any emergency treatment deemed necessary including, hospitalization, injection, anesthesia or surgery. I agree that I will be responsible for the payment of any and all medical services rendered. I give permission for my child or I to appear in media coverage approved by the YMCA and for the YMCA to use photographs and videos of my child or I for promotional purposes and social media. I give permission to the Camp Health Staff to give my child or I over-the-counter camp medications (as directed) in the event of minor pain/ailment (i.e. headache, stomach ache, body aches, insect bites, sun protection, etc...) I give permission for my child or I to use sunscreen (Rocky Mountain Sunscreen SPF 50 Lotion for Kids) and insect repellent and receive assistance as needed from Counselors, unless otherwise noted on my child's or my Health History form. I hereby apply for a reservation for my child as a program participant. I agree to pay the total camp fee on or before the payment due date. I understand that failure to pay by the due date may forfeit my application and deposit. Furthermore, if my child or I are forced to leave the program due to illness, injury, or inappropriate behavior, a refund may not be available. I hereby state that the information I have provided is accurate and complete. I understand that it is my responsibility to provide any changes/updates regarding emergency and health information to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize my child's or my registration and/or participation in this program.

I have carefully read, initialed and fully understand the above warning of risk and parent/guardian consent and waiver & release sections. I fully understand that by signing this form I have given my parent/guardian consent on all sections contained within.

_____ _____

Parent/Guardian Signature **Date**

Completed paperwork and payment can be mailed or dropped off at
The Stevens Point Area YMCA – Camp Registration, 1000 Division Street, Stevens Point, WI 54481
(715)342-2999

YMCA CAMP GLACIER HOLLOW
2025 Refer A Friend & Trading Post Form

Participant Name: _____ **Camp Attending:** __**Day Camp** __**Overnight Camp** ___**LIT/CIT**

RECRUIT A FRIEND TRADING POST CREDIT

Recruit a friend (non-sibling) who has not attended one of our Camps before and you will receive a $25 Trading Post Credit. The friend that you refer will also receive a $25 Trading Post credit. There is no maximum credit amount, so recruit more than one friend and get additional credits! Credits are not redeemable for cash.

❒ **I recruited:** _____

❒ **I was recruited by:** _____

New for 2024:

Cash will **not** be accepted for adding funds this year. Funds can be added using this form, online, or over the phone by calling the Stevens Point YMCA at **(715) 342-2980**. **Do NOT send cash with Campers.**

Authorization for Trading Post Account Funds

I hereby authorize The Stevens Point Area YMCA to charge the credit/debit card provided on the previous page to fund the Trading Post account for the camper listed below. I understand and agree that:

1. This authorization allows The Stevens Point Area YMCA to charge the card for an initial deposit to the camper's Trading Post account.
2. The camper(s) will use the Trading Post account for purchases during their stay, and funds will be deducted from the account as items are purchased.
3. The card will only be charged for the initial deposit and any additional approved funds.
4. The SPYMCA will not automatically process additional payments without your authorization. (See Below)

Authorization Statement: By signing below, I acknowledge and give permission to The Stevens Point Area YMCA to process charges using the card information provided earlier for the purposes of funding the Trading Post account. A $20 service fee will be charged on any returned bank draft. I understand that all transactions will be processed securely and any unspent funds (Except for Recruit-A-Friend Credits) may be refunded at the end of the camp session, according to camp policy.

Cardholder Signature: _____ **Date:** _____

Name(s) of Camper(s)_____ **Amount: $** _____

***Card #:** _____ **Exp. Date:** _____

Name on Card: _____ **Total Amount Paid Today: $** _____

Completed paperwork and payment can be mailed or dropped off at
The Stevens Point Area YMCA – Camp Registration, 1000 Division Street, Stevens Point, WI 54481
(715)342-2999

Stevens Point Area YMCA

School Age/Day Camp – Health History and Care Form

FULLY COMPLETE ALL SECTIONS of this REQUIRED Health and Care Form and return to:
Stevens Point Area YMCA, Child Development Office, 1000 Division Street, Stevens Point, WI 54481 (715) 342-2999

First Day of Attendance: _____

Participant Name _____ Birth Date _____ Age _____ ❑ M ❑ F

Street Address _____
Street City State Zip

Home Phone _____ School _____ Grade_____ Height _____ Weight_____

Parent/Guardian Name _____ **Parent/Guardian Name**_____

Home Address _____ Home Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Place of Employment and Phone # _____ Place of Employment and Phone # _____

_____ _____

Cell Ph._____ Home Ph. _____ Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____ Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care: Email Where Reachable While Child is in Care:

_____ _____

Please Indicate any Custody Issues _____

Emergency Contacts (other than Parent/Guardian) and Persons Authorized to Pick Up Child.

Emergency Contact Name _____ **Emergency Contact Name**_____

Relationship to Child _____ Relationship to Child _____

Place of Employment and Phone # _____ Place of Employment and Phone # _____

_____ _____

Cell Ph._____ Home Ph. _____ Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____ Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care: Email Where Reachable While Child is in Care:

_____ _____

Participant Physician _____ Phone _____
Dr. Name/Facility Office Address

Participant Dentist _____ Phone _____
Dr. Name/Facility Office Address

Insurance Information: Is Participant covered by family medical/hospital insurance? ☐ YES ☐ NO

Carrier or Plan Name _____ Member ID # _____ Group # _____

Carrier Address & Phone # _____

Name of Insured _____ Relationship to Participant _____

Emergency Treatment Authorization: In the event I cannot be reached in an emergency, I authorize the YMCA staff to transport to and/or secure from any licensed hospital, physician and/or medical personnel any emergency care or treatment deemed necessary for my child. I agree that I will be responsible for the payment of any and all medical services rendered.

Signature of Parent/Guardian _____ **Date** _____

OVER

Participant Name _____ **Birth Date** _____ **Age** _____ ☐ M ☐ F

HEALTH CONDITIONS: (Check any that apply to the participant and explain below, include severity.)

- ❑ Sleepwalking
- ❑ Bed-wetting
- ❑ Athlete's Foot
- ❑ Warts
- ❑ Eating Disorder
- ❑ Diarrhea/Constipation
- ❑ Abnormal Menstruation
- ❑ Homesickness
- ❑ Doesn't Swim (describe)
- ❑ Nightmares
- ❑ Exercise Induced Difficulties
- ❑ Frequent Ear Infections
- ❑ Heart Defect/Disease
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Frequent Headaches
- ❑ Indigestion
- ❑ Sinus Trouble
- ❑ Frequent Nose Bleeds
- ❑ Bleeding Clotting Disorder
- ❑ Fainting/Dizziness
- ❑ Emotional/Behavior Disorder
- ❑ Skin Problems
- ❑ Joint/Bone Problems
- ❑ Head/Neck/Back Injuries
- ❑ Epilepsy/Convulsions/Seizures
- ❑ Visual Impairment/Glasses…
- ❑ Hearing Impairment/Aids…
- ❑ Speech Impairment
- ❑ Learning Disability
- ❑ ADD or ADHD
- ❑ Cognitive Disability
- ❑ Chronic Illness/Condition
- ❑ Cerebral Palsy/Motor
- ❑ Picky Eater
- ❑ Vegetarian
- ❑ Allergies
- ❑ Asthma
- ❑ Other _____
- ❑ Other _____
- ❑ Does participant have a School IEP? If yes please provide a copy.

Give details including triggers, signs/symptoms, care procedures and when to call parent and/or 911 for any conditions checked above: _____

_____

_____

Identify any YMCA staff that you have given specialized instructions/training to: _____

ALLERGIES Describe reaction/symptoms, management instructions and when to call parent or 911.

Medications (list)

_____ _____

_____ _____

Foods (list)

_____ _____

_____ _____

Insects, Animals, Plants…

_____ _____

_____ _____

MEDICATIONS

Will participant medication need to be taken during this program? ☐ Yes ☐ No ☐ Maybe *If yes or maybe, a* Authorization to Administer Medication form must be completed (Attached to this packet). All Medications are required to be in original containers and be clearly labeled.

List and describe any other participant Health Conditions/Disorders/Impairments/Diseases/Illnesses/Major Surgeries/ Special Needs and indicate if there are any Restrictions: _____

_____

_____

*** A copy of participant's immunization records or provided form must be attached.**

I hereby state that the information I have provided is accurate and complete. I understand that it is my responsibility to provide any changes/updates regarding emergency and health information to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize my child's participation in this program.

_____ _____ _____

Participant Name - Please Print | Signature of Parent/Guardian | Date

Review dates: _____ _____ _____ _____ _____

Authorization to Administer Medication – Child Care Centers
Instructions For Use

Use of form: This form is mandatory for licensed family child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers, day camps, and certified providers; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a., DCF 252.44(6)(e)1.a., and DCF 202.08(4)(f)2.b. Wis. Admin. Codes. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: When a parent is requesting that the provider administer prescription or non-prescription medication to a child in care, this form shall be completed and signed by the parent or guardian before any medication is administered. A separate form shall be used for each medication. Place the form in the child's file when the medication is no longer required / authorized. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

CERTIFIED CHILD CARE OPERATORS

This form is voluntary for certified providers; however, completion of Page 1 *Medication Information and Authorization* and Page 2 *Documentation of Medication Administration – Certified Child Care Providers* meets the requirements of DCF 202.08(4)(f)2.b., Wis. Admin. Codes.

Have the child's parent or guardian complete and sign Page 1 *Medication Information and Authorization*. Record administration of the authorized medication in the spaces provided on Page *2 Documentation of Medication Administration – Certified Child Care Providers*. Lines should not be skipped.

LICENSED FAMILY CHILD CARE CENTERS:

Page 1 *Medication Information and Authorization* is mandatory for licensed family child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement.

Have the child's parent or guardian complete and sign Page 1 *Medication Information and Authorization*.

Page 2 *Documentation of Medication Administration – Certified Child Care Providers*, is only for use by certified child care providers. It is not used by Family Child Care Centers because medication administration must be documented in the center medical log book on the day that the medication is administered.

Log the dates and times medication was administered in the center medical log book. Blanket authorizations that exceed the length of time specified on the label are prohibited; no medication intended for use by a child in the care of the center may be kept at the center without a current medication administration authorization from the parent. For more information, see the document *Center Medication and Injury Log – Directions for Use* available from the Child Care Information Center website as part of the Appendix J Resource List.

LICENSED GROUP CHILD CARE AND DAY CAMPS:

Page 1 *Medication Information and Authorization* is voluntary for group child care centers and day camps; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a. and DCF 252.44(6)(e)1.a., Wis. Admin. Codes.

Have the child's parent or guardian complete and sign Page 1 *Medication Information and Authorization*.

Page 2 *Documentation of Medication Administration – Certified Child Care Providers*, is only for use by certified child care providers. It is not used by Group Child Care Centers because medication administration must be documented in the center medical log book on the day that the medication is administered.

Log the dates and times medication was administered in the center medical log book. Blanket authorizations that exceed the length of time specified on the label are prohibited; no medication intended for use by a child in the care of the center may be kept at the center without a current medication administration authorization from the parent. For more information, see the document *Center Medication and Injury Log – Directions for Use* available from the Child Care Information Center website as part of the Appendix J Resource List.

Authorization to Administer Medication – Child Care Centers
Medication Information and Authorization

A. FACILITY AND CHILD INFORMATION

Child Care Center Name

Child Name	Birthdate (mm/dd/yyyy)

B. MEDICATION INFORMATION: Medication shall be in the original container and labeled with the child's name. The label shall include dosage and directions for administration.

Name – Medication	Dosage	Time(s) of Day to be Administered	How to be Administered	Dates – Medication Time Period	
				From	To
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			
		☐ AM ☐ PM			

☐ Yes ☐ No **Does the over-the-counter (OTC) medication label indicate the child's physician should be consulted?** If "Yes," I have consulted with my child's physician, and I am authorizing a dosage consistent with the physician's recommendation.

OTC Medication Name	Parent Initials

Additional information / special instructions / contraindications – Specify.

C. AUTHORIZATION

I hereby authorize administration of the above medication to my child by staff of the child care center listed above.

SIGNATURE – Parent or Guardian	Date Signed

Authorization to Administer Medication – Child Care Centers
Documentation of Medication Administration – Certified Child Care Providers

Instructions: This section is to be completed only by **certified child care providers** to document the actual administration of the medication. Lines should not be skipped.

	Name of Medication	Date Administered	Time Administered	Dosage	Signature / Initials of Person Who Administered the Medication
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
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25.					
26.					
27.					
28.					

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (02/2023)

STATE OF WISCONSIN
Wis. Stat. § 252.04

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.

STEP 1 PERSONAL DATA — PLEASE PRINT

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)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. 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 *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (Chickenpox)					

History of Varicella/Chickenpox

In accordance with DHS 144.03(2)(g), I attest that this child has a reliable history of varicella disease and is not required to receive Varicella vaccine.

_____ _____

SIGNATURE – Physician/PA/APNP Date Signed

STEP 3 REQUIREMENTS

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

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

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

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

[4]Children entering kindergarten must have received one dose after the fourth birthday (either the third, fourth or fifth) to be compliant (Note: a dose 4 days or less before the fourth birthday is also acceptable).

STEP 4 COMPLIANCE DATA AND WAIVERS

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 $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):

STEP 5 SIGNATURE

To the best of my knowledge, this form is complete and accurate.

_____ _____
SIGNATURE - Parent, Guardian or Legal Custodian Date Signed

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
HOUSEHOLD LETTER (Non-Pricing Programs)

For Group Child Care & Outside of School Hours Centers
FFY 2025, Rev. 6/24

Dear Parent or Guardian:

Stevens Point Area YMCA (Childcare | School Age + Camp) is enrolled in the CACFP, a USDA program which
(Name of Agency)

provides federal assistance dollars to eligible child care centers for serving more nutritious meals. The amount of money our agency receives from this program is based on the income levels of our families. **In order to continue providing a quality meal service without additional charge, we request every family of our enrolled children to complete new a Household Size-Income Statement form (HSIS) each year. Please complete and return the attached HSIS form to our office. This information will be kept strictly confidential in our files.** Only one completed HSIS is required for all children in your household. Once we have properly approved your HSIS as eligible, our agency will receive the higher *("Free" or "Reduced-price")* meal reimbursement rates for your enrolled children, for 12 months from the *Effective Month of Determination* regardless of any change in your household size and/or income or termination from Benefits Programs.

- You are not required to complete this HSIS if no one in your household receives benefits from FoodShare WI (the Supplemental Nutrition Assistance Program (SNAP)), FDPIR (Food Distribution Program on Indian Reservations), Wisconsin Works Programs and your household income is higher than the amount shown for your household size within the table below. In this case, however, we would appreciate you returning the HSIS to us with "N/A" written on it along with your signature and date.

Determining Eligibility based on Participation in Benefits Programs → *Complete Part 1 and Part 3 of HSIS form*

Our agency receives the Free meal reimbursement rate for children in households receiving benefits from FoodShare WI, FDPIR, or WI Works Programs. **Wisconsin Works Programs** is Wisconsin's Temporary Assistance for Needy Families (TANF) program. **It provides temporary cash assistance through work placement and training programs and IS NOT the WI Child Care Subsidy Program.** WI Works Programs include Trial Employment Match Program (TEMP), Community Service Jobs (CSJ), Case Management, W-2 Transitions (W-2T), Custodial Parent of an Infant (CMC), Minor Parents Services, Noncustodial Parents, Pregnant Women, Learnfare and Emergency Payments.

You must include the following information on the HSIS (a-c) for eligibility based on receiving benefits from FoodShare WI, FDPIR, WI Works Programs:

(a) The names of your enrolled children;
(b) Checked box for the benefit your household receives and its case number; &
(c) The signature of an adult member in the household & signature date

- DO NOT list case numbers for:
- Medicaid, SSI, OR Wisconsin Child Care Subsidy program AND
- DO NOT list 16-digit Quest Card number *(starts with 5077)* for FoodShare WI

Determining Eligibility by Household Size and Income → *Complete Part 2 and Part 3 of HSIS form*

Household-Size Income Scale (Effective July 1, 2024 to June 30, 2025)

Household Size	Annual Income Level (at or below)
1	$ 27,861
2	$ 37,814
3	$ 47,767
4	$ 57,720
5	$ 67,673
6	$ 77,626
7	$ 87,579
8	$ 97,532
For each additional Household Member, add:	+$ 9,953

If your household earns a total income that is less than or equal to the income levels listed within this table, we will receive higher meal reimbursement rates *("Free" or "Reduced-price" meal rate)* for your children. **For determining eligibility based on your household size and income, you must include the following information on the HSIS (a-e):**

(a) Full names of all household members who share income and expenses, including children, parents, and non-related persons;
(b) Income received by each household member identified by source of income and its pay frequency;
(c) Total number of household members;
(d) The signature of an adult member of the household and signature date; and
(e) The last four digits of the social security number of the adult household member signing the HSIS or an indication he/she does not have a social security number.

- Disclosure of United States citizenship or immigration status is not required and is not a condition of eligibility for higher meal reimbursement rates.

Eligibilities of Foster, Runaway, Homeless, and Migrant Children, and Children enrolled in Head Start: Our agency will receive the Free meal reimbursement rates for foster, runaway, homeless, and migrant children and children enrolled in Head Start who reside in your household, when you provide the respective documentation listed below. **The respective documentation is required for these children to be eligible for Free Meals: These children's eligibility for Free meals does not extend to other children in your household.**

- **Foster children:** Your completed HSIS with the 'Foster Child' box checked next to your foster children's names. When including them on your HSIS completed for your non-foster children, any income reported for your foster children must only be for their personal use. Your foster children will then be eligible at the "Free" meal rate. Your non-foster children's eligibilities will be based on the benefits or income information provided on your household's completed HSIS form.
- **Children Enrolled In Head Start:** Written certification of your child's Head Start enrollment eligibility period from the Head Start administering agency.
- **Runaway, Homeless, and Migrant Children:** Written certification of the child's status from an official of the appropriate Runaway and Homeless Youth Program, Migrant Education Program, or school official.

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You are not required to provide this information, but if you do not, our agency cannot receive higher reimbursement rates for meals served to your children. You must include the last four digits of the social security number of the household member signing the form unless: the HSIS is only for your foster child(ren); you list a case number for receiving benefits from FoodShare WI, WI Works Cash Programs, or FDPIR; or when the household member signing the HSIS checks "None" for not having a SS#.

Sharing Eligibility Information: Children's eligibility information may be shared in accordance with disclosure protection requirements without prior notification, with education, health, and nutrition programs to assess their eligibility for benefits. The law allows us to share your children's eligibility information with programs such as Medicaid or BadgerCare for ensuring their access to free or low cost health insurance, **unless you tell us not to.** This information may only be used for determining eligibility for their programs; if your children are eligible, they may contact you to offer their enrollment options. Filling out this HSIS does not automatically enroll your children in these programs. **If you do not want your information to be shared with these programs, notify us in writing. This notification will not change whether your children's meals are eligible for meal reimbursement.** Your eligibility information provided on the HSIS may also be shared with auditors for program reviews and law enforcement officials for the purpose of investigating violations of program rules.

Refer to the USDA Non-Discrimination Statement and Complaint Filing Procedure (https://dpi.wi.gov/nutrition#discrimination).
This institution is an equal opportunity provider.

Signature of Agency Representative

CACFP ENROLLMENT FORM

Child Care Name:

Parent/Guardian Instructions:
This form can be used for up to three children per household. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. **This form can be used for three years for the same child(ren), to meet the annual updating requirements.**

HOURS AND MEALS WHILE IN CARE

						Meals Normally Received While in Care (Check ✓)					
Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

HOURS AND MEALS WHILE IN CARE

						Meals Normally Received While in Care (Check ✓)					
Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

HOURS AND MEALS WHILE IN CARE

						Meals Normally Received While in Care (Check ✓)					
Child's Name:	Days Normally in Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
	☐ Sunday					☐	☐	☐	☐	☐	☐
	☐ Monday					☐	☐	☐	☐	☐	☐
	☐ Tuesday					☐	☐	☐	☐	☐	☐
Date of Birth:	☐ Wednesday					☐	☐	☐	☐	☐	☐
	☐ Thursday					☐	☐	☐	☐	☐	☐
	☐ Friday					☐	☐	☐	☐	☐	☐
	☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

PARENT/GUARDIAN SIGNATURE

Parent/Guardian Signature (Year One): Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Two):* Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Three):* Date *Mo./Day/Yr.*

CACFP

Group Child Care & Outside of School Hours Centers

FFY 2025, Rev. 6/24

HOUSEHOLD SIZE—INCOME STATEMENT

Child and Adult Care Food Program

An adult household member must complete this form (HSIS) and return it to the center. Complete one HSIS per household.
Refer to the accompanying *Household Letter* for instructions on completing this form.

First and Last Name(s) of Enrolled Child(ren):	Center

PART 1: BENEFITS

Do any household members currently participate in FoodShare WI, WI Works Programs, or FDPIR?
If yes, check the program and write the corresponding case number below; then go to Part 3. If no, skip to Part 2.

☐ **FoodShare Wisconsin (10-digit case number):** DO NOT list a 16-digit Quest Card number or number that starts with 5077.

____

☐ **Wisconsin Works Programs (10-digit case number):** DO NOT provide a WI Childcare Subsidy number. This is NOT a WI Works Program and does not qualify a child as free in CACFP.

____

☐ **FDPIR (9-digit case number):**

____

PART 2: HOUSEHOLD SIZE AND INCOME

If you did not complete PART 1, complete a, b, and c below; then go to PART 3.

a) **Household Members Information:** List full names of all members in first column, including yourself and all children.

b) **List all income** on the same line as the person who receives it.
- Record each income source only once.
- Check the box for how often each income source is received.

Household Member Names **Household Member:** anyone who is living with you and shares income and expenses, even if not related.	(Optional) Age	Check if Foster Child	Check if No Income	Gross wages, Net income (self-employed), Tips, Commission, Cash bonuses, Military pay & allowances, Work comp, Unemployment	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Retirement, Social Security, SSI, Disability, VA benefits, Child Support, Alimony	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually	Private pensions, Trusts, Annuities, Investments, Interest, Net rental income, Savings withdrawals, Any other income	Weekly	Every 2 Weeks	Twice per Month	Monthly	Annually
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐
		☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐	$	☐	☐	☐	☐	☐

c) Record total # of household members: _____

PART 3: SIGNATURE

An adult household member must sign and date this form
If PART 2 is completed, the adult signing the form **must list the last four digits of their SS#** OR check "None" if they do not have a SS#.

ETHNICITY AND RACE DATA COLLECTION – *Completion is optional*
This center is required by Federal law to ask the following two questions concerning ethnicity and race. Your answers are strictly for statistical reporting and will have no effect on determination of eligibility for benefits. **Please answer both questions.**

IS YOUR CHILD(REN) HISPANIC OR LATINO? ☐ Yes, Hispanic or Latino ☐ No, neither Hispanic nor Latino

SELECT ONE OR MORE OF THE FOLLOWING CATEGORIES THAT APPLY TO YOUR CHILD(REN):
☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

I CERTIFY that all information on this form is true. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.

Signature of Adult Household Member	Signature Date *Mo./Day/Yr.*	Last 4 digits of SS# (or check "None" if you do not have a SS#)
		***-**-___ ___ ___ ___ ☐ None

FOR CENTER USE ONLY – Complete all 3 sections

Section 1: Basis of Determining Eligibility (*A or B*)		Section 2: Eligibility Determination	Section 3: Determining Official's Initials/Approval Date Effective Month of Determination
A. *Household Size & Income* Total Household Size ________ *Total Income $________/_______ ($ Amount) (Time Period)	B. *Benefits/Foster* ☐ FoodShare WI ☐ W-2 Programs ☐ FDPIR ☐ Foster Child(ren)	☐ Free ☐ Reduced ☐ Non-Needy	Initials/Date: ____________________ **Effective Month of Determination: ____________________ Month/Year

*Convert to yearly income <u>only</u> when multiple pay frequencies are reported, using only these multipliers:	Weekly x 52 Every 2 weeks x 26	Twice a month x 24 Monthly x 12	**This form expires one year from the *Effective Month of Determination.*

This institution is an equal opportunity provider.