

## How to Enroll in Lodgic Kids Camp

Looking to use Lodgic Kids Camp? Make sure your ducks are in a row. There are a variety of forms and requirements to prepare in order to get your child enrolled. You'll only need to do this once, then you can use Lodgic Kids Camp any time, any way you want!

### 1. Complete your enrollment forms.

Print the forms below or pick up hard copies of these forms at the front desk of Lodgic Kids Camp. If you have questions, please call 608-470-5700 or email [KidsCamp.Madison@Lodgic.org](mailto:KidsCamp.Madison@Lodgic.org).

### 2. Gather your documents.

You'll need to get a few things together so we can get you started.

- Your child's **immunization records**. ([These can be printed from the WI Immunization Registry.](#))
- Within 30 days: Child Health Report, signed by physician.**

### 3. You are ready to enroll.

Give us a call 608-470-5700 to set up a convenient time for you to drop off paperwork! One of our friendly staff will be happy to process your enrollment forms and get you registered to begin care with Kids Camp.

### 4. That's all. Let the adventures begin!

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### 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
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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.

<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.

- 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:** \_\_\_\_\_

## INTAKE FOR CHILD UNDER 2 YEARS – CHILD CARE CENTERS

**Use of form:** This form is mandatory for family child care centers to comply with DCF 250.09(1)(c)1. and for certified providers to comply with 202.08(12)(g). Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers; however, it meets the requirements of DCF 251.09(1)(am). This form collects information about children under 2 years of age in order to aid child care workers in individualizing the program of care for the child in a family or group child care center. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** This form is to be completed by a parent / guardian and must be on file at the center prior to a child's first day of attendance. Regular updates can be noted. This form should be kept in the room where care is provided. If additional space is needed, attach a separate sheet.

First Day of Attendance (mm/dd/yyyy)

### PARENT / CHILD NAME AND ADDRESS

Name – Child (Last, First, MI)

Nickname (If any)

Birthdate (mm/dd/yyyy)

Name – Parent(s) (Last, First, MI)

Telephone Number – Home

Address – Parent(s) (Street, City, State, Zip Code)

**HEALTH** Note: Health conditions that may affect the care of the child must be recorded on the department's form, *Health History and Emergency Care Plan*. The form should be shared with any person who provides care for the child.

Child has frequent colds, ear infections, colic, etc. – Describe.

UPDATES

### MEALS

Current feeding schedule

Length of time on current schedule

Food type

Breast milk  Formula  Strained  Junior  Table  Milk type – Specify:

New food timetable

When eating, child is –

Held in lap  In highchair  Other – Specify:

Feeds self

Yes  No If "Yes", uses:  Spoon  Fork  Hands

Special feeding problems

Yes  No If "Yes" – Specify:

Food allergies

Yes  No If "Yes" – Specify:

Favorite foods – Specify.

Refused foods – Specify.

UPDATES

**SLEEP**

Current sleep schedule	Length of time on current schedule
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Falls asleep easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Mood upon awakening – Describe.
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Takes favorite toy(s) to bed – **child over age 1 year**  
 Yes  No If "Yes" – list toy(s):

Sleep position – **child under age 1 year**  
**Note:** Children under age 1 year must be placed to sleep on their back unless a written statement from the child's physician is attached.  
 Back for children under age 1 year  Side or stomach (physician statement attached)

Sleep position – **child age 1 year and older**  
 Back  Side or stomach

UPDATES

**DIAPERING / TOILETING**

Diaper – type <input type="checkbox"/> Cloth <input type="checkbox"/> Disposable	Diapers provided by parent <input type="checkbox"/> Yes <input type="checkbox"/> No
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Plastic pants used  
 Always  Never  Sometimes If "Sometimes" – Specify:

Highly sensitive skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent diaper rash <input type="checkbox"/> Yes <input type="checkbox"/> No
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Lotions, powders, or salves used  
 Yes  No If "Yes", product name(s) – Specify:

Toilet training attempted  
 Yes  No If "Yes", describe routine.

Type of toilet seat used at home  
 Potty chair  Special toilet seat  Regular toilet seat

Regular bowel movements  
 Yes  No How often: \_\_\_\_\_ Time(s) of day: \_\_\_\_\_

Toileting problems  
 Yes  No If "Yes" – Describe.

UPDATES

**VERBAL COMMUNICATION**

Family's spoken language.  
 English  Spanish  Other If "Other" – Specify:

Age child began talking	Child speaks in <input type="checkbox"/> Words <input type="checkbox"/> Sentences
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Words used to describe special needs – Specify.

UPDATES

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**COMFORTING**

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Does child have a fussy time?

Yes  No If "Yes" – Specify time.

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How is fussy time handled?

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Child likes to be:

Held  Sung to  Rocked  Read to  Other – Specify:

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Special things you say or do to comfort child.

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UPDATES

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**SELF-EXPRESSION**

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What causes your child to feel angry or frustrated?

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What frightens your child and how is it shown?

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How does your child express feelings of happiness, enjoyment, etc.?

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Additional comments

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UPDATES

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**PHYSICAL AND SOCIAL DEVELOPMENT**

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Is your child able to – (Check all that apply)

Sit up alone     Pull up     Crawl     Walk holding on     Walk without support

Yes     No    Is your child used to playmates?

Comments

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UPDATES

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**MISCELLANEOUS**

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Child's favorite **indoor** toys and activities – Specify.

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Child's favorite **outdoor** toys and activities – Specify.

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By providing complete information about your child, you will be assisting staff in creating a positive experience for him / her while in care. List any information about your child's habits, abilities, or personality that you feel will be helpful to the staff while caring for your child.

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UPDATES

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**SIGNATURE** – Parent or Guardian

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Date Signed



## 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

## Non-Prescription Diaper Ointment and Sunscreen Authorization

Date: \_\_\_\_\_

Parent/Guardian's Name (Last, First): \_\_\_\_\_

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

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

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

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

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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

Emergency Contact and Phone Number: \_\_\_\_\_

I agree to allow a Lodgic Kids Camp staff member to apply the provided non-prescriptive diaper rash\* ointment on my child(ren). I also understand that if my child has an open wound or broken skin that the staff member is not allowed to apply the ointment unless a prescribing practitioner provides written permission and instructions.

**Brand of Diaper Rash Ointment Provided by Parent:** \_\_\_\_\_

*\*If child(ren) require prescriptive diaper rash ointment, complete form P113.*

I agree to let a Lodgic Kids Camp staff member apply either the center's sunscreen or sunscreen that I have provided.

**Center's Sunscreen Brand:** \_\_\_\_\_  Yes  No

If NO, please provide sunscreen daily to the center.

**I also understand that the Lodgic Kids Camp staff member, its owners, and any other Lodgic Kids Camp partner, other Lodgic Kids Camp Centers, or the Lodgic Kids Camp Corporation is not responsible for any complications that this ointment/sunscreen might cause.**

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

Date: \_\_\_\_\_

## Photo/Media Authorization

I understand that my child may be photographed, videotaped, or interviewed as part of various activities or events during their visit at Lodgic Kids Camp. It is my understanding that I can accept or decline the use of such photographs/videos/interviews or portions thereof being used for public view.

In choosing to agree to participate in this project, I will do so without financial remuneration, and I understand that this releases photographers/interviewers from any future claims as well as from any liability arising from the use of said photograph/interview.

**Yes.**

My child's photograph/video/interview **may** be reproduced for use in the media.

**No.**

My child's photograph/video/interview **may not** be reproduced for use in the media.

Name of Child(*ren*): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email (*optional*): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (*please print*): \_\_\_\_\_



## Lodgic Kids Camp Madison

### Parent Agreement

During this difficult time, we at Lodgic Kids Camp Madison want you to know that we value the safety and wellbeing of you and your child(ren). For this reason, we ask that you take time to read through the following statements that we have put into place to keep everyone healthy and safe:

- Please do not visit or pick up/drop off a child at our program if you meet any of the following criteria:
  - Have underlying health conditions, including those with compromised immune systems or respiratory conditions like severe asthma.
  - Have symptoms of COVID-19 (fever, cough, shortness of breath).
  - Have been in contact with someone with COVID-19 in the last 14 days.
  - Have returned from travel to areas with community spread of COVID-19 [as defined by the CDC](#) in the last 14 days.
- When picking up or dropping off a child(ren), please wait outside the lobby and a teacher/staff person will assist you. Please note that you may be asked to stagger your arrival/departure times; the program will work this out with you ahead of time.
- We also ask that you practice “social distancing” (6 feet) at all times. Limit of one family in the lobby at a time.
- If you need to enter the program for any reason, we ask that you wash or sanitize your hands immediately upon entry.
- If your child becomes ill while in our program, you will be asked to pick up your child within one hour of the program contacting you. Please have plans in place to ensure you or a designated person is available if this should occur.
- Please review your enrollment information to ensure we have your current contact information as well as emergency contact information.

We thank you for helping us keep you and your child(ren) safe during this time. If you have any questions, please contact the **Center Director, Amy Miller at 608-470-5700.**

Child/Children’s Name: \_\_\_\_\_

Designated Parent for Drop Offs: \_\_\_\_\_ Date: \_\_\_\_\_

## CHILD HEALTH REPORT – CHILD CARE CENTERS

**Use of form:** Use of this form is voluntary; however, 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 HealthCheck 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)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

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

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

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.

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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.

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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**

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 HealthCheck Provider (type or print)

Address (Street, City, State, Zip Code)

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**SIGNATURE** – MD, PA, or other HealthCheck Provider

Date of Examination