

*Please print packet single-sided.*

*Please call the center for any questions.*



Dear Parents,

Welcome! Thank you for your interest in Excel Preschool's 4K Summer Camp program! In Excel's 4K Summer Camp, we strive to set up enriching and engaging hands on activities that take advantage of the beautiful summer weather and continue to promote kindergarten readiness! Explored areas include dirt, bugs, plants, water & weather, and more!

At Excel, we pride ourselves on offering you and your child a quality early learning experience. We strive to incorporate learning and fun in an effortless fashion that makes our students eager to return each day!

Excel welcomes parent check-ins any time during operating hours. Doors will be locked throughout the day for child safety. Parents need only check in at the front desk if they would like to observe.

Additional questions, please contact us!

*Please complete this registration packet and return it to the front desk at the address listed below at least 2 WEEKS PRIOR TO START.*

Excel Preschool  
4500 Industrial Park Rd, Stevens Point  
715-544-0832

### 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 - admin only
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**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
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Home Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
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b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
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Home Address (Street, City, State, Zip)	Does child reside at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Employment and Work Phone No.
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**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.
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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.
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**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.
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#### PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number
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#### 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. **No pets are in attendance at Excel Preschool.**

<b>SIGNATURE</b> – Parent or Guardian	Date Signed
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## 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., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. 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)	Birthdate (mm/dd/yyyy)	First Day of Attendance (mm/dd/yyyy)
Home Address (Street, City, State, Zip Code)		

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

Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number
Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number

### PHYSICIAN / MEDICAL FACILITY INFORMATION

Physician Name	Medical Facility Address	Telephone Number
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**SUNSCREEN / INSECT REPELLENT AUTHORIZATION** If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.		
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply repellent.		

### 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.
 

<input type="checkbox"/> No specific medical condition	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gastrointestinal or feeding concerns, including special diet and supplements
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy / seizure disorder	<input type="checkbox"/> Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism
<input type="checkbox"/> Cerebral palsy / motor disorder		
<input type="checkbox"/> 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.

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2. Triggers that may cause problems – Specify.

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3. Signs or symptoms to watch for – Specify.

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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 – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

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

a.

b.

c.

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

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

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8. Additional information that may be helpful to the child care provider.

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**SIGNATURE** – Parent or Guardian

Date Signed (mm/dd/yyyy)

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**Review dates:** \_\_\_\_\_



## PARENT INTERVIEW

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

Date of Birth: \_\_\_\_\_

Child's Nicknames (name he/she is typically called): \_\_\_\_\_

Parent Names: \_\_\_\_\_

**Parents:** Please complete the following interview by writing your response in the boxes provided. Skip any questions that are not relevant to your child.

### HOME

Who lives in the home with you and your child? ( <i>List all siblings and ages</i> )	
Any religious or cultural considerations staff should be aware of?	
What languages are spoken in the home?	

### HEALTH

List any diagnosed medical/developmental conditions.	
List any special health needs or concerns.	
List any allergies, sensitivities or intolerances & instructions.	

## DEVELOPMENT

What are some of your child's interests?	
What are some things your child is good at?	
What are some things your child finds more difficult or frustrating?	
How does your child currently communicate his/her wants and needs?	
Any concerns with your child's speech?	Describe:
Does your child have Birth to 3 services or an IEP?	<i>(If so, please attach the IFSP or IEP.)</i>
Does your child engage in problem behavior such as kicking or hitting others or hitting him/herself?	Describe:

## BATHROOM

Is your child potty trained? If no, describe current toileting or diapering routine/training.	
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Please list anything else you would like us to know about your child here:



## EXCEL POLICY

By signing below, you indicate that you have reviewed the entire list of policies and procedures outlined in the official Parent & Family Handbook. The handbook can be found on the website [www.excelwi.org](http://www.excelwi.org).

Please label EVERY individual item that belongs to your child (i.e. each mitten, shoe, sock, toy, cup, spoon, lunchbox, backpack etc.) with his/her first two initials of the first and last name (i.e. JaDo).

Fill out ONLY if applicable:

**Custodial parent name:** \_\_\_\_\_. As a condition of enrollment, a copy of the custody decree indicating primary placement and current custody agreement for the child MUST be on file.

By signing below, you acknowledge you have read through the handbook and policies in its entirety and understand and agree to all policies and announcements outlined here and in the Excel Parent & Family Handbook.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Print Child Name





## FINANCIAL AGREEMENT & FEE SCHEDULE

Submission of this form does not guarantee schedule requested. Schedule is subject to classroom availability.

Child's Name: \_\_\_\_\_ Child's DOB: \_\_\_\_\_

MARK SELECTION	SCHEDULE	DAYS	DROP OFF	PICK UP	TUITION
<b>4K Summer Camp</b> <b>June 12 – August 18, 2023</b> <i>Must be 4 years of age to enroll.</i>					
	<b>2 days</b>	<i>Circle one</i> Mon/Wed <i>or</i> Tues/Thurs	12:30-1PM	4:00pm	\$80/week
	<b>4 days</b>	Mon - Thurs	12:30-1PM	4:00pm	\$120/week

4K Summer Camp session includes a snack time.

Financial Agreement effective January 2021:

- Fees for services are subject to change and a 30-day written notice will be provided, when possible, if changes occur.
- The parent/guardian is expected to pay any outstanding personal balance in full each month or according to the agreed upon payment schedule.
- Should financial hardship arise, the parent/guardian should contact Excel immediately to arrange a satisfactory means for addressing the obligation.
- It is understood that Excel, with proper notice, may suspend services if at any time it is determined that satisfactory progress is not being made to retire the outstanding debt.

By signing below, I agree to the financial schedule selected for my child \_\_\_\_\_ (child name) and understand it is subject to change. I also understand the Fee Charges and Yearly Registration Fee. I accept responsibility for the charges as outlined in the policies and agreements.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Parent DOB



## BANK TRANSFER AUTHORIZATION FORM

I authorize Excel Preschool/Arrow Academy Inc. to electronically debit my bank account according to the terms outlined below for my child, \_\_\_\_\_ (child's name). I acknowledge that electronic debits against my account must comply with United States law.

**Bank account information:**     Checking    OR     Savings

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

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

Payment is processed every other Monday in the totaled amount specified and signed to from the Financial Agreement. Payments are processed in advance of the services being rendered and begin upon the Monday of the week of first attendance.

This payment authorization is to remain in effect until I notify Excel of the child's disenrollment in the program with proper advanced written notice from the parent/guardian in enough time for the business and receiving financial institution to have reasonable opportunity to act on it. I certify that I am an authorized user of this bank account and that I will not dispute the payment with my bank; so long as the transaction corresponds to the terms indicated in this form.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-mail Address

\_\_\_\_\_  
Phone Number

**ATTACH VOIDED CHECK HERE**



**PICTURE/VIDEO RELEASE**

Child Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Excel uses photographs and/or videos of children receiving services in our school for marketing, website development, child learning or staff training.

I have indicated below that photographs/digital images, video clips, and/or quoted remarks may be used as follows: (circle all that you authorize)

Yes	No	Pictures used internally for child learning such as crafts or in-room art
Yes	No	Video used to train staff or provide feedback to staff on curriculum instruction
Yes	No	Printed publication or materials (such as newsletters, brochures, marketing materials)
Yes	No	Electronic publications or presentations (TV or another broadcast media)
Yes	No	Website and social media (Excel website, Facebook)

I authorize the use of these materials (as indicated above) indefinitely without compensation to me. All prints, digital reproductions and video or audio recordings shall be the property of Excel.

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

\_\_\_\_\_  
Date

Please have your child's physician complete the following 2 health-related forms required for registration.

Return the signed physician forms to the Excel Preschool front desk at time of registration

OR

have physician fax forms to 715-600-9046

OR

sign the attached HIPAA form and we will fax the forms for you.



## HIPAA Privacy Authorization Form

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

### AUTHORIZATION

I authorize EXCEL PRESCHOOL to **use, disclose** and **exchange** the protected health information described below with

\_\_\_\_\_ (individual/entity seeking or holding the information).

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Behavioral Records                        | <input type="checkbox"/> Diagnostic/Assessment/Progress Reports                    | <input type="checkbox"/> Direct Observations |
| <input type="checkbox"/> Individualized Education Plan (IEP)       | <input type="checkbox"/> Medical Records (i.e. wellness check, immunizations etc.) |  |
| <input type="checkbox"/> Individualized Family Service Plan (IFSP) | <input type="checkbox"/> Other _____   |  |

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until services are terminated. At which time, this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Printed- Child Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

Relation to client (circle one of the following):

**MOTHER    FATHER    LEGAL GAURDIAN**

**other** \_\_\_\_\_

## Child Health Report – Child Care Centers

**Use of form:** Use of this form is required unless the health examination report is on an electronic printout from a licensed physician, physician assistant, or other EPSDT provider. Completion of this form meets the requirements of DCF 202.08 (4), DCF 250.04 (6) (a) 4. and DCF 251.04 (6) (a) 8. Failure to comply with these rules 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:** Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other EPSDT provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

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**PARENT OR GUARDIAN** – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)	Child's Birthdate (mm/dd/yyyy)
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Child's Address (Street, City, State, Zip Code)

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Parent or Guardian Name (Last, First, MI)

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Parent or Guardian Address (Street, City, State, Zip Code)

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**HEALTH PROFESSIONAL** – This section should be completed by the health professional

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Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

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Yes  No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

---

Yes  No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

---

Date of child's most recent blood lead test: \_\_\_\_\_ (mm/dd/yyyy).

Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

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Immunization(s) not to be administered to child due to medical reason(s) – Specify.

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**AUTHORIZATION**

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I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other EPSDT Provider (type or print)	Address (Street, City, State, Zip Code)
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<b>SIGNATURE</b> – MD, PA, or other EPSDT Provider	Date of Examination
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## 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.

### PERSONAL DATA

PLEASE PRINT

<b>STEP 1</b>	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)	

### IMMUNIZATION HISTORY

**STEP 2** List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (X) except to indicate whether the child has had chickenpox. 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 <i>Influenzae</i> 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 disease.					

**Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.**

- Yes year \_\_\_\_\_ (Vaccine is not required)  
 No or Unsure (Vaccine is required)

### REQUIREMENTS

**STEP 3** 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 <sup>1</sup>	3 PCV <sup>2</sup>	2 Hep B	1 MMR <sup>3</sup>
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib <sup>1</sup>	3 PCV <sup>2</sup>	3 Hep B	1 MMR <sup>3</sup> 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT <sup>4</sup>	4 Polio			3 Hep B	2 MMR <sup>3</sup> 2 Varicella

<sup>1</sup>If the child began the Hib series at 12-14 months of age, only 2 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 4 days or less before the first birthday is also acceptable).

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

<sup>3</sup>MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1<sup>st</sup> birthday is also acceptable).

<sup>4</sup>Children entering kindergarten must have received one dose after the 4<sup>th</sup> birthday (either the 3<sup>rd</sup>, 4<sup>th</sup> or 5<sup>th</sup>) to be compliant (Note: a dose 4 days or less before the 4<sup>th</sup> birthday is also acceptable).

### COMPLIANCE DATA AND WAIVERS

**STEP 4** **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 up to \$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):

### SIGNATURE

**STEP 5** To the best of my knowledge, this form is complete and accurate.

\_\_\_\_\_  
SIGNATURE - Parent, Guardian or Legal Custodian

\_\_\_\_\_  
Date Signed