



## Welcome To the Milestones Family!

My name is Cheryl Zagorski. I am the School Age Director. Your family's happiness is our number one goal here at Milestones. If you ever have any questions or concerns please feel free to contact me at 414-964-5545 or [czagorski@milestonesprograms.org](mailto:czagorski@milestonesprograms.org)

Thank you for choosing Milestones as your childcare provider.

### WHAT YOU CAN EXPECT FROM MILESTONES:

- Exceptional child to staff ratios that are far below state standards—at least two staff in every classroom at all times
- On-site Managers available from 7:00am to 6:00pm
- State Licensed Programs
- Highly trained, educated, caring staff
- Homework support everyday
- Connections to the school district staff to align with district goals
- Developmentally appropriate, intentional curriculum philosophy and practice
- Support of student achievement
- Programs that encourage social emotional development
- Warm, enriched classroom environments
- Over thirty three years of child care experience
- Child care is what we do - Your tuition dollars go towards providing the best child care experiences for your child
- Reliability- an exceptional record of providing care
- Rated by the North Shore community as one of the top child care providers in 2012
- A Director who has been serving on the State Affiliate board of the National Afterschool Association for over 14 years.
- An Administrative team with eighty five years of combined experience in the child care field
- Scholarship/Financial Assistance program
- Consistency of program through the school year and summer
- Strong connection to the community- A thirty three year history of serving families in the North Shore



## CHECKLIST FOR MILESTONES SCHOOL YEAR PROGRAMS

To register for any school year program you need to complete:

- Milestones School Age Registration Form
- Health History and Emergency Care Plan
- SCHOOL AGE Registration Agreement
- Child's Requested Schedule
- Confidential Family/Child Information Sheet (REQUIRED)
- Child's Immunization Record
- Processing Fee (\$45.00 for individual/\$60.00 for family)

Questions? Please contact us at (414) 964-5545 or email us at [RegSA@milestonesprograms.org](mailto:RegSA@milestonesprograms.org)

The completed materials may be mailed or dropped off at  
our administrative office located at:

2214 E Capitol Drive  
Milwaukee, WI 53211

*Wisconsin State licensing laws require that each line in each section of the registration form for child care be filled out completely and accurately. Please help us to maintain our compliance with these regulations by double-checking your application(s) before you send them into our office.*

***Please allow at least 5 business days for processing applications.***

*Thank you!*

(Please type/print using black/blue ink)

MILESTONES SCHOOL AGE REGISTRATION FORM – CHILD INFORMATION

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Street Address: \_\_\_\_\_ Child Resides With: \_\_\_\_\_
City/Zip: \_\_\_\_\_ Requested Starting Date: \_\_\_\_\_ Application Date: \_\_\_\_\_

Child's School: \_\_\_\_\_ Summer location requested: \_\_\_\_\_ Fall location requested: \_\_\_\_\_ Grade in 2014/2015 School Year: (circle) BB K4 K5 1 2 3 4 5 6 7 8

Parent/Guardian: \_\_\_\_\_
Address: \_\_\_\_\_
City/Zip: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_
E-mail: \_\_\_\_\_

Employer or Address during hours of Program operation
Name: \_\_\_\_\_
Address: \_\_\_\_\_
City/Zip: \_\_\_\_\_
Day Time Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Family Status (check one)
[ ] Married
[ ] Separated
[ ] Divorced
[ ] Single
[ ] Widowed
[ ] \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_
Address: \_\_\_\_\_
City/Zip: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_
E-mail: \_\_\_\_\_

Employer or Address during hours of Program operation
Name: \_\_\_\_\_
Address: \_\_\_\_\_
City/Zip: \_\_\_\_\_
Day Time Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Physician or medical facility:
Name: \_\_\_\_\_
Address: \_\_\_\_\_
City/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

In addition to parents, persons authorized to pick up child: (Please indicate if 'NONE')
Name: \_\_\_\_\_
Address: \_\_\_\_\_
City/Zip: \_\_\_\_\_

Departure Procedures for my child:
[ ] go to school from the program site
[ ] walk home from the program at \_\_\_\_\_ pm (departure time)
[ ] wait for authorized pick up

Emergency contact: (A person who can be notified during program hours when you are unavailable and who lives/works within 20 miles of the program.)
Name: \_\_\_\_\_
Address: \_\_\_\_\_
City/Zip: \_\_\_\_\_
Phones: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_
Relationship to child: \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_
Relationship to Child: \_\_\_\_\_
Name: \_\_\_\_\_
Address: \_\_\_\_\_
City/Zip: \_\_\_\_\_
Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_
Relationship to Child: \_\_\_\_\_

I give permission for my child to be photographed for educational/news publicity purposes [ ] yes [ ] no
Billing Preference: [ ] 4 weeks/in advance [ ] 2 weeks/in advance [ ] credit card/4 weeks

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

FOR OFFICE USE ONLY

Processing Fee: \_\_\_\_\_ Acceptance: \_\_\_\_\_ Wait List Letter: \_\_\_\_\_ Cancel Date: \_\_\_\_\_ First Date of Attendance: \_\_\_\_\_

**CHILD'S REQUESTED SCHEDULE**

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

Grade in 2014-2015 School Year \_\_\_\_\_ Program Location \_\_\_\_\_

My child will attend the following: (Please circle component(s) and days requested)

**Full Day K5 & 1st-5th Grade Programs**

**Before Full Day Kindergarten & 1st-5th Grade**  
(From 7:00 AM until the start of school)

**After Full Day Kindergarten & 1st-5th Grade**  
(From the end of school until 6:00 PM)

<b>M</b>	<b>T</b>	<b>W</b>	<b>Th</b>	<b>F</b>	<b>M</b>	<b>T</b>	<b>W</b>	<b>Th</b>	<b>F</b>
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Additional information: \_\_\_\_\_

\_\_\_\_\_

**Half Day Kindergarten Programs**

**Before AM Kindergarten**  
(From 7:00 AM until the start of AM K)

**After AM Kind/School Dismissal**  
(End of AM K until **School Dismissal Time**)

**After AM Kindergarten/6:00 PM**  
(From the end of AM K until 6:00 PM)

<b>M</b>	<b>T</b>	<b>W</b>	<b>Th</b>	<b>F</b>	<b>M</b>	<b>T</b>	<b>W</b>	<b>Th</b>	<b>F</b>	<b>M</b>	<b>T</b>	<b>W</b>	<b>Th</b>	<b>F</b>
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(AFTER AM K IS NOT AVAILABLE AT PARKWAY)

Additional information: \_\_\_\_\_

\_\_\_\_\_

**Before PM Kindergarten**  
(From 7:00 AM until the start of PM K)

**After PM Kindergarten**  
(From the end of PM K until 6:00 PM)

<b>M</b>	<b>T</b>	<b>W</b>	<b>Th</b>	<b>F</b>	<b>M</b>	<b>T</b>	<b>W</b>	<b>Th</b>	<b>F</b>
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(BEFORE PM K IS NOT AVAILABLE AT PARKWAY)

Additional information: \_\_\_\_\_

\_\_\_\_\_

I understand what I have circled above constitutes my child's contracted schedule, and I am responsible for all fees related to it. Any changes to this schedule must be made in writing (email permissible) to and approved by Milestones Programs for Children.

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_

**Milestones, Programs for Children  
Family Status/Child Information**

1. Child's Legal Name: \_\_\_\_\_
2. Child's Parents \_\_\_\_\_
3. Family Status (check all that apply):

<input type="checkbox"/> Married	<input type="checkbox"/> Single
<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<input type="checkbox"/> Separated	<input type="checkbox"/> Unmarried
<input type="checkbox"/> Remarried	<input type="checkbox"/> _____
4. Name of Parent/Guardian with whom the child resides: \_\_\_\_\_
5. Guardian's relationship to child: \_\_\_\_\_
6. Are there any issues related to custody or authorized pick up? \_\_\_\_\_ Yes \_\_\_\_\_ No
7. Does the non-custodial parent have any court restrictions placed on his/her parental rights? \_\_\_\_\_ Yes \_\_\_\_\_ No
8. If yes, what are the restrictions? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note: These restrictions must be substantiated.  
Please provide Milestones with a copy of the most current court order.**

9. If the child lives with surrogate parents (relatives or friends), are the surrogate parents the legal guardians? \_\_\_\_\_ Yes \_\_\_\_\_ No

**If YES, substantiate by providing Milestones with a copy of the court order.**

10. The court order already on file in the Milestones' office is it still current. \_\_\_\_\_ Yes \_\_\_\_\_ No
11. \_\_\_\_\_ (Signature of Parent/Legal Guardian) \_\_\_\_\_ (Date)

Please see Milestones Policies and Procedures  
Section VI for additional information/clarification

**SCHOOL YEAR PROGRAM 2014/15  
REGISTRATION AGREEMENT**

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

Milestones, Programs for Children

1. I understand that I am responsible for payment of contracted fees, paid in advance on the first Monday of each tuition period.
2. I understand that there is a \$7.00 charge for changes made to my child's schedule.
3. I understand that a \$25.00 late payment fee will be assessed for payments more than 10 days past due.
4. I agree to call my child's Milestones classroom **prior** to school dismissal time if for any reason my child will not be attending on a regularly scheduled day. I understand that there is \$10.00 "No Call/No Show" charge if my child is absent and I fail to properly inform Milestones of this absence and that chronic failure will result in my child's enrollment being terminated.
5. I understand that I must give two weeks written notice of withdrawal from the program.
6. I understand that if Milestones must provide lunch for my child, I am subject to a \$10.00 No Lunch Fee.
7. I understand that there are no pets in the classrooms.
8. I UNDERSTAND THAT I DO NOT RECEIVE ADJUSTMENTS IN FEES FOR HOLIDAYS, NO SCHOOL DAYS, OR DAYS MISSED. In the event of illness, school vacation, inclement weather, closings, personal vacation, or other absences (such as scouts, music lessons, and other out-of-school activities) the School Age Program staff will be notified and I am responsible for my child and tuition payment.
9. I understand that a \$25.00 charge is assessed for each Non-Sufficient Funds (NSF) check.
10. I am aware of the program hours of operation (7:00 AM to 6:00 PM).
11. I understand that for each **minute** that my child stays past the program closing time of 6:00 PM. I will be assessed a \$2.00 per minute late pick up charge.
12. I understand that if my child is scheduled only until **school dismissal time**, that for each **minute** that my child stays past scheduled time of departure. I will be assessed a \$2.00 per minute late pick up charge.
13. I understand that Milestones' responsibility for my child begins at the time s/he arrives and signs in at the program site and continues until s/he signs out (if written permission to walk home has been received by the program staff) or is signed out by a parent or authorized person.
14. I give my child permission to participate in walks and transported field trips. I understand I will be given advance notice of all transported field trips. I understand alternative care will **not** be provided if I elect not to send my child on the field trip.
15. I give permission for my child to be escorted by Milestones personnel to a neighboring school for care if applicable.
16. I understand if my child has special needs, I must indicate them on the Health History/Emergency Care Plan. Doing so will aid the staff in providing the most positive and successful environment for my child.
17. I understand that if an illness or medical emergency arises, the School Age Program staff will try to contact me. If I cannot be reached and THE EMERGENCY IS SUCH THAT IMMEDIATE ATTENTION IS NECESSARY, THE STAFF HAS MY PERMISSION TO TAKE MY CHILD TO THE NEAREST HOSPITAL. THE HOSPITAL HAS MY PERMISSION TO GIVE MY CHILD IMMEDIATE MEDICAL CARE.
18. I understand that the Wisconsin Rules for Licensing Day Care Centers is available for my review.
  - **I give my child permission to participate fully in this program.**
  - **I agree to adhere to all Milestones rules and policies including but not limited to the Milestones School Age Policies and Procedures and the Milestones School Age Parent Handbook.**
  - **I understand that failure to follow Milestones rules and policies is grounds for termination of enrollment.**
  - **NOTE: Registration Packet must be accompanied by the non-refundable Processing Fee of \$45.00 per child/\$60.00 per family (\$30.00 for continuing child/\$40.00 for continuing family)**

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

### HEALTH HISTORY AND EMERGENCY CARE PLAN

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

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

**CHILD INFORMATION**

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

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

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

**PHYSICIAN / MEDICAL FACILITY INFORMATION**

Name – Physician	Address – Medical Facility	Telephone Number
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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 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<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* 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:** \_\_\_\_\_



## DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER. State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day 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 (4) 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 day care entrance. Children who reach a new age/grade level while attending this day 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 day care center), OR**  
**IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day 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 day care center in writing as each dose is received.

**NOTE: Failure to stay on schedule or report immunizations to the day 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