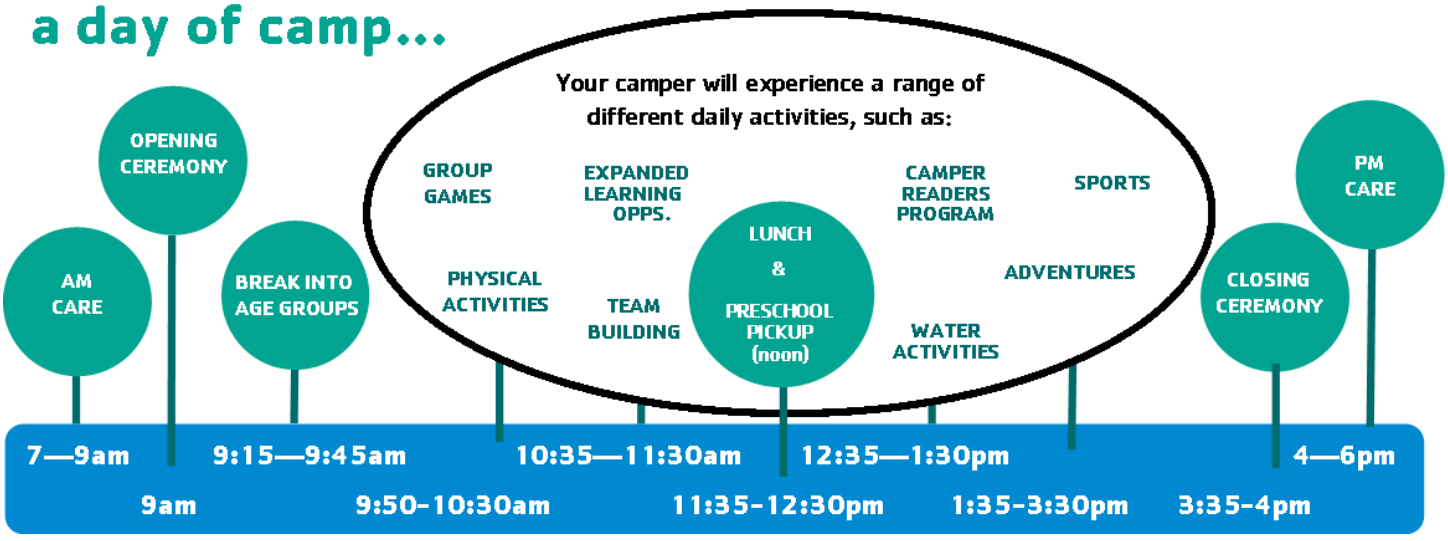
Camp Dakota

Summer 2020

ALONG WITH THESE GREAT HIGHLIGHTS
this is what you'll experience at

a day of camp...



CAMP DAKOTA LOCATIONS:

444 Albany Ave.
Hartford, CT 06112
June 15-19 & Aug. 17-21th

43 Vernon Street
Hartford, CT06106
June 22-Aug. 14th

REGISTRATION MADE EASY

keep this page for your records!

STEP one

REGISTRATION—In person, or Over the phone

- ☐ **Reserve your spot & pay a 20% deposit**
  *If you got our intro email, you've already done this!
- ☐ **If it applies, fill out a financial aid packet**
  Visit ***ghymca.org*** **for more information**
- ☐ **Make Your Payments**
- ☐ **$20 One –Time Registration fee** (This is not refundable)

PAYMENT SCHEDULE

SESSION DATE	DUE DATE
June Sessions	May 15 2020
July Sessions	June 15, 2020
August Sessions	July 15, 2020

Your child is not ready for camp until this packet is **100%** completed and submitted and your camp payments are made **on time.**

STEP two

COMPLETE ALL REQUIRED FORMS and MEDICAL FORMS

- ☐ **Camper Contact Information and Pick Up Authorization Form**
- ☐ **Waiver of Liability and Photo Release Agreement**
- ☐ **Sunscreen Authorization Form**
- ☐ **Youth Camp Health Exam/Record (3 pages)**
  Dated no later than September 1, 2018
- ☐ **Asthma Care Plan**
- ☐ **Allergy Care Plan**
- ☐ **General Medication Requirements**

If you don't have a copy of the medical forms, use the forms we've provided, or you can request them from your **school.** If you need to contact your **Dr.** for a copy dated no later than 9-1-2016, we advise that families reach out as soon as possible. If your child does not have asthma, allergies, or take medication, do not leave out those forms. Please check **"NONE"** on them and submit.

STEP three

SUBMIT ALL YOUR REQUIRED FORMS

WHERE TO SUBMIT YOUR FORMS:

WILSON-GRAY YMCA
444 Albany Ave.
Hartford, CT 06112

WAYS TO SUBMIT YOUR FORMS:

- ☐ **Send by Mail (send to address on left)**
- ☐ **Drop it off at the front desk at the YMCA**
- ☐ **Fax: (860) 293-2120**
- ☐ **Email: campdakota@ghymca.org**

STEP four

STAY TUNED!

OPEN HOUSES
FIND OUT MORE ABOUT CAMP!
When:
Friday, May 15th 5:30pm-7:30pm
Friday, June 5th 5:30pm-7:30pm
Where: 43 Vernon St. Hartford CT 06106

Look out for emails from Camp Director, Jeff Spadaccini, and pay special attention to your inbox for an **email the week prior to camp!**

Don't forget!
PREVIEW Week June 15th – June 19st

Where: 444 Albany Ave. Hartford CT 06112

REQUIRED FORM

CAMPER CONTACT INFORMATION and pick up authorization form

PLEASE PRINT CLEARLY

Each child that attends our summer camp is required by the State Department of Health to have this information on file.

Child's Name _____ Male _____ Female_____ D.O.B. ___/___/____Age _____
Home Address _____Town/City _____State _____Zip_____
Home Phone (___) _____School_____ Grade in September 2018_____
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 ( ) _____*Please * primary contact #*
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 ( ) _____*Please * primary contact #*
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 ( ) _____

Name_____Relationship to child_____
Home Phone ( ) _____ Work ( ) _____ Cell ( ) _____

CHILD PICK UP AUTHORIZATION Other than Legal Custodians
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. I also understand that payments not received in full by due dates will result in cancellation and deposit will be forfeited.

_____
Parent/ Guardian Signature Date

Wilson-Gray YMCA (Camp Dakota)
444 Albany Ave.
Hartford, CT06112

p: (860) 241-9622
f: (860) 293-2120
campdakota@*ghymca.org*

REQUIRED FORM

RELEASE/WAIVER OF LIABILITY/IDEMNITY and photo/talent release agreement

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 your family has more than one child attending camp, one Waiver of Liability Form will suffice.

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_____). Pictures are used to show you what they are doing!*

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 releases 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. **FIELD TRIP RELEASE**: I authorize the YMCA to take my camper on field trips.

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 Camper: _____

Signature of Participant or Parent/Guardian: _____

REQUIRED FORM

SUNSCREEN APPLICATION and authorization form

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.

Camper's 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. The sunscreen is always a concern for us. We want you to know that we are committed to making sure your child is safe from the sun. We strongly encourage you to your camper with **SPRAY ON SUNSCREEN**. We will assist all campers when reapplying sunscreen and educate them on remembering to do it as well. If sun exposure is ever a problem please notify a director immediately so that the extra precautions can be made.

☐ 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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AGES 3 AND UP HEALTH ASSESSMENT

fill out if your child is three or older

REQUIRED FORM

State of Connecticut Department of Education

Health Assessment Record

To Parent or Guardian:

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

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

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ 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. 4/2010

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

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ALL AGES HEALTH ASSESSMENT

fill out if your child is attending camp

REQUIRED FORM

HAR-3 REV. 4/2010

Part II — Medical Evaluation

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

Student Name _____ Birth Date _____ Date of Exam _____

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

Physical Exam

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

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

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

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

Screenings

***Vision Screening**

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

❑ Referral made

***Auditory Screening**

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

❑ Referral made

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

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

*IMMUNIZATIONS

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

***Chronic Disease Assessment:**

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

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

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

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

Seizures ❑ No ❑ Yes, type:

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

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

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

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

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

ALL AGES HEALTH ASSESSMENT

fill out if your child is attending camp

REQUIRED FORM

HAR-3 REV. 4/2010

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

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ASHTMA CARE PLAN

does your child have asthma?

CHECK ONE: If "yes" form must be signed by physician
If "no" only parent must sign

REQUIRED FORM

☐ YES
☐ NO

Camper's Name: _____ **Birthday:** _____

Typical signs and symptoms of the child's asthma episodes (check all that apply):

__ fatigue
__ flaring nostrils, mouth opens (panting)
__ dark circles under eyes
__ gray or blue lips or fingernails
__ persistent cough
__ difficulty playing, eating, drinking, talking
__ wheezing
__ restlessness/agitation
__ red face/pale or swollen
__ grunting
__ sucking in chest/neck
__ complains of chest pains/tightness
__ breathing faster
__ other:_____

Steps to take during an asthma episode:

1. Give medications as listed below:

Name of Medication	Amount	When to use
1.		
2.		
3.		
4.		

Medication Requirements: (check one)

1. _____ No medication required while attending Camp. Physician initials required: _____
2. _____ Medication required at camp (Bring original prescription to first day of camp, label clearly showing camper's name, birthday, and expiration date)

**Special Instructions _____

_____

2. Observe for decreased symptoms
3. Contact Parent/Guardian if emergency medication is required
4. Call 911 if:

After receiving treatment, you observe the child:

- o Is working hard to breathe or
- o grunting
- o Is breathing fast at rest (>50/min)
- o Has trouble walking or talking
- o Has nostrils open wider than usual
- o Is extremely agitated or sleepy
- o Has sucking in of the skin (chest/neck) with breathing
- o Won't play
- o Has gray or blue lips/finger nails
- o Cries more softly and briefly
- o Is hunched over to breathe

Physician's name: _____

Physician's signature: _____

Phone number: (____) - _____ Date: _____

Parent's Signature: _____ **Date:** _____

Camp Director: _____ Date: _____

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ALLERGY CARE PLAN

does your child have any allergy?

CHECK ONE: If "yes" form must be signed by physician
If "no" only parent must sign

REQUIRED FORM

☐ YES
☐ NO

Campers Name: _____ **Birth Date:** _____

Camper is Allergic to: _____

Steps to take during an allergy episode:

1. SIGNS OF AN ALLERGIC REACTION: (please check the following)

- ☐ **Mouth/Throat:** itching & swelling of tongue, mouth, throat, throat tightness, hoarseness or cough
- ☐ **Skin:** hives, itchy rash, or swelling
- ☐ **Gut:** nausea, abdominal cramps, vomiting, diarrhea
- ☐ **Lung:** shortness of breath, coughing, wheezing
- ☐ **Heart:** pulse is hard to detect, "passing out"

ACTION FOR MINOR REACTION:
If only symptom (s) are:_____, give_____

Then call: Parent/Guardian_____ Phone#_____

Action Steps for Major Reaction:
1. If symptom (s) are:

_____

_____

2. Give_____
3. Call 911
4. Call Parent/Guardian:_____ Phone#:_____
5. If Parent/ Guardian are unreachable, contact Emergency Contacts

Medication Requirements: (check one)
1. _____ No medication required while attending Camp. Physician initials required: _____
2. _____ Medication required at camp (Bring original prescription to first day of camp, label clearly showing camper's name, birthday, and expiration date)

Physician's Name: _____

Physician's Signature: _____

Phone number: (_____) - _____ Date: _____

Parent's Signature: _____ **Date:** _____

Camp Director: _____ Date: _____

First- Aid Director: _____ Date: _____

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REQUIRED FORM

GENERAL INDIVIDUAL CARE PLAN

will your child take any meds at camp?

CHECK ONE: If "yes" form must be signed by physician
If "no" only parent must sign

☐ YES
☐ NO

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:

Physician's Name: _____

Physician's Signature: _____

Phone number: (____) - _____ Date: _____

Parent's Signature: _____ **Date:** _____

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MEDICATION AUTHORIZATION

will your child take any meds at camp?

CHECK ONE: If "yes" form must be signed by physician
If "no" only parent must sign

REQUIRED FORM

☐ YES
☐ NO

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: _____

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 with the exception of emergency medications 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 or electronic) _____

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

Wilson-Gray YMCA (Camp Dakota)
444 Albany Ave.
Hartford, CT06112

p: (860) 241-9622
f: (860) 293-2120
campdakota@*ghymca.org*

2020 Registration Form

Session	Dates	Summer Day Camp	Pre-Camp Am Only	Post– Camp PM Only	Pre& Post AM& PM	Pre-K Ages 3-4 Fees	Traditional Ages 5-12
Session 1 Preview week	6/15-6/22	☐	☐	☐	☐	$ 225	$ 220
Session 2 Aloha Week	6/22-6/26	☐	☐	☐	☐	$ 225	$ 220
Session 3 Holiday Week	6/29-7/3	☐	☐	☐	☐	$ 180	$176
Session 4 Sport Week	7/6-7/10	☐	☐	☐	☐	$225	$ 220
Session 5 Water Week	7/13-7/17	☐	☐	☐	☐	$ 225	$220
Session 6 Science Week	7/20-7/24	☐	☐	☐	☐	$ 225	$220
Session 7 Carnival Week	7/27-7/31	☐	☐	☐	☐	$ 225	$220
Session 8 Y-Tube Week	8/3-8/7	☐	☐	☐	☐	$225	$220
Session 9 Nature Week	8/10-8/14	☐	☐	☐	☐	$225	$220
Session 10 Multi-cultural	8/17-8/21	☐	☐	☐	☐	$225	$220

☐ Bus Transportation needed From Wilson– Gray To learning Corridor For 8am Total :_____

☐ Bus Transportation needed From the Learning Corridor back to Wilson-Gray YMCA for 4:30pm.

☐ Bus Transportation needed for both Am and Pm

Payment Information

Total Session Fees: $_____

Total Deposit Due: $_____

(Deposit is 20% of each session's Total Fee)

Less YMCA Credit: $ _____

(attach credit Slip)

Method of payment (circle one)

Cash Personal Check Visa Mastercard Discover Amex

Credit Card #_____

Exp. Date:_____ Security Code:_____

Signature: _____

Date:_____ Total Fee Paid: $_____

I authorize the YMCA of Greater Hartford to debit my account. Should any preauthorize 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.

_____ _____

Parent/Guardian Signature Date

THANK YOU FOR CHOOSING CAMP Dakota

We know it takes a lot of paperwork to ensure the safety of your children during summer camp, but thanks for sticking with it. Now you can take a deep breath…

CONGRATS!

you've completed the registration packet!

We can't wait to see you at Camp Dakota

Remember to make sure to <u>submit this packet.</u>

If at any time you'd like to speak with us, or if you need any information, please contact our main office at (860) 241-9622 or email **campdakota@ghymca.org**.

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