FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CENTRAL CONNECTICUT COAST YMCA
Summer Camp Registration & Release Form

Member ID# _____

Camper's First Name_____ Last_____ Gender_____

Address_____ City_____ State _____ Zip_____

Date of Birth _____ Age entering camp yrs._____ mos._____ Grade entering in Sept._____ Child lives with_____

Parent # 1_____ Parent # 2_____

Home Address_____ Home address_____

Please Check Which Phone Number You Would Like Used As Primary Contact Number

☐ Home Phone # ( )_____ ☐ Home Phone # ( )_____

☐ Cell Phone # ( )_____ ☐ Cell Phone # ( )_____

☐ Work Phone # ( )_____ ☐ Work Phone # ( )_____

Parent/Guardian E-Mail Address (camp info will be sent via e-mail) _____
If parent cannot be reached, give name and relationship of person to be called in case of emergency.

Name:_____ Relationship:_____
Home # ( )_____ Work # ( )_____ Cell # ( )_____
Does your child require special accommodations (social, behavioral, medicine)? No_____ Yes _____ Will you be providing an individualized care plan? Yes _____ No _____

Parent/Guardian Permission: I hereby give permission for my child to participate in all activities (including field trips) that are part of the camp program. I understand there are risks associated with camp activities and programs in which my child is a participant. I hold the Y Branch, the Central Connecticut Coast YMCA, its employees, representatives, agents, and assigns from any and all claims whatsoever against said parties resulting from or caused by my child's participation. I grant permission to have my child transported to one the YMCA's other facilities in case of inclement weather. I also grant permission for any pictures taken of my child while at camp to be used for publicity and promotional purposes.
Authorization for Medical Attention: I give permission for the YMCA Certified First-Aid staff to treat my child, if needed. I authorize the camp staff to consent to emergency treatment (under advice of a Connecticut licensed physician) for my child when the need for such treatment is immediate and when efforts to contact me are unsuccessful. My child will be transported to the nearest emergency facility. I understand that any expenses incurred, through transportation and the treatment of my child, are my responsibility.
Concussion Information: I have read the CDC Concussion Fact Sheet and will talk to my child about the information. (http://www.cdc.gov/headsup/)
Sunscreen/Bug Spray Release: I hereby give permission for the YMCA to apply sunscreen and/or bug spray to my child. I will supply sunscreen and/or bug spray for my child as well as apply to my child every morning. The YMCA is NOT responsible for lost or stolen bottles of sunscreen/bug spray. (Please label containers).
Guardian Authorization: In order to ensure the well-being of all our campers and our ability to help you with picking up your child, please include every person that could assume the custody of your child for any unforeseen circumstances. The YMCA WILL require photo I.D. to release any child to an authorized pick up person listed on this form. I authorize the YMCA to release my child to the custody of the following people other than me:

Name: _____Relationship: _____Phone:_____ Phone:_____

Name: _____Relationship: _____Phone:_____ Phone:_____

Name: _____Relationship: _____Phone:_____ Phone:_____

The YMCA is required to permit either parent to pick up the child unless the YMCA is furnished with a copy of a court order to the contrary. Please list below any <u>persons not authorized</u> to pick-up this camper and attach a copy of the court order.

Name: _____ Relationship_____

Name: _____ Relationship_____

I understand that the Central Connecticut Coast Young Men's Christian Association, Inc. (the "Parent Company") and all of its branches are a charitable organization that makes its programs and facilities available to persons only on the condition that they agree to assume full responsibility for injury and damage. Therefore in exchange for acceptance of the child in the YMCA programs, I release, on behalf of the child, myself and members of the child's family, the YMCA, the Parent Company, and officers, directors, employees and volunteers from all claims of damage or loss to the child's property and claims of personal injury or property damage caused to others by the child, including injury or damage to YMCA property or personnel.
I understand the financial requirements, registration, payment obligations and deadlines as outlined in the Summer Camp Brochure.
I have read the above and agree to the terms and conditions.

Signature of Parent/Guardian _____Date_____

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LAKEWOOD-TRUMBULL YMCA
2017 Camp Tepee Summer Camp Session Registration Form

Child's Name _____ **MEMBER ID #**_____

T-SHIRT SIZE, please check one: Youth Sizes ❑small ❑med ❑large ❑xlarge **Adult Sizes** ❑small ❑medium

CAMPER UNIT	WEEK 1 6/19-6/23	WEEK 2 6/26-6/30	WEEK 3 7/3-7/7	WEEK 4 7/10-7/14	WEEK 5 7/17-7/21	WEEK 6 7/24-7/28	WEEK 7 7/31-8/4	WEEK 8 8/7-8/11	WEEK 9 8/14-8/18	WEEK 10 8/21-8/25 Vacation Fun Week	TOTAL WEEKS
DISCOVERY (Preschool) Member $305 Community $449	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
GREENHORNS (K-1st) Member $277 Community $405	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
EXPLORERS (2ND-3RD) Member $277 Community $405	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
PIONEERS (4TH-6TH) Member $277 Community $405	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
ADVENTURERS (7TH-8TH) Member $305 Community $449	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
CITS (9TH-10TH) Member $120 Community $180	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
PRE CARE Member $55 Community $55	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
POST CARE Member $75 Community $75	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
AM BUS Member $60 Community $60 **(Bus service not available for Camp Discovery)**	❑	❑	❑	❑	❑	❑	❑	❑	❑	No Bus	
PM BUS Member $60 Community $60 **(Bus service not available for Camp Discovery)**	❑	❑	❑	❑	❑	❑	❑	❑	❑	No Bus	

REGISTRATION FEE (PER CHILD) $___25.00__ BUS # _____

TOTAL WEEKS_____ X $50 DEPOSIT = $_____ AM BUS STOP_____

*(Please note that all deposits are non-refundable and non-transferrable)

SIBLING DISCOUNT ($50) PER CHILD $_____ PM BUS STOP_____

TOTAL DUE AT REGISTRATION $_____ STAFF INITIALS_____

LAKEWOOD TRUMBULL YMCA
20 Trefoil Drive, Trumbull, CT 06611
P 203 445 9633 **F** 203 445 9080 **W** lakewoodtrumbullymca.org

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LAKEWOOD-TRUMBULL YMCA

2017 Gymnastics Summer Camp Session Registration Form

CHILD'S NAME _____ **MEMBER ID#**_____

T-SHIRT SIZE, please check one:
Youth Sizes: ☐**small** ☐**medium** ☐**large** ☐**xlarge** **Adult Sizes:** ☐**small** ☐**medium**

GYMNASTICS CAMP	**WEEK 1** 6/19-6/23	**WEEK 2** 6/26-6/30	**WEEK 3** 7/3-7/7	**WEEK 4** 7/10-7/14	**WEEK 5** 7/17-7/21	**WEEK 6** 7/24-7/28	**WEEK 7** 7/31-8/4	**WEEK 8** 8/7-8/11	**WEEK 9** 8/14-8/18	**WEEK 10** 8/21-8/25	**TOTAL WEEKS**
HALF-DAY **Preschool only** Member $115 Community $230	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
FULL DAY Pre K-7th Member $175 Community $350	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
PRE CARE 7:30-9:00am Member $42 Community $42	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
POST CARE 3:30-6:00PM Member $72 Community $72	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
PRE & POST CARE Member $100 Community $100	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

REGISTRATION FEE (PER CHILD) $ $25.00

TOTAL WEEKS_____ X $50 DEPOSIT = $_____
*(Please note that all deposits are non-refundable and non-transferrable)

SIBLING DISCOUNT (10%) PER CHILD $_____

TOTAL DUE AT REGISTRATION $_____

STAFF INITIALS_____

LAKEWOOD-TRUMBULL YMCA
20 Trefoil Drive, Trumbull CT 06611
P 203 445 9633 **F** 203 445 9080 **W** lakewoodtrumbullymca.org

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LAKEWOOD-TRUMBULL YMCA

2017 Specialty Clinics Registration Form

CHILD'S NAME _____ **MEMBER ID#**_____

T-SHIRT SIZE, please check one:
Youth Sizes: ☐**small** ☐**medium** ☐**large** ☐**xlarge** **Adult Sizes:** ☐**small** ☐**medium**

Specialty Clinics – 9:30-1:30
5 Day Clinics - $140 Member/$280 Community – Monday - Friday
4 Day Clinics - $112 Member/$224 Community – Monday - Thursday
(Friday will be a make-up for inclement weather)

SPECIALTY CLINICS	Grades K – 1	Grades 2 – 3	Grades 5 and up	Total Fees
June 19 – June 22	☐Soccer/T-Ball			
June 26 – June 29		☐Fort Building & Adventure		
June 26 – June 30	☐Martial Arts	☐Martial Arts	☐Martial Arts	
July 10 – July 14	☐Basketball/Floor Hockey	☐Basketball/Floor Hockey		
July 17 – July 20	☐Five Sport Mix	☐Five Sport Mix		
July 24 – July 27		☐Fort Building & Adventure		
July 24 – July 28	☐Martial Arts	☐Martial Arts	☐Martial Arts	
July 31 – August 4	☐Soccer/T-Ball		☐Creative Dance	
August 7 – August 10	☐Five Sport Mix	☐Five Sport Mix		
August 7 – August 11			☐Modern Dance Fusion	
August 14 - August 18	☐Basketball/Floor Hockey	☐Basketball/Floor Hockey		
August 21 – August 25	☐Martial Arts	☐Martial Arts	☐Martial Arts	
			Total	

STAFF INITIALS_____

LAKEWOOD-TRUMBULL YMCA
20 Trefoil Drive, Trumbull CT 06611
P 203 445 9633 **F** 203 445 9080 **W** lakewoodtrumbullymca.org

FOR YOUTH DEVELOPMENT®
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CENTRAL CONNECTICUT COAST YMCA
Summer Camp Payment Authorizations

Child's First Name_____ Last_____ Gender_____

Summer Camp Agreement (Check One)

☐ I _____, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the 1st of each month (March, April, May, and June) in the amount of $_____ to act as payment for Summer Camp services. I understand that final payment for each session is due no later than the Wednesday before each session begins. If the session balance is not paid by that date, I am aware that my child will not be able to attend camp until the balance has been paid in full.

☐ I _____, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the Wednesday before each session begins to act as payment for Summer Camp services for the following week. I understand that final payment for each session is due no later than the Wednesday before each session begins. If the session balance is not paid by that date, I am aware that my child will not be able to attend camp until the balance has been paid in full.

I understand that I must provide a minimum of 2 weeks notice, in writing, if I wish to discontinue this service. **There will be a $20.00 charge for any EFT or charge returned by the bank. Also a $25.00 late payment fee will be added to the account if not paid prior to the first day of the session. These fees will be automatically drafted from my Summer Camp account.** I understand it is my responsibility to notify the YMCA of any change in address, bank account information (if utilizing bank draft for payment of summer camp) or credit card information/expiration date (if utilizing credit card for payment of summer camp).

Please print your name _____

Address _____

Email _____

Signature _____Date_____

I authorize my bank to honor preauthorized Electronic Funds Transfers (or credit card charges) against my account for (summer camp tuition) payments as indicated below. When the bank honors the EFT (or credit card) by charging my account, such transfer shall constitute notice of payment due and my receipt for the payment. Should any preauthorized EFT (or credit card) not be honored by said bank when received by them, then it is understood that the payment is to be made by me in the amount of said payment plus service charge. It is further understood that if such payment is not honored by the bank (or credit card institution), then the YMCA, at its discretion, may resubmit the amount due for payment on a future date.

☐ I choose to utilize the EFT option for payment (direct debit from my ☐Checking ☐Savings account)
Bank Name _____ Name on Account_____
Routing/Transit Number _____ Account Number _____
Authorized Signature: _____ Date: _____

☐ I choose to utilize a credit card on file at the Y. Reference_____
Authorized Signature: _____ Date: _____

☐ I choose to utilize the Credit Card Payment option for monthly payment (automatic direct charge to credit card)
Your Credit Card must be swiped at the YMCA Branch. Card Type □ American Express □ MC □ Visa
Card Holder Name_____
Card Holder Address _____
Authorized Signature: _____ Date: _____

2017

SUMMER CAMP ONLY

Attach voided check here for EFT Accounts

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CENTRAL CONNECTICUT COAST YMCA
Summer Camp Behavior Contract for Participants, Parents, Families and Campers

EXPECTIONS

- Show respect by treating other children and adults the way I would want to be treated.
- Be honest, will always tell the truth about actions and feelings.
- Be a friend that others can trust.
- Demonstrate caring by helping others and treating them kindly.
- Take responsibility for my own behavior and accept the consequences for my actions.
- To be free from cruel teasing and insults.
- Have a safe, calm, clean and orderly environment.
- Make mistakes without being ridiculed by others.
- Seek help from those that are there to help. Talk with Camp Staff when frustrated or feel mistreated.
- Be treated with dignity and respect by everyone.
- Use appropriate, acceptable language, don't talk back or use obscene, threating language or speak in an unkind manner.
- Avoid fights or verbal abuse.
- Be fair and accepting of others eager to join any activity.
- Work and play safely.
- Be kind, considerate, helpful, and respectful toward others.
- Follow directions and listen attentively while participating in activities.
- Share equipment and materials fairly and use them properly.
- Respect property, especially things that do not belong to me.
- Cooperate with others who are there to help.
- Speak up when witnessing unfairness or offensive language or behavior of others.
- Be a good sport whether I win or lose.
- Be truthful with everyone.

CONSEQUENCES

- Letter of discipline for talking back, destroying property, bullying children, disrupting the program, refusing obey. Parent will be required to sign these reports acknowledging that they have read the report. After three reports child and parent may be required to meet with the Camp Leadership Staff.
- Letter of discipline and immediately suspended for a minimum of one day for hitting, kicking, biting, spitting, scratching, swearing, making degrading or racial remarks, or leaving the group. Parents may be required to meet with the Camp Director before the child can return to the program.
- Camp services may also be terminated if the parent is physically or verbally abusive to a staff member. It is our desire that every child enjoys his/her experience in the program.
- Participation in the Summer Camp program may be limited or discontinued if this contract is not followed.

_____ _____

Signature **Signature**

_____

Date

CENTRAL CONNECTICUT COAST YMCA
1240 Chapel Street, New Haven, CT 06511
P 203 777 9622 **F** 203 773 8950 **W** cccymca.org

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LAKEWOOD-TRUMBULL YMCA
Camp Tepee and Gymnastics Camp
2017 Transportation Permission Form

I hereby give permission for my child, _____, to be enrolled in daily transportation to and from Camp Tepee as indicated on my child's enrollment form as well as for emergency situations when the camp needs to be evacuated for the safety of the children.

In the event of an emergency and I cannot be reached please call:

_____ at _____
(Emergency Contact) (Phone Number)

I prefer my child to be taken to _____hospital and in the event that my child requires emergency medical attention the following physician should be notified.

_____
(Physician's Name and number)

_____
Signature of Parent/ Guardian

_____
Date

LAKEWOOD-TRUMBULL YMCA
20 Trefoil Drive, Trumbull, CT 06611
P 203 445 9633 **F** 203 445 9080 **W** lakewoodtrumbull.org

CENTRAL CONNECTICUT COAST YMCA
CONFIDENTIAL
FINANCIAL ASSISTANCE APPLICATION

The Central Connecticut Coast YMCA offers financial assistance for programs to qualified members. We are community based and believe that our programs should be available to everyone and that no one should be turned away because of their inability to pay. Our Financial Assistance Program is made possible because caring people and businesses in our communities fund the program through our Annual Campaign. Financial Assistance is available on a sliding scale that is based on family size and household income.

It's easy to apply:

1. Please circle all programs for which you would like financial assistance.
2. Complete both sides of the application, including name and contact details, household members, and itemized income information. Please include any registration materials for the program(s) for which you are requesting financial assistance.
3. Child Care and Summer Camp applicants must also complete the CT Department of Social Services Care-4-Kids application in order for this application to be processed or reviewed.
4. A copy of your most recent Internal Revenue Service tax statement (tax return) and the last three pay stubs of all working adults must be included to process the application. Your SSI Allocation statement, DSS budget worksheet and any unemployment documents (if applicable) must also be included. Include any other documentation that supports your current income. (This information will be held confidential).
5. If you need assistance completing the application, please work with our Member Service Team.

Program: (Circle all that apply) Child Care Camp Aquatics Youth/Teen Other:_____

Have you previously applied for financial assistance at the YMCA? Yes No If yes, which YMCA? _____

Today's Date_____

Your Name _____Date of Birth_____

Address_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____Cell Phone_____

Place of Current Employment_____Length of Employment _____

Household Members (List all)

Last Name	First Name	Date of Birth

CENTRAL CONNECTICUT COAST YMCA
CONFIDENTIAL FINANCIAL ASSISTANCE APPLICATION page 2

Household Income	Monthly
Wages, Salaries & Tips (all sources in household)	$
Unemployment Compensation	$
Social Security Compensation	$
Disability Compensation	$
Child Support	$
Alimony	$
Aid to Dependent Children	$
Food Stamps	$
Housing Assistance	$
Utility Assistance	$
401K/Retirement	$
	$

If necessary, include documentation of any special expenses, extenuating circumstances, or crisis expense situations of which we should be aware.

Total amount you feel you can pay per month for program fees. $_____
An amount must be entered or the application will not be processed.

REMEMBER: A copy of the most recent Internal Revenue Service tax statement (tax return) and the last three pay stubs of all working adults must be included for this application to be processed. Your SSI Allocation statement, DSS budget worksheet and any unemployment documents (if applicable) must also be included. You may choose to include your W-2's, and/or any other documentation that supports your current income. (This information will be held confidential). Child Care and Summer Camp applicants must also complete the Department of Social Services Care-4-Kids application and return it with this application in order for this application to be processed or reviewed.

I certify that the above information is true and complete to the best of my knowledge. If requested, I will provide further substantiation of all facts included above. I understand that applications take at least two weeks to process, after which a YMCA representative will contact me. I acknowledge that an incomplete application will not be processed.

Applicant's Name (print)_____

Applicant's Signature_____

Office Use Only
Date Received:_____
Program:_____ Date(s) of Program:_____
Financial Assistance Awarded (%):_____

Branch Signature:_____ Date Approved:_____

State of Connecticut Department of Education

Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
Lead:	
***HCT/HGB:**	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption

Religious _____ Medical: Permanent _____ Temporary _____ Date _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN
DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6
DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12
Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

PARENT & ATHLETE CONCUSSION INFORMATION SHEET

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

[INSERT YOUR LOGO]

"IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON"

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

STUDENT-ATHLETE NAME PRINTED

STUDENT-ATHLETE NAME SIGNED

DATE

PARENT OR GUARDIAN NAME PRINTED

PARENT OR GUARDIAN NAME SIGNED

DATE

JOIN THE CONVERSATION www.facebook.com/CDCHeadsUp

HEADS UP

TO LEARN MORE GO TO >> WWW.CDC.GOV/CONCUSSION

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE).

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Dosage _____Method /Route_____ Time of Administration _____ Start Date ____/____/____ End Date ____/____/____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

Note: This form is a sample form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Medication Administration Record (MAR)

Name of Child/Student_____ **Date of Birth** _____/_____/_____

Pharmacy Name _____ **Prescription Number** _____

Medication Order_____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

Person Accepting Medication (print name) _____ **Date** _____/_____/____