



## CENTRAL CONNECTICUT COAST YMCA Summer Camp Registration & Release Form

Member ID# \_\_\_\_\_

Camper's First Name \_\_\_\_\_ Last \_\_\_\_\_ Boy \_\_\_ Girl \_\_\_

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.

### 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 persons not authorized 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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# **WOODRUFF FAMILY YMCA** **Summer Camp Session Registration Form**

**Child's Name** \_\_\_\_\_ **MEMBER ID #** \_\_\_\_\_

CAMPER UNIT	WEEK 1 6/15-6/19	WEEK 2 6/22-6/26	WEEK 3 6/29-7/3	WEEK 4 7/6-7/10	WEEK 5 7/13-7/17	WEEK 6 7/20-7/24	WEEK 7 7/27-7/31	WEEK 8 8/3-8/7	WEEK 9 8/10-8/14	WEEK 10 8/17-8/21	TOTAL WEEKS
<b>DISCOVERY</b> (Preschool) <b>Part time 2 days</b> Member \$114 Community \$171	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>DISCOVERY</b> (Preschool) <b>Full time 2 days</b> Member \$170 Community \$255	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>DISCOVERY</b> (Preschool) <b>Part time 5 Days</b> Member \$178 Community \$267	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>DISCOVERY</b> (Preschool) <b>Full time 5 days</b> Member \$309 Community \$464	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GREENHORNS</b> (K-1 <sup>st</sup> ) Member \$158 Community \$237	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>EXPLORERS</b> (2 <sup>ND</sup> -3 <sup>RD</sup> ) Member \$158 Community \$237	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>PIONEERS</b> (4 <sup>TH</sup> -6 <sup>TH</sup> ) Member \$158 Community \$237	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>SPECIALTY CAMPS</b> (4 <sup>TH</sup> -6 <sup>TH</sup> ) Archery & Challenge Member \$218 Community \$327		Archery <input type="checkbox"/>	Challenge <input type="checkbox"/>	Archery <input type="checkbox"/>	Challenge <input type="checkbox"/>	Archery <input type="checkbox"/>	Challenge <input type="checkbox"/>	Archery <input type="checkbox"/>	Challenge <input type="checkbox"/>		
<b>ADVENTURERS</b> (7 <sup>TH</sup> -9 <sup>TH</sup> ) Member \$206 Community \$309	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>CITS</b> (14 & 15 YRS) Member \$117 Community \$176	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>PRE CARE</b> Member \$32 Community \$48	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>POST CARE</b> Member \$46 Community \$69	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

REGISTRATION FEE (PER CHILD) \$25.00

+

T-Shirt Size \_\_\_\_\_

TOTAL WEEKS \_\_\_\_\_ X \$50 DEPOSIT = \_\_\_\_\_

TOTAL DUE AT REGISTRATION \_\_\_\_\_

Staff Initial \_\_\_\_\_



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## CENTRAL CONNECTICUT COAST YMCA Summer Camp Payment Authorizations

Child's First Name \_\_\_\_\_ Last \_\_\_\_\_ Gender \_\_\_\_\_

### Summer Camp Agreement (Check One)

- ☐ If registering prior to June: I \_\_\_\_\_, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the 1<sup>st</sup> 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.
- ☐ If registering after June: 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 week's 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 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 \_\_\_\_\_

To end your membership, complete and sign the Y cancellation form and submit it with your membership cards to your local center. We ask that you provide 48 hour written notice prior to your next monthly bank draft. All cancellations must be in writing.

# 2015

# SUMMER CAMP ONLY

## Attach voided check here for EFT Accounts



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## **WOODRUFF FAMILY YMCA Summer Camp Behavior Contract for Participants**

I understand the Summer Camp Behavior Contract.

I will be honest about my actions and feelings. When I am frustrated or believe that I am being mistreated, I will talk with my counselors and I will not act out in an inappropriate way.

I will act in a caring and respectful manner to others. I will not talk back, use obscene or threatening language, or speak in an unkind manner about others. I will follow directions and listen attentively while participating in activities.

I will take responsibility for my own behavior, not blaming others for the choices I make. If I destroy something as a result of my inappropriate behavior or actions I will replace it.

I understand that my participation in the Summer Camp program may be limited or discontinued if I do not follow this contract.

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**Child's signature**

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**Parent's signature**

---

**Date**



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## WOODRUFF FAMILY YMCA Summer Camp Behavior Contract

### CHARACTER CODE FOR CHILDREN AND PARENTS

I will show respect by treating other children and adults the way I would want to be treated.

I will be honest, will always tell the truth, and will be a friend that others can trust.

I will demonstrate caring by helping others and treating them kindly.

I will take responsibility for my own behavior and accept the consequences for my actions.

### CHILDREN'S RIGHTS

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 adults who are there to help.

Be treated with dignity and respect by everyone.

### CHILDREN AND PARENTS RESPONSIBILITY

#### Expectations:

Avoid fights or verbal abuse of other children.

Be fair and accepting of others eager to join any activity.

Work and play safely.

Use appropriate, acceptable language.

Be kind, considerate, helpful, and respectful toward others.

Share equipment and materials fairly and use them properly.

Respect property, especially things that do not belong to me.

Cooperate with others and with adults who are here to help.

Speak out when witnessing unfairness or offensive language or behavior of other.

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.
- I understand the Camper Behavior Contract.
- I will be honest about my actions and feelings. When I am frustrated or believe that I am being mistreated, I will talk with my head teacher and I will not act out in an inappropriate way.
- I will act in a caring and respectful manner to others. I will not talk back, use obscene or threatening language, or speak in an unkind manner about others. I will follow directions and listen attentively while participating in activities.
- I will take responsibility for my own behavior, not blaming others for the choices I make. If I destroy something as a result of my inappropriate behavior or actions I will replace it.
- I understand that my participation in the Summer Camp program may be limited or discontinued if I do not follow this contract.



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**WOODRUFF FAMILY YMCA CAMP WEPAWAUG**  
**2015 Summer Camp Field Trip/ Transportation Permission Form**

I hereby give permission for my child, \_\_\_\_\_, to go on all field trips with the Woodruff Family YMCA Camp Wepawaug. I also give my permission 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



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# Open Door Application

## CONFIDENTIAL SCHOLARSHIP ASSISTANCE APPLICATION

The Central Connecticut Coast YMCA offers financial assistance to those in need. We believe that no one should be turned away because of their inability to pay. Our **Open Door** Program makes this possible because caring people and businesses in our communities fund this program through our Annual Strong Kids Campaign. **Open Door** subsidizes program services on a sliding scale that is based on family size and household income.

**Open Door** is easy and confidential – come by any of our branches and apply for the program of your choice.

### Instructions:

1. **Please circle all programs for which you would like financial assistance.**
2. **Complete both sides of this form, 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 Department of Social Services Care-4-Kids application in order for this application to be processed or reviewed.\***
4. **You must include a copy of the most recent Internal Revenue Service tax statement (tax return) and the last three pay stubs of all working adults in order for this application to be processed.** You must also include your SSI Allocation statement, DSS budget worksheet and any unemployment documents (if applicable). You may choose to include any other documentation that supports your current income. (This information will be held confidential).

If you need assistance completing this application please contact our front desk.

**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 \_\_\_\_\_

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**


## Open Door Application (page 2)

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

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: You must include a copy of the most recent Internal Revenue Service tax statement (tax return) and the last three pay stubs of all working adults in order for this application to be processed.** You must also include your SSI Allocation statement, DSS budget worksheet and any unemployment documents (if applicable). 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)** \_\_\_\_\_ **Signature** \_\_\_\_\_

Office Use Only

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

Program: \_\_\_\_\_

Date(s) of Program: \_\_\_\_\_

Financial Assistance Awarded (%): \_\_\_\_\_

Branch Signature: \_\_\_\_\_

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

02/01/13





# 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other
Primary Care Provider		
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
<b>Family History</b> Any relative ever have a sudden unexplained death (less than 50 years old) Y N Any immediate family members have high cholesterol Y N				Seizure treatment (past 2 years)	Y N
				Diabetes	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

## Part II — Medical Evaluation

HAR-3 REV. 4/2010

### 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			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

### Screenings

*Vision Screening			*Auditory Screening			Lead:	Date
Type:	<u>Right</u>	<u>Left</u>	Type:	<u>Right</u>	<u>Left</u>		
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass			
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail			
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made			*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

## 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
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> 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 \_\_\_\_/\_\_\_\_/\_\_\_\_