

University of Wisconsin Oshkosh Children's Center

Summer Adventure Program Registration

All information must be completely filled out and submitted before your child is registered.

Child(ren's) Information					
Name (Last, First)	Birthdate	Sex	Home Address(Street, City, State)	Zip Code	Telephone

Parent or Guardian								
Relationship to Child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Home Phone	Cell Phone	Email	Work Name & Address	Work Phone

Please list your main email address to receive School-Age correspondence. _____

Parent's Marital Status: Married Single Divorced Separated Spouse Deceased

Note any custody arrangements or restrictions (Attach court order if applicable): _____

Emergency Contact (List information of person to contact when mother, father or guardian cannot be reached.)							
Relationship to child	Name (Last, First)	Home Address (Street, City, State)	Zip Code	Home Phone	Cell Phone	Work Name & Address	Work Phone

Persons Authorized to Pick Up Child(ren)-Include Parents						
Relationship to Child	Name(Last, First)	Home Address (if not listed above)	Home Phone	Cell Phone	Work Name & Address (if not listed above)	Work Phone

Signature: _____ Date: _____

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Summer Adventure Program Registration
Parent Consent/Authorization

1. Child's Name: Birth Date:
2. Child's Name: Birth Date:

Check the weeks and days your child will be attending:
(Each child must attend a minimum of 6 weeks, either 3 days or five days per week)

Table with 12 rows representing weeks from June 12-16 to August 28-Sept. 1. Columns include week number, dates, and days of the week (Mon-Fri) with checkboxes.

Rates: Rates include breakfast, snacks and field trip costs.
Faculty, Staff and Community:
Full Week: \$180.00 3 Days Per Week: \$165.00
Students: Full Week: \$158.00 3 Days Per Week: \$114.00
(must be enrolled for UW Oshkosh Summer 2016)

Policies:
\$20 per week/per child deposit is due at time of registration. Deposits will be applied to your weekly rate and are non-refundable.

Parent Consent/Authorization:
Please initial each line and sign at bottom stating you have read and understand each item.
I am aware that a copy of the Wisconsin Licensing Rules for Childcare is available at the Children's Center for review at any time.
I authorize the Summer Adventure Program to take my child on all field trips via bus or walking during any of the days my child is registered.
I give permission for promotional photographs to be taken of my child.
In the event of an emergency, I authorize any medical treatment that may be needed. I understand that in the event of an injury, I will be contacted first and this waiver will only be necessary if I or my emergency contact cannot be reached.
I understand that all enrollment information is confidential and is only used as a guide in understanding my child.

Parent/Guardian Signature: Date:

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Summer Adventure Program
Health Information Enrollment Questionnaire

Student's Name: _____
Last First Middle

Student's Birth Date: ____ - ____ - ____ Grade: (Fall current year) _____

School: _____

Parent/Guardian Name: _____

Home Phone: _____ Cell: _____ Email: _____

Student Address: _____

Does your child have any of the following health conditions?

___ NO PHYSICAL DISABILITY AT THIS TIME

___ Activity Restrictions: _____

___ Serious Allergies: ___ Bee Stings ___ Food Milk ___ Sunscreen ___ Food/Milk ___ Other

___ Asthma: ___ Inhaler ___ Nebulizer

___ Bone/Muscle Problems

___ Chronic Bladder/Kidney Problems ___ Chronic Eye Problems ___ Chronic Heart Problems

___ Diabetes

___ Ear Problems: ___ Infections ___ Hearing Aids ___ Tubes

___ Epilepsy/Seizures

___ Health Equipment

___ Medications: Name of medication: _____

 Taken at School: _____ Taken at Home: _____

___ Other Health Concerns: _____

Preferred Hospital: _____ Phone: _____

Other Information you feel would be helpful for us to know: _____

Parent Guardian Signature: _____ Date: _____

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION**. State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local health departments. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that reason only. If you have questions on immunizations or how to complete this form, contact your child's school or local health department.

PERSONAL DATA

PLEASE PRINT

Step 1	Student's Name	Birthdate (Mo/Day/Yr)	Gender	School	Grade	School Year
	Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)			Telephone Number ()	

IMMUNIZATION HISTORY

Step 2 List the MONTH, DAY AND YEAR your child received each of the following immunizations. DO NOT USE A (✓) OR (X) except to answer the question about chickenpox, Tdap or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) <input type="checkbox"/> Tdap <input type="checkbox"/> Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine Vaccine is required only if your child has not had chickenpox disease. See below:					
Has your child had Varicella (chickenpox) disease? Check the appropriate box And provide the year if known: <input type="checkbox"/> YES _____ year (Vaccine not required) <input type="checkbox"/> NO or Unsure (Vaccine required)					

REQUIREMENTS

Step 3 Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

COMPLIANCE DATA

Step 4 **STUDENT MEETS ALL REQUIREMENTS**
Sign at Step 5 and return this form to school.

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETELY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

Although my child has NOT received ALL required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: Failure to stay on schedule and notify the school may result in court action and a fine of up to \$25.00 per day of violation.

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

For health reasons this student should not receive the following immunizations _____

SIGNATURE - Physician

Date Signed

For religious reasons this student should not be immunized.

For personal conviction reasons this student should not be immunized.

LIST VACCINE(S) WAIVED

SIGNATURE

Step 5 This form is complete and accurate to the best of my knowledge. Check one: (I do I do not) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student

Date Signed