

Registration/Waiver

PLEASE SIGN and DATE WAIVER

Child's Last Name _____

First Name _____

Parent's Last Name _____

First Name _____

Parent Emergency Phone Number(s): Home _____

Work _____ Cell _____

Preferred Hospital: _____

Ins Co./HMO: _____

Emergency Contacts (List contacts in case you are not available):

(1) Name: _____

(2) Name: _____

Phone: _____

Phone: _____

Relation: _____

Relation: _____

Allergies: _____

Special Needs: _____

Check this box to give KEVA permission to apply bug-spray and/or sunscreen to my child: YES

Please list the names of other adults allowed to pick up your child:

Name: _____

Relation: _____

I have read this release

Parent Signature _____

Date _____

In consideration of being allowed to participate in My First Sports LLC's and Keva Sports Center programs and related events and activities at Keva Sports Center, the undersigned:

1. Agree that prior to participating, they will inspect the facilities and equipment to be used, and if they believe that anything is unsafe, they will immediately advise the supervisor of such condition (s) and refuse to participate.
2. Agree that parent (s) or legal guardian (s) will instruct any minor participant that prior to participating, s/he should inspect the facilities and equipment to be used, and if the advise the supervisor of such conditions and refuse.
3. Acknowledge & fully understand that each participant's own action, inaction, or negligence, but the actions, inactions, or negligence of others, the rules of play or the conditions of the premises or any equipment used. Further, that there may be other risks not known to us, or reasonably foreseeable at this time and assume all of the foregoing risks and accepts personal responsibility for the damages following such injury.
4. Intending to be legally bound, do hereby release, waive, discharge and covenant not to sue My First Sports LLC's or Keva Sports Center, administrators, officers, directors, agents and other employees and volunteers, their participants, owners and lessors of the location used to conduct the activities, all which are hereinafter referred to as "lessees" from any and all liability to each of the undersigned, his or her heirs, personal representatives, guarantians, parents or other representatives, from any claims, demands, losses, or damages on account of injury, including death, or damage to property caused or alleged to be caused in whole or in part, by negligence of the release or otherwise in connection with association or participation in and/or arising out of travel to, participation in, and returning from participation in My First Sports LLC's and Keva programs.
5. In event that the undersigned sustains injury or illness while participating in My First Sports LLC's and Keva programs, I hereby authorized any emergency services, first aid, medication, medical treatment or surgery deemed necessary by licensed medical personnel, or other necessary medical personnel. Also give my permission forms, or other necessary medical documents, and to act on behalf of the undersigned in the undersigned or his/her parent are not immediately available to do so.
6. By providing your name and telephone number, you hereby expressly permit and authorize Keva Sports Center and My First Sports LLC, representatives to contact you via telephone or internet to discuss your interest in our programs. We reserve the right to use photos for promotional events and future use. Keva Sports Center does not sell your personal information to other parties.

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

STEP 1	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 Influenzae 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 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

¹If 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).

²If 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.

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

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th 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 \$26.00 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

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(9)(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)	Address - Home (Street, City)	Telephone Number	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.

Relationship to Child	Name	Address - Home (Street, City)	Home / Cell Telephone No.	Name and Address - Place of Employment OR Where Reachable While Child is in Care	Telephone No.
Mother					
Father					
Guardian					
Guardian					

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."

Relationship to Child	Name	Address - Home (Street, City)	Home / Cell Telephone No.	Name and Address - Place of Employment OR Where Reachable While Child is in Care	Telephone No.

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.

Relationship to Child	Name	Address - Home (Street, City)	Home / Cell Telephone No.	Name and Address - Place of Employment OR Where Reachable While Child is in Care	Telephone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number
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AUTHORIZATION

- 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 field trips and other activities during operating hours. Transported Walking
- 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.

SIGNATURE - Parent or Guardian _____ Date Signed _____

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.

- No specific medical condition
- Asthma
- Cerebral palsy / motor disorder
- Other condition(s) requiring special care - Specify.
- Diabetes
- Gastrointestinal or feeding concerns including special diet and supplements
- Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism

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.

2. Triggers that may cause problems – Specify.
3. Signs or symptoms to watch for – Specify.
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.
5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
 - a.
 - b.
 - c.
6. When to call parents regarding symptoms or failure to respond to treatment.
7. When to consider that the condition requires emergency medical care or reassessment.
8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates:

**AUTHORIZATION TO ADMINISTER MEDICATION – CHILD CARE CENTERS
 MEDICATION INFORMATION AND AUTHORIZATION**

A. FACILITY AND CHILD INFORMATION

Name – Child Care Center _____

Name – Child _____

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
		<input type="checkbox"/> AM <input type="checkbox"/> PM			
		<input type="checkbox"/> AM <input type="checkbox"/> PM			
		<input type="checkbox"/> AM <input type="checkbox"/> PM			
		<input type="checkbox"/> AM <input type="checkbox"/> 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. Name – OTC Medication _____ 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 _____

RELEASE, INDEMNIFICATION AND HOLD HARMLESS AGREEMENT

In consideration of participating in Keva Sports Center, LLC's programs and activities, and for other good and valuable consideration, I hereby agree on behalf of myself and my children, parents, heirs, assigns, personal representatives and estate, as applicable, to **release and discharge from liability**, Keva Sports Center, LLC, (hereinafter "Keva") and its owners, directors, officers, employees, agents, volunteers, participants, and all other persons or entities acting for them (hereinafter collectively referred to as "Releasees") as follows:

1. I acknowledge that participating in Keva's activities, or acting as an observer of Keva's activities involves known and unanticipated risks which could result in physical or emotional injury, paralysis or permanent disability, illness, death, and property damage. Risks include, but are not limited to, broken bones, torn ligaments, bruises, pain, or injuries as a result of exercise, physical activity; medical conditions resulting from exercise physical activity, or otherwise; sickness, paralysis, and/or damaged personal property. I understand such risks simply cannot be eliminated, despite the use of safety equipment, without jeopardizing the essential qualities of the activity.

2. I acknowledge the highly contagious nature of COVID-19, a novel coronavirus that has been declared a worldwide pandemic by the World Health Organization, which may be spread through person-to-person contact or through the air, and that I or the registrant may be exposed to or infected by COVID-19 by participation or observation of Keva's activities. I further acknowledge that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Keva may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Keva's employees, volunteers, and program participants and their families. I acknowledge that Keva has put in place preventative measures to reduce the spread of COVID-19; however, Keva cannot guarantee that you or the registrant will not become infected with COVID-19. I agree that I and my children or parents, as applicable, will practice safe social distancing and hygiene during our participation or observation.

My participation in or observation of this activity is purely voluntary and I elect to participate in, or observe such activity, despite the above described risks. In addition, if at any time I believe that event conditions are unsafe or that I am unable to participate in or observe such activity due to physical or medical conditions, or increased risk of exposure to, or infection of COVID-19, or other diseases then I will immediately discontinue my participation or observation.

3. **I expressly accept and assume: (i) all of the risks as set forth above in Sections (1) - (2); (ii) all of the risks that are inherent in this activity; and (iii) risks that might have been caused by the negligence of the Releasees or otherwise.**

4. **I voluntarily release, forever discharge, and agree to indemnify and hold harmless Releasees from any and all injuries, claims, demands, causes of action, damages, liabilities, or expenses to myself or my children, or to any of our property, that are in any way connected to my participation in or observation of this activity, or my use of Releasees' s equipment or facilities (collectively "Claims"), whether arising from the Releasees' s or my own negligence. I understand and agree that this release includes any Claims related to COVID-19 or other diseases based on the actions, omissions, or negligence of Keva, its employees, agents, and representatives, whether a COVID-19 infection or other infection occurs before, during, or after participation at Keva.**

Notwithstanding anything to the contrary, this release does not apply to Claims arising from intentional conduct. Should Releasees or anyone acting on their behalf be required to incur

attorney's fees and costs to enforce this Agreement, I agree to indemnify and hold them harmless for all such fees and costs.

5. I represent that I have adequate insurance to cover any injury, illness, or damage I may suffer or cause while participating in this activity, or else I hereby agree to bear the costs of any such injury, illness, or damage myself. I further represent that I have no medical or physical condition which could interfere with my safety in this activity, or else I hereby assume – and further agree to bear the costs of – all risks that may be created, directly or indirectly, by any such condition.

6. By providing your contact information, Keva reserves the right to contact you in regards to future programs at Keva and/or to use photos for promotional marketing material for future use. Keva does not sell any personal information to other parties.

7. With full knowledge of the risks of injury in programs at Keva, I hereby authorize, the following persons to administer emergency medical treatment to the registrant, for any injury or other medical emergency while at a practice, game, tournament, scrimmage, or while participating in or attending any other activity: (i) all coaches and managers of me or my child's team; (ii) all officers and officials of Keva's programs to which me or my child's team belongs; (iii) all directors, officers, sponsors, officials or agents of any league or tournament that registrant may participate in; and (iv) Keva's staff members. This consent also extends the right to those persons listed above to arrange for immediate medical treatment by a licensed physician and/or other trained medical personnel, and for them to provide such emergency medical care, as they deem appropriate to preserve the life or wellbeing of the registrant. The registrant and I (if parent or legal guardian) hereby release, hold harmless and indemnify the above-listed persons of any injury or damage related to administration of emergency medical care as authorized herein.

8. I agree that the laws of Wisconsin shall govern this Agreement and that any dispute arising out of or in connection with my participation in any activity at Keva, shall be exclusively adjudicated in a court of general jurisdiction in Dane, County, Wisconsin. I further agree that if any portion of this Agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

9. I acknowledge and further agree that I have had enough time to read this entire Agreement and, should I choose to do so, consult with legal counsel prior to signing. I further acknowledge and agree that: (i) the opportunity to participate in this activity at the stated cost in return for the execution of this release is a reasonable bargain, and (ii) the cost to engage in this activity would be significantly greater if I were to choose to not sign this Agreement as-is, or bargain for modified terms of this Agreement, and in consideration of the foregoing, I hereby waive my right to bargain over the terms of this Agreement.

I have read and understood this Agreement and I agree to be bound by its terms. By signing this Agreement, I agree that I may be found by a court of law to have waived my right to maintain a lawsuit against the parties being released hereunder on the basis of any claim for negligence, if during my participation in this activity: (i) I am hurt or my property is damaged; or (ii) I am exposed to, or infected by, COVID-19 or other diseases.

Signature

Date