# West Hartford YMCA
# ST. BRIGID - Day Camp

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

## Welcome to the 2015 West Hartford YMCA Saint Brigid Summer Day Camp

Dear Camp Families,

We are excited to continue to grow our YMCA camp located at St. Brigid's School. We have been working diligently during the off-season to learn new ways to incorporate learning with fun and exciting new activities. We realize that 80% of children have summer learning loss and with the help of the help of some of our favorite St. Brigid teachers and YMCA staff we've developed an amazing summer curriculum that meets the needs of all campers and ensures that they will be sent home with huge smiles on their faces and endless stories to tell.

Please take a moment to check out "Quick Information" at the bottom of this letter. If you have any further questions about the registration process or payments, please contact our Administrative Offices at 860.521.5830. For questions about camp activities, please send an email to the West Hartford Program Director's email address ashley.sharp@ghymca.org or call (860) 707-3587 and we will get back to you as soon as possible.

We look forward to spending our summer with you all.

Sincerely,
Ashley
Youth and Family Program Director

## QUICK INFORMATION

| | |
|---|---|
| Camp Address: | St. Brigid School, 100 Mayflower Street, West Hartford, CT 06110 |
| Camp Phone: | 860.561.2436 (used Monday through Friday during dates of camp) |
| Camp Hours: | 7:00am-6:00pm (camp activities run from 9:00am-4:00pm)<br>**Pre-School Camp Hours 9:00am – 12:00pm** |
| Camp Open Houses: | May 27th and June 15th : 6-8 pm |
| Camp Family Nights: | July 9th and August 6th: 6-8 pm |
| Swimming: | **Pre-School Campers do not participate in swimming activities.**<br>We will be swimming at Beachland Park twice a week – we share a walking path with Beachland which makes for easy access.<br>We plan progressive swimming activities for each week of the summer. Every swimmer is swim-tested by the lifeguarding staff before swimming for the first time, and counselors are in the water with swimmers at all times, in addition to the lifeguards stationed on the pool deck. |

### WHAT TO BRING TO CAMP EVERYDAY

1. **Labeled** Sunscreen
2. **Labeled** Water Bottle
3. Sneakers (flip-flops are **ONLY** permitted at swimming and water activities)
4. Bathing Suit and Towel **(labeled)**
5. Lunch & 3 Snacks with an ice-pack – **(Preschool, no lunch just a snack with an ice-pack).**
6. A backpack to carry around at camp that closes securely and fits everything
7. A BIG SMILE!!

### WHAT TO LEAVE AT HOME

1. Valuable and fragile items
2. Glass bottles or containers
3. **Video games and electronics** (if they are welcome for special days, counselors will send a note home)
4. Foods that require cooking or heating
5. BOREDOM!!

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## 2015 REGISTRATION FORM

Camper's Name: ______________________________

My Child Enjoys: ____________________ My Child Dislikes: ____________________

Helpful Hint About My Child: ______________________________

**PRE-WEEK OF CAMP 2015** (Check all days that apply)

☐ Monday 6/15 ☐ Tuesday 6/16 ☐ Wednesday 6/17 ☐ Thursday 6/18 ☐ Friday 6/19

_____# of days X $47 per day = $_______

TOTAL PRE-WEEK FEE $

| SESSION & DATES | FUN IN THE SUN (F.I.T.S.) | SUMMER ADVENTURE DAY CAMP (Grades K-5) Full Week | SUMMER ADVENTURE DAY CAMP (Grades K-5) 3-Day Option | LEADERS IN TRAINING (Grades 6/7/8) | COUNSELORS IN TRAINING (Grades 9/10) | AM CARE | PM CARE | TOTAL SESSION FEE |
|---|---|---|---|---|---|---|---|---|
| SESSION 1 6/22-6/26 | $140 | $230 | $160 | $220 | $150 | FREE | FREE | $ |
| SESSION 2 6/29-7/3 | $140 | $230 | $160 | $220 | $150 | FREE | FREE | $ |
| SESSION 3 7/6-7/10 | $140 | $230 | $160 | $220 | $150 | FREE | FREE | $ |
| SESSION 4 7/13-7/17 | $140 | $230 | $160 | $220 | $150 | FREE | FREE | $ |
| SESSION 5 7/20-7/24 | $140 | $230 | $160 | $220 | $150 | FREE | FREE | $ |
| SESSION 6 7/27-7/31 | $140 | $230 | $160 | $220 | $150 | FREE | FREE | $ |
| SESSION 7 8/3-8/7 | $140 | $230 | $160 | $220 | $150 | FREE | FREE | $ |
| SESSION 8 8/10-8/14 | $140 | $230 | $160 | $220 | $150 | FREE | FREE | $ |
| SESSION 9 8/17-8/21 | $140 | $230 | $160 | $220 | $150 | FREE | FREE | $ |
| | | | | | | | TOTAL | $ |

**PAYMENT INFORMATION**

Total Session Fees: $______________________

Total Deposit Due: $______________________

(Deposit Is 20% Of Each Session's Total Fee)

**METHOD OF PAYMENT** (CIRCLE ONE)

Cash • Personal Check • Visa • MasterCard • Discover • Amex

Credit Card #: ______________________

Exp. Date: ______________________

Signature: ______________________

Date: ______________________

Total Fee Paid: $ __________

**OFFICE USE ONLY**

| Date Received | Date Entered | Receipt Number | Member # | Staff Initials |
|---|---|---|---|---|
| | | | | |

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## REGISTRATION CHECKLIST

Thank you for choosing our summer program! We are very excited for camp this year and are ready to provide your child with a memorable camp experience. If you need any information, please contact our main office at (860) 521-5830 .

Enclosed you will find the following forms. Please complete and return to the YMCA Office. All forms must be received at least one week prior to your camper's start date.

☐ CONTACT & AUTHORIZATION FORM
Each child that attends our summer camp is required by the State Dept of Health to have this information on file.

☐ PAYMENT AGREEMENT FORM
All participants must agree to the payment terms listed. There are NO exceptions to payment due dates and campers will not be permitted into camp if payments have not been made on time. Remember that all deposits are non-refundable and non-transferable. Please retain all receipts for tax purposes.

☐ WAIVER OF LIABILITY
Each family participating in YMCA programs or camps must have a waiver of liability on file with the office prior to arrival at camp. If you family has more than one child attending camp, one Waiver of Liability Form will suffice.

☐ SUNSCREEN AUTHORIZATION
Connecticut Department of Public Health regulations require us to have written parental permission in order for YMCA Staff members to assist children in reapplying sunscreen throughout the day. Please complete the enclosed form and return to the office if your child will need our assistance. Campers must label and supply their own sunscreen.

☐ YOUTH CAMP HEALTH EXAM/RECORD (and Authorization for the Administration of Medication, if necessary)
Each child attending a camp program is required to have a physician-signed medical form on file prior to arrival. Campers without medical forms will not be permitted into camp. Medical forms are valid for two years from the date of exam.

☐ GETTING TO KNOW YOUR CAMPERS QUESTIONNARIE
This form will allow us to get to know our campers a little better and improve our program offerings.

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## Camper Contact Information

*PLEASE PRINT CLEARLY*

Child's Name ______ Male ____Female D.O.B. __/__/__Age ______
Home Address ______Town/City ______State ______Zip______
Home Phone ( ) ______School______ Grade in September 2015 ____
In case of emergency, which parent/guardian listed should we contact first?______

Parent/Guardian Name______Parent/Guardian Name______
Relationship to Child ______Relationship to Child______
Parent/Guardian D.O.B. ___/__/____ Parent/Guardian D.O.B. ___/__/____
Address______Address ______
Town/City ______State___Zip______Town/City ______State___Zip______
Home Phone( )______Work( ) ______Home Phone( )______Work ( )______
Cell Phone( ) ______ Cell Phone ( ) ______
Place of Work ______Place of Work ______
Business Address ______Business Address ______
Email Address ______Email Address ______

***Unless informed otherwise, the YMCA assumes both parents listed above may pick up the child. If a parent may not pick up the child, legal documentation of that fact is required.***

### EMERGENCY INFORMATION

In case of emergency, and the YMCA is unable to reach the parents/guardians listed above, the following individuals have permission to make decisions regarding the care of my child, including permission to pick up my child from the YMCA in case of emergency or early dismissal from the YMCA.

Name______Relationship to child______
Home Phone ( ) ______ Work ( ) ______ Cell ( ) ______

Name______Relationship to child______
Home Phone ( ) ______ Work ( ) ______ Cell ( ) ______

### CHILD PICK UP AUTHORIZATION

I give permission for my child to be released from the YMCA program to the people listed below at any time. I understand that YMCA staff requires these people to furnish Photo Identification before releasing my child.

Name______Name______Name______
Address______Address______Address______
______ ______ ______
Home Phone ( ) ______Home Phone ( ) ______Home Phone ( ) ______
Work Phone ( ) ______Work Phone ( ) ______Work Phone ( ) ______
Relationship______Relationship______Relationship______
Special Orders for picking up child (Please enclose legal documents if specified people are named). ______
______

### BILLING PARTY INFORMATION *PLEASE PRINT CLEARLY*

Billing Name______ Child's Name______
Address ______Town ______State______Zip______
Home Phone ( )______Place of Work ______Work Phone( )______

MY SIGNATURE ACKNOWLEDGES MY UNDERSTANDING OF AND AGREEMENT TO THE ABOVE.

______

**Parent/ Guardian Signature** **Date**

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## DAY CAMP PAYMENT AGREEMENT/AUTHORIZATION FORM

West Hartford YMCA Summer Camp 2014 balances are due based on the following schedule:

| DUE DATE | SESSION BILLED FOR |
|---|---|
| May 15, 2015 | All June Sessions |
| June 15, 2015 | All July Sessions |
| July 15, 2015 | All August Sessions |

All participants must agree to the payment terms listed. There are NO exceptions to payment due dates and campers will not be permitted into camp if payments have not been made on time. Remember that all deposits are non-refundable and non-transferable. Please retain all receipts for tax purposes.

Our **Refund Policy** states that all deposits are non-refundable. Cancellations prior to May 15th will be refunded less the 20% deposit. Cancellations between May 15th and May 31st are eligible for a 50% refund less 20% deposit. Any refund requests made after May 31st will not be accepted. All refund requests must be made in writing. If withdrawing due to a medical reason, a signed doctor's note must be presented and a full refund less the 20% deposit will be issued. All **schedule changes** must be made in writing at least **one week** prior to session start date.

**PAYMENT OPTIONS**

☐ **Automatic Payments**

**Please set up payment to come out of my checking, savings, debit or credit card on the above due dates.**

It is my complete understanding that if I wish to terminate my child's enrollment, I must submit a letter in writing canceling my EFT transaction two (2) weeks prior to my child's withdrawal date. I understand that the monthly debit to my account will vary based on my child's session enrollment. An estimate of this charge is listed above; however it is subject to change based on enrollment changes that I request. Should any pre-authorized check/charge (EFT) not be honored by my financial institution when received by them, I understand that the payment is to be made by me in the amount of said payment, and I realize that I am responsible for that payment, plus a service charge. I understand that if two EFT payments are rejected my child's enrollment will be subject to termination. I understand that the YMCA may utilize third party companies to assist with its collection efforts. Any service charge from the YMCA or its third party agencies does not include possible fees imposed by my financial institution.

I, ____________________________________________________, have read, understand and agree to the above.

**CREDIT/DEBIT CARD**

__VISA __MC __Discover __AMEX

Name: _____________________________Cardholder Signature: ____________________________ Date: ________

Credit/Debit Card Number _______________________ Exp. Date:__________________________________________

**CHECKING/SAVINGS ACCOUNT**

Name on Account: _____________________________ Account Holder Signature: _____________________________

Routing Number: _____________________________ Account Number: ____________________________________

Select which type of account: ___Checking ___Savings

☐ **Bill Me**

Please send me a bill for each remaining payment. I understand that payment is due in full by the above dates in order to remain enrolled in the program.

☐ **Pay in Full**

I have paid my balance in full at registration and understand the refund policies outlined above.

**Signature: ________________________________________Date:_________________ Child's Name ______________________**

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**RELEASE and WAIVER OF LIABILITY and INDEMNITY**
**And PHOTO/TALENT RELEASE AGREEMENT**

IN CONSIDERATION of being permitted to utilize the facilities, services and programs of the YMCA for any purpose, including, but not limited to observation or use of facilities, or equipment, or participation in any off-site program affiliated with the YMCA, the undersigned, for himself or herself, or on behalf of a minor child under age 18, and for any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has, inspected and carefully considered, or will immediately upon entering and/or participating, inspect and carefully consider, such premises and facilities or the affiliated program. It is further warranted that such entry into the YMCA constitutes an acknowledgement that that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use or participation.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE YMCA FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY OFF-SITE PROGRAM AFFILIATED WITH THE YMCA, THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING ON HIS OR HER BEHALF AND/OR BEHALF OF HIS/HER CHILDREN OR GUESTS (herein referred to as "the undersigned"):

1. MEMBER CONDUCT I agree to abide by all rules and regulations of the YMCA of Metropolitan Hartford (hereafter "YMCA"), and I understand that failure to act in accordance with the rules may result in expulsion from the YMCA and cancellation of membership.

2. INSURANCE I understand that the YMCA does not provide any accident or health insurance for its members or participants and it is my responsibility to provide such coverage.

3. PROPERTY LOSS I understand that the YMCA is not responsible for personal property lost, damaged or stolen while using YMCA facilities or participating in YMCA programs.

4. ASSUME FULL RESPONSIBILITY I hereby assume full responsibility for and risk of bodily injury, death or property damage while in about or upon the premises of the YMCA and/or while using the premises, or any facilities or equipment thereon or participating in any program affiliated with the YMCA.

5. PHOTO/TALENT RELEASE I hereby irrevocably release, consent and allow the YMCA and its agents to use my photograph, likeness, voice, as it pertains to my participation with the YMCA, in any manner for promotional efforts without expectation of any reimbursement for its use. (My initials here revoke photo/talent release_______________).

6. RELEASEE, WAIVE, DISCHARGES I hereby release, waive, discharge and covenant not to sue the YMCA, its directors, officers, employees, and agents (hereinafter referred to as "releases") from all liability to the undersigned, his personal representatives, assigns, heirs, and next of kin for any loss or damages, and any claim or demands therefore on account of injury to the person or loss of property while the undersigned is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with the YMCA.

7. INDEMNIFY AND SAVE AND HOLD HARMLESS I hereby agree to indemnify and save and hold harmless the releasees from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about the YMCA premises or in any way observing or using any facilities or equipment of the YMCA or participating in any program affiliated with the YMCA.

8. MEDICAL RELEASE I authorize the YMCA, as my agent, to give consent to medical treatment by a licensed physician or hospital when such treatment is deemed necessary by the physician, and I am unable to give such consent. I authorize a qualified YMCA staff member to administer CPR or first aid if necessary. I understand that it may be necessary for me to provide a release form from my physician regarding my current health status.

THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of Connecticut and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding continue in full legal force and effect.

THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AND PHOTO/TALENT RELEASE AGREEMENT, and further agrees that no oral representations, statement or inducement apart from the foregoing written agreement have been made. I HAVE READ THIS RELEASE

Printed Name of Participant_______________________________________________

Signature of Participant or Parent/Guardian: ___________________________________

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## SUNSCREEN APPLICATION AUTHORIZATION

**Camper Name:** ______________________

Your camper will be spending a lot of the time at camp running around in the sun. It is imperative that the children reapply sunscreen throughout the day.

☐ I give permission to apply sunscreen

☐ I do not give permission to apply sunscreen

I give permission to designated YMCA staff to assist my child in applying sunscreen throughout the camp day. I understand that it is my responsibility to provide sunscreen for my child each day and to apply sunscreen prior to their arrival at camp. Furthermore, I will assist the staff in educating my child in the importance of applying and reapplying sunscreen throughout the day.

Name of parent/ Guardian (please print): ____________________________________________

Signature of Parent/Guardian ______________________________________ **Date:**__________

**Comments/Notes:** ____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Reviewed by:

Name of staff (print): ______________________________________ Date: ____________

Signature of Staff: ________________________________________________________

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## General Permission Slip

Childs Name: ______________________________________________________________

Please Print

The YMCA's Summer Camp will be going on field trips.

- Wednesday's and Friday's by bus.

A schedule of field trips will be available on our website for review.

In the case of an emergency, please call Camp Director Ashley Sharp at 860-707-3587 or our offices at 860-521-5830.

By signing this permission slip you are allowing your child to participate in our field trip activities.

Parents Name:______________________________________________________________

Parents Signature:___________________________________________________________

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## GETTING TO KNOW YOUR CAMPER QUESTIONNAIRE

1. What is your child's favorite outdoor activity?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

2. Was your child born in the United States? If not, where?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

3. What is your child's favorite animal?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

4. What is your child's favorite sport?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

5. What is your child's favorite food?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

6. Does your child enjoy working on long-term projects?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

7. Has your child ever participated in team sports?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

8. Does your child enjoy building things with their hands?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

9. If your child could have one superpower, what would it be?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

10. What is your child most excited about for camp?

______________________________________________________________________________
______________________________________________________________________________
__________________________________________________________________________

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HEALTH ASSESSMENT RECORD
INSTRUCTIONS

Step 1:

Complete State of CT Health Assessment Record (pages 8-10) or you may obtain a copy from your Doctor and submit it with your registration and step 2 if it applies to your child.

Step 2:

If any of the health history questions on the State of CT Health Assessment Record are answered "YES" then the appropriate attached individual care plan must be completed. i.e. ASTHMA(page 11), ALLERGY(pages 12) or GENERAL Form (page 13).

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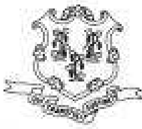

## State of Connecticut Department of Education
# Health Assessment Record

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, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base 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<br>❑ American Indian/ Alaskan Native<br>❑ Hispanic/Latino | ❑ Black, not of Hispanic origin<br>❑ White, not of Hispanic origin<br>❑ Asian/Pacific Islander<br>❑ 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 |
| **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**

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HAR-3 REV. 4/2012

## 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 | | | ***Postural** ❑ No spinal abnormality | ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made | |
| Genitalia/ hernia | | | | | |
| Skin | | | | | |

## Screenings

***Vision Screening**

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

❑ Referral made

***Auditory Screening**

| Type: | Right | Left |
|---|---|---|
| | ❑ Pass<br>❑ Fail | ❑ Pass<br>❑ Fail |

❑ Referral made

| | Date |
|---|---|
| History of Lead level ≥ 5μg/dL ❑ No ❑ Yes | |
| ***HCT/HGB:** | |
| ***Speech** (school entry only) | |
| 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 Allergies** ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*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

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# ST. BRIGID – Day Camp

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

**Student Name:** ______________________________ **Birth Date:** ________________ HAR-3 REV. 4/2012

## 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** | * | | | | Required for 7th grade entry | |
| **IPV/OPV** | * | * | * | | | |
| **MMR** | * | * | | | Required K-12th grade | |
| **Measles** | * | * | | | Required K-12th grade | |
| **Mumps** | * | * | | | Required K-12th grade | |
| **Rubella** | * | * | | | Required K-12th grade | |
| **HIB** | * | | | | PK and K (Students under age 5) | |
| **Hep A** | * | * | | | PK and K (born 1/1/2007 or later) | |
| **Hep B** | * | * | * | | Required PK-12th grade | |
| **Varicella** | * | * | | | 2 doses required for K & 7th grade as of 8/1/2011 | |
| **PCV** | * | | | | PK and K (born 1/1/2007 or later) | |
| **Meningococcal** | * | | | | Required for 7th grade entry | |
| **HPV** | | | | | | |
| **Flu** | * | | | | PK students 24-59 months old – given annually | |
| **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: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart- 1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 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 of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart- 1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

**GRADE 7**

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

**GRADES 8-12**

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart- 1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 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 or verification of disease*.

* **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.

**Note:** The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nation-wide shortage of supply for such vaccine.

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

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## Individual Care Plan
## Asthma

Child's Name___________________________
Date of Birth_________

Parent/Guardian Name____________________________

**Emergency Phone Numbers:**

Mother______________Father___________________

*****See emergency contact information for alternate contacts if parents are unavailable

Primary Health provider's name:______________
Emergency Phone______________________

Asthma specialist's name:_________________
Emergency Phone______________________

Known Triggers (Check the ones which apply to your child)

_Colds _Mold _Exercise _Tree Pollen
_Strong Odors _Grass _House dust _Flowers
_Animals _Smoke _Excitement _Weather change
_Room Deodorizers _Pets

Foods (specify)______________________________

Other (specify)______________________________

Activities for which this child has needed special attention in the past (check all that apply)

__Field Trips __Running hard __Jumping in leaves
__Outdoor on cold or windy days
__Playing in freshly cut grass
__Art projects with chalk, glues, and fumes
__Sitting on carpet
__Recent pesticides application in facility
__Painting or renovation in facility

Other(specify)____________________________________

_____________________________________ _______________________
**Parent's Signature** **Date:**

_____________________________________ _______________________
**Doctor's Signature** **Date:**

_____________________________________ _______________________
**Staff Signature** **Date:**

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**Individual Care Plan**
**Allergy**

Child's Name _______________________________

Date of Birth ________

Parent/Guardian Name __________________________

**Emergency Phone Numbers:**

Mother__________________ Father______________

*****See emergency contact information for alternate contacts if parents are unavailable

Primary Health provider's name: _____________
Emergency Phone: ______

Allergy specialist's name: _________________
Emergency Phone: ______

**Allergy to: (specify in detail all allergies)**

**List the child's symptoms:**

ACTION FOR MINOR REACTION
If only symptom(s) are:_____________________________________________
___________________________________________________________________________________________________________________
______________________________________________________________

give_______________________________________________
Medication/dose/route

Then call: Parent______________, Parent_______________, or emergency contacts.
If condition does not improve within 10 minutes, follow steps below in ACTION FOR MAJOR REACTION.

ACTION FOR MAJOR REACTION
If ingestion is suspected and/or symptom(s) are: _______________________________
___________________________________________________________________________________________________________________
______________________________________________________________

GIVE ___________________________IMMEDIATELY!

Then call:
1) Emergency medical services (911) and ask for advanced life support.
2) Parent_____________, Parent____________, or emergency contacts.

DO NOT HESITATE TO CALL EMERGENCY SERVICES!!

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| OTHER SIGNS OF AN ALLERGIC REACTION TO WATCH FOR:<br><br>Mouth—itching and swelling of the lips, tongue, or mouth<br><br>Throat**--itching and/or a sense of tightness in the throat, hoarseness, and hacking cough<br><br>Skin—hives, itchy rash, and/or swelling about the face or extremities<br><br>Gut—nausea, abdominal cramps, vomiting, and/or diarrhea<br><br>Lung**--shortness of breath, repetitive coughing, and/or wheezing<br><br>Heart**-- "thready" pulse, "passing out"<br><br>More reaction symptoms: |
|---|
| |
| |
| The severity of symptoms can change quickly.<br><br>** All of the above symptoms can potentially progress to a life-threatening situation. |

Parent's Signature ____________________ Date

Doctor's Signature ____________________ Date

Staff Signature ____________________ Date

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## General Individual Care Plan

Child's Name______________________________
Date of Birth________

Parent/Guardian Name_________________________

**Emergency Phone Numbers:**

Mother_________________Father______________

*****See emergency contact information for alternate contacts if parents are unavailable

Primary Health provider's name: ______________
Emergency Phone______

Specialist's name & field__________________
Emergency Phone______

Specialist's name & field:__________________
Emergency Phone______

**Diagnosis/Medical History: (please be specific)**

**Daily Medications:**

**As Needed Medications:**

| **Minor Symptoms:**<br><br><br>**If you see these symptoms DO THIS:** |
|---|

| **Major Symptoms:**<br><br><br>**If you see these symptoms DO THIS:** |
|---|

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Dietary/Nutritional Restrictions:

Communication:

Gross Motor:

Social-Emotional:

Sleep:

____________________________________
Parent Signature Date

____________________________________
Doctor signature Date

____________________________________
Staff Signature Date