FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Dear YMCA Family,

Thank you for choosing the Tri- Town YMCA for your school age child care needs. We are excited to welcome you and your family to our program!

The Y's focus is on youth development, healthy living, and social responsibility. At the YMCA of Greater Hartford, the goal of our child development program is to nurture young people by providing a safe place to learn foundational skills, develop healthy, trusting relationships, and build self-confidence.

Our early childhood and before and after school programs follow the State of Connecticut requirements and regulations for child care programs. In addition to meeting the state's expectations, we also collaborate with many local and state organizations to offer the highest quality enrichment experience for your child.

Please review this registration packet carefully. Complete and accurate information helps us to provide the best possible care for your child. If you have questions or need any additional information, please feel free to call or to email me.

Sincerely,

Jeff Spadaccini
Program Director

Here is some information that we hope you find helpful about your child's new program:

Jeff Spadaccini; Program Director
860-462-6209
Jeff.spadaccini@ghymca.org

Pam Eisch, Office Manager
860-521-5830
Pam.eisch@ghymca.org

School Aged Child Care Monthly Fees

	5 Day	3 Day
AM Care	$304.00	$232.00
PM Care	$399.00	$305.00
AM/PM Care	$556.00	$397.00

SACD 2015-2016

FOR YOUTH DEVELOPMENT
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Child's Name:____

Site Name: ______________________ **Start Date:**______________________

Emerson Williams School	**Hanmer School**	**Highcrest School**	**Webb School***	**Charles Wright****
461 Wells Road	50 Francis St	95 Highcrest Road	51 Willow Street	186 Nott Street
Wethersfield	Wethersfield, CT	Wethersfield, CT	Wethersfield, CT	Wethersfield, CT
AM 7:00-8:20	AM 7:00-8:45	AM 7:00-8:45am	AM 7:00- 8:45am	**ONLY PM CARE**
PM 2:30-6:00	PM 3:00- 6:00	PM 3:00-6:00pm	PM 3:00- 6:00pm	3:00-6:00pm

*Webb students will attend care at Emerson Williams Elementary. Transportation will be provided from our program in the morning to school at Webb, and Webb to our program in the afternoon.

**Charles Wright Students will attend care at Hanmer School. Transportation will be provided from Charles Wright to our program at Hanmer School in the afternoon. Only PM care is available.

Child Care programs are held every day that Wethersfield Public Schools are in session. On minimum school days (schedule half-days or early closings) the program begins at the end of the school day and is open until 6:00pm

Please check one of the following programs. I understand and accept that I must pay my monthly fee by automatic Payment (EFT). Please choose your selections carefully.

AM CHILD CARE ONLY 7:00 AM until school begins – Includes delayed openings				
				MONTHLY FEE
Full-Time	☐	5 Days per week	☐	$304
Part-Time	☐	3 Days or fewer per week	☐	$232
PM CHILD CARE ONLY From school dismissal until 6:00pm – Includes early dismissals				
				MONTHLY FEE
Full-Time	☐	5 Days per week	☐	$399
Part-Time	☐	3 Days or fewer per week	☐	$305
AM & PM CHILD CARE From school dismissal until 6:00pm – Includes early dismissals				
				MONTHLY FEE
Full-Time	☐	5 Days per week	☐	$556
Part-Time	☐	3 Days or fewer per week	☐	$397

Please complete the Child Development Electronic Payment Form on page 9.

The automatic EFT or credit card drafts will occur on the first day of the each month of care.

If you would prefer to have different automatic draft date other than the 1st of the month, please specify here: ____

PLEASE NOTE; if you choose to exercise that choice, the draft will automatically occur on that day, each month, **prior** to the month of care (for example, if you choose the 5th of the month, the payment for **September** will occur on the 5th of **August**).

SACD 2015-2016

FOR YOUTH DEVELOPMENT
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Tri- Town YMCA Child Care Registration Form 2015-2016

CHILD/FAMILY INFORMATION

Child's Name ______________________ Male ________Female ________D.O.B. _____/____/______Age___
Home Address ______________________ Town/City ________________State _________Zip___________
Home Phone (_____) ____-_______ School child attends ________________ Grade in September 2014 _____
In case of emergency, which parent/guardian listed should we contact first?______________________

Parent/Guardian Name______________________
Relationship to Child ______________________
Parent/Guardian D.O.B. _/_______/____________
Address______________________
Town/City ________________State ________Zip____
Home Phone (_____) ____-_____Work (_____) ___-_____
Cell Phone (_____) ____-_____
Place of Work ______________________
Business Address ______________________
Email Address ______________________

Parent/Guardian Name ______________________
Relationship to Child ______________________
Parent/Guardian D.O.B. _/_______/__________
Address ______________________
Town/City ________________State ________Zip____
Home Phone (_____) ____-_____Work (_____) ___-_____
Cell Phone (_____) ____-_____
Place of Work ______________________
Business 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 (_____) _______-________
Address____

Name______________________ Relationship to child__________________

Home Phone (_____) ________-__________Work (_____) ______-________ Cell (_____) _______-________
Address____

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__________________
Address__________________
____
Home Phone (_____) ____-______
Work Phone (_____) ____-______
Relationship__________________

Name__________________
Address__________________
____
Home Phone (_____) ____-______
Work Phone (_____) ____-______
Relationship__________________

Name__________________
Address__________________
____
Home Phone (_____) ____-______
Work Phone (_____) ____-______
Relationship__________________

Special Orders for picking up child (Please enclose legal documents if specified people are named). ____________
____

REGISTRATION INFORMATION (please check all that apply)

Site: Emerson Williams ______ Hanmer Elementary ______ Highcrest ______

Child's Schedule: 5 days/wk ___ 3 days/wk ____ AM (only) ___ PM(only) ____ AM&PM ___

Designated Days: Monday ___ Tuesday ___ Wednesday ___ Thursday___ Friday___

Start Date:__________________

SACD 2015-2016

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BILLING PARTY INFORMATION

Billing Name____ Child's Name____

Address ____ Town ________________________ State__________ Zip__________

Home Phone (_____) _____-__________ Work Phone (_____) _____-__________ Place of Work ______________________

HEALTH INFORMATION – Indicate "yes" where it applies and explain as necessary.

HEALTH						ALLERGIES	
Asthma	___	Convulsions	___	Emotional	___	Hay Fever	___
Diabetes	___	Hearing	___	Psychological	___	Poison Ivy	___
Special Diet	___	Vision	___	Learning Disability	___	Insect	___
Physical	___	Illness	___	ADD/ADHD	___	Medication	___
Restraints	___	Injury	___	Operations	___	Food	___
Other	___						

Please explain details of above "yes" answers ____

____

Special health or emotional note ____

Is this child currently taking prescribed or over-the-counter medication? _______Yes_____No____ Why? __________

Are you covered by any hospitalization/medical care policy? Yes _____ No ____ Preferred Hospital ______

Name of Insurance Company_______________________________________ Phone (_____) _____-______________

Address ____ Town/City ____________State __________Zip ____

Policy Holder's Name ______________________________________ Policy Holder's D.O.B. ____/____/____________

Policy Number ____

Name of Physician ____ Phone (_____) _____-_______________________

Name of Dentist ____ Phone (_____) _____-_______________________

Special Services received through school or other agency:

____

PARENT/GUARDIAN AGREEMENT

I understand:

1. Any registration or deposit fee is non-refundable, non-transferable and for administration purposes only.
2. All changes in my child's schedule of care must be made two weeks in advance in writing.
3. The YMCA requires 2 week notice for termination of care. I am responsible for full payment of the two week notice
4. The YMCA assumes responsibility for my child's well being during the hours of operation in which my child attends the program.
5. I am responsible for the cost of all medical treatment and care.
6. The information on this form is complete and accurate. I have provided the YMCA with all of the necessary information to properly care for my child's needs.
7. I must notify the YMCA staff in writing immediately of any changes to this form.
8. It is my responsibility to notify the YMCA my child will be absent from the program.
9. YMCA staff is not allowed to baby-sit or transport children at any time outside of the YMCA program.

I have read the YMCA Child Care Handbook and agree to these policies and procedures.

Please check each additional statement with which you agree:

☐ The YMCA has permission to use photographs of my child in promotional materials such as brochures, ads, televisions/videos, YMCA website, or newspaper releases. I will not be informed or reimbursed for such photographs.

☐ I give permission to the YMCA staff to administer First Aid in case of injury. In the event my child needs immediate attention and I cannot be contacted I give the YMCA staff permission to authorize medical treatment for my child.

☐ I give the YMCA permission to transport my child for daily school schedule, in the event of an emergency and for field trips. Prior written notice will be given for all field trips.

☐ **As per State Regulations, we must have a signed consent for the children to participate in activities outside of licensed child care space (i.e.: library, another classroom in the event the school needs the cafeteria) I give permission for my child to participate in activities outside licensed child care space under the supervision of the YMCA Staff.**

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

____

Parent/Guardian Signature *Date*

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Child Care Memorandum of Understanding

Child Name Site/Program

Parent/Guardian Name

1. Parents/guardians are required to sign child in & out of program every day. This includes the time of drop off & pick up as well as a signature.
2. Each child must be able to fully participate in all activities. If they are ill and cannot fully participate, a parent/guardian will be contacted to pick them up within one hour's time.
3. The YMCA promotes a safe environment for all children and staff. If a child acts inappropriately the behavior management policy lays out guidelines and the procedures that the YMCA will take.
4. The YMCA follows all State of CT guidelines when administering medications, including but not limited to: only certified staff may administer medication; collection of the appropriate forms signed by parents and physician where applicable; medication must be in original, labeled container.
5. The YMCA must have accurate and up-to-date health and medical information for each child according to CT Department of Public Health regulations. Children may not participate in child care programs if health and medical forms are absent or expired.
6. **A two week written notice must be provided to the office when changing your child's schedule or when withdrawing from the program.**
7. Child Care payment is due monthly for the month of service. For example, payments for the month of October are due October 1st. *Beginning with programs starting in September 2015, all payments must be made using an electronic draft. Flexible payment plans can be set up as needed. See Child Care Electronic Payment Form on Page 9.*
8. Two-party payments are available upon request of the parent/guardian.
9. The YMCA agrees not to share information with non-regulatory outside agencies who have not been designated by the parent or guardian. All changes to this policy must be written and handed in to the YMCA.
10. The YMCA is required to collect copies of all court orders & custody agreements regarding the child's limited access to the parents and/or guardians.
11. All YMCA School Age Child Care programs follow the public school calendar of the town they serve. If the public schools are closed due to weather or vacations, the YMCA School Age Child Care programs will also be closed. Delayed openings and early released are determined by the schools administration. Please contact your YMCA branch for additional information.

I have read and understand all policies and procedures including but not limited to the items outlined above.

Parent/Guardian Signature *Date*

FOR YOUTH DEVELOPMENT
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Child Guidance and Discipline Policies: 2015-2016 School Year

It is YMCA procedure to use positive techniques of guidance with all children. Staff will set appropriate expectations and will have guidelines and environments that will minimize the need for discipline. Staff will be aware that all children are different and respond to different disciplinary techniques. The best results are achieved when parents and staff work together. Therefore, staff will communicate any behavior issues to parents promptly and be available for discussion.

Staff will be responsible for managing child behavior using techniques based on developmentally appropriate practice, including positive guidance, redirection, and setting clear limits that encourage children to develop self-control, self-discipline, and positive self-esteem.

The following are YMCA policies of positive guidance and discipline techniques:

1. Staff will divert attention away from any activity that they disapprove of by substituting another toy/game or leading the child to another activity.
2. Staff will offer children choices of activities/games they can participate in.
3. Staff will set limits for children that are consistently enforced and are based on reasons children can understand.
4. Children will be given warnings when they have done something wrong. Warnings are necessary to allow children to know in advance what to expect, reduce resistance and ease transitions.
5. Staff will structure the environment in such a way to help reduce misbehavior and accidents.
6. Staff will redirect behavior. It is necessary at times to move a child away from a behavior by suggesting an alternative acceptable behavior.
7. Staff will model appropriate behaviors for children.
8. Staff will be aware when a conflict between children arises. Staff will engage children in helping to solve the problem by analyzing the situation and all possible solutions, and working with the children to pick one they all agree as the best one.
9. Staff will separate children if they are having difficulty getting along.
10. Staff will remain objective when there is a problem with a child.
11. Staff will give children positive attention, and will engage children in behaving positively.
12. Staff will encourage children to behave positively and to continue to behave in appropriate ways.
13. Staff will explain the consequences of misbehavior to all children, and will continually remind students of the consequences.
14. No child will be physically restrained unless it is necessary to protect the health and safety of the child and others.
15. Site Directors and staff will discuss positive guidance techniques with parents, and will review these techniques as needed during the period of the child’s enrollment.

(Continued on next page)

Child Guidance and Discipline Policies: 2015-2016 School Year (continued)

16. If a child's behavior is determined by the Program Director and Executive Director to be a danger to the child, to other children or to the staff in a program, parents/guardians will be required to withdraw the child from the program.
17. Staff will report actual or suspected child abuse or neglect, or imminent risk of serious harm of any child to the Department of Children and Families as mandated by section 17a-101 to section 17a-101e inclusive, of the Connecticut General Statutes. Connecticut General Statutes identifies professionals who, because their work involves regular contact with children, are mandated by law to report suspected child abuse and neglect. All YMCA employees are considered Mandated Reporters by the State of CT. Mandated Reporters are required to report abuse or neglect based on a reasonable cause to suspect, such as what is observed, what is told or said.

I have read, understood, and discussed the Child Guidance and Discipline policies of the Tri-Town YMCA.

____

Parent/Guardian Signature Date

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of GREATER HARTFORD
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 "releasees") 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.
9. 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.
10. 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

Date: ________ Printed Name of Participant ____

Printed Name of Parent/Guardian ____

Signature of Participant or Parent/Guardian ____

FOR YOUTH DEVELOPMENT
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FOR SOCIAL RESPONSIBILITY

Child Development Electronic Payment Form

TERMS AND CONDITIONS

It is my complete understanding that if I terminate my child's enrollment I must submit a letter in writing canceling my Electronic Payment giving the YMCA **Two (2) week(s) written notice** prior to my child's withdrawal date. I understand that paying under the Electronic Payment method, I am subject to fee increases periodically by the Board of Directors, and the YMCA may adjust the monthly rate applicable to my child's enrollment category. I will be notified 30 days in advance of any increases. I understand that the monthly debit to my account is a continual draft for ten (10) months equal to the school calendar. Should any pre-authorized electronic payment not be honored by my financial institution when received, I agree that the payment is to be made by me in the amount of said payment, and I agree that I am responsible for that payment plus a service charge (contact your branch for current fees). This service charge does not include possible fees imposed by my financial institution. I understand that if two electronic payments are rejected my child's enrollment will be terminated.

I, the undersigned, have read and agree to the above Terms and Conditions.

Parent/guardian Signature ________________________ Date Signed ________________________

ELECTRONIC FUNDS TRANSFER (EFT) OR CREDIT CARD AUTHORIZATION

I authorize the YMCA of Greater Hartford to debit my account as indicated below on a monthly basis. Should any preauthorized EFT or Credit Card payment not be honored by my financial institution at the time of the draft, I understand and agree to the YMCA re-submitting, at their discretion, the request for payment.

CREDIT/DEBIT CARD

Card Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover Expiration Date: _______________

Name on Card (print) ______________________________ Card Number ______________________________

I agree the monthly payment amount debited will be $__________ and will draft on the 1st day of each month. My first draft will begin on ______________ (date).

Authorized Signature ______________________________ Date ____________________________________

EFT

Financial Institution Name & Address ____

Name on Account (print) _____________________ ☐ Checking Account ☐ Savings Account

Routing Number (9 digits) __ __ __ __ __ __ __ __ __ Account Number ____________________________

I agree the monthly payment amount debited will be $__________ and will draft on the 1st day of each month. My first draft will begin on ______________ (date).

Authorized Signature ______________________________ Date ____________________________________

Office Use Only: Deposit Payment $ ________ Receipt Number ___________
Form Entered by __________ Date Entered _____________
System Account # _________

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Child Care Payment Agreement

Child Name | Site/Program

Parent/Guardian Name | Address

Grade | Start Date

1. I understand and accept that a deposit of 20% of the first month's fee is required to secure a spot in the program. If proper notice is not given in writing regarding withdrawal, I am responsible for accruing fees until the YMCA is notified.

2. I understand and accept that my Child Care payment is due monthly for the month of service. For example, payments for the month of October are due October 1st. All payments must be made using an electronic draft OR balance must be current by the 1st of the month. Flexible payment plans can be set up as needed. See EFT form, page 9 of this packet. Overdue accounts will be assessed a late fee on the 8th of the month.

3. I understand and accept that School Age Child Care monthly fees are based on 180 days of school and are divided by 10 months (September-June); therefore, fees are not discounted or prorated for shortened weeks due to holiday, days off or inclement weather. I understand and accept that monthly fees are always the same and will not be credited or reduced due to snow days, vacation days and inclement weather closings and those fees will not be increased due to half days, delayed openings, and early dismissals.

4. I understand and accept that if my child is absent, regardless of days absent, I will still pay the regular monthly fee.

5. I understand and accept that failure to pay required monthly fees will prevent my child from further participation in any YMCA program.

6. I understand that and accept that I must pay my monthly fee by Automatic Payment (ATS). I understand I have the option to have my monthly payments drafted directly from my Checking or Savings Account or Credit or Debit Card. I will complete the Child Development ATS Authorization form and provide all necessary documentation including account numbers and/or a voided check.

7. I understand that and accept that YMCA Vacation Days and Snow Days that my child attends <u>are not</u> included in my monthly fee and that they are considered separate programs that will need to be registered and paid for separately.

8. I understand that my child will not be allowed to participate in the program until such time that I have provided completed and up to date Registration forms, Child Guidance and Discipline Policy, updated physical signed by your physician, and Special Health Care plans as needed.

9. I understand and accept that failure to comply with these terms may result in my child being unable to participate in the YMCA Child Care program.

10. I understand and accept that the morning programs will start at 7:00 AM (unless noted otherwise) and my child (ren) will not be able to be dropped off before this time and that if my child is picked up after 6:00 PM, I will be charged $1 for every minute after 6:00 pm and that the late pick-up fee will be due within five (5) business days.

Parent/Guardian Signature | Date

FOR YOUTH DEVELOPMENT
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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).

FOR YOUTH DEVELOPMENT
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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 ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ 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

HAR-3 REV. 4/2012

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

Part II — Medical Evaluation

HAR-3 REV. 4/2012

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			*Auditory Screening				Date
Type:	Right	Left	Type:	Right	Left	History of Lead level ≥ 5μg/dL ❑ No ❑ Yes	
With glasses	20/	20/		❑ Pass ❑ Fail	❑ Pass ❑ Fail	***HCT/HGB:**	
Without glasses	20/	20/				***Speech** (school entry only)	
❑ Referral made			❑ Referral made			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

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 ______

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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:**

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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!!

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

OTHER SIGNS OF AN ALLERGIC REACTION TO WATCH FOR:

Mouth—itching and swelling of the lips, tongue, or mouth

Throat**--itching and/or a sense of tightness in the throat, hoarseness, and hacking cough

Skin—hives, itchy rash, and/or swelling about the face or extremities

Gut—nausea, abdominal cramps, vomiting, and/or diarrhea

Lung**--shortness of breath, repetitive coughing, and/or wheezing

Heart**-- "thready" pulse, "passing out"

More reaction symptoms:

The severity of symptoms can change quickly.

**** All of the above symptoms can potentially progress to a life-threatening situation.**

Parent's Signature **Date**

Doctor's Signature **Date**

Staff Signature **Date**

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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:

If you see these symptoms DO THIS:

Major Symptoms:

If you see these symptoms DO THIS:

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Dietary/Nutritional Restrictions:

Communication:

Gross Motor:

Social-Emotional:

Sleep:

______________________	______________________
Parent Signature	**Date**
Doctor signature	**Date**
Staff Signature	**Date**