Glastonbury Family YMCA

CAMP GLAWACKUS, CAMP LIGER and SPECIALTY CAMPS

REGISTRATION PACKET

CAMP LOCATION

30 High Street
South Glastonbury, CT 06073
860-541-1812

REGISTRATION MADE EASY

Keep this page for your records!

STEP one

REGISTRATION Done online, In person, or Over the phone

- ☐ Reserve your spot and pay a 20% deposit
  Swim lessons must be paid in full.
- ☐ If it applies, fill out a financial aid packet
  Visit ***ghymca.org*** for more information
- ☐ Make Your Payments

PAYMENT SCHEDULE

20% DEPOSIT IS DUE UPON REGISTRATION
PAYMENT IN FULL IS DUE NO LATER THAN THE WEDNESDAY PRIOR TO THE FIRST DAY OF THE SESSION.

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
- ☐ Registration Form.
- ☐ Waiver of Liability and Photo Release Agreement
- ☐ Sunscreen Authorization Form
- ☐ Youth Camp Health Exam/Record (3 pages)
  Dated no later than August 24, 2018
- ☐ Asthma Care Plan
- ☐ Allergy Care Plan
- ☐ General Medication Requirements

For your convenience, the forms can be found in this packet. If you need to contact your **DOCTOR** for a form, dated **ON OR AFTER August 24, 2018,** 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:

Glastonbury Family YMCA
95 Oakwood Drive
Glastonbury, CT 06033

WAYS TO SUBMIT YOUR FORMS:

- ☐ Snail Mail (send to address on left)
- ☐ Drop it off at the front desk at the YMCA
- ☐ Fax: (860) 659-330 (Please confirm your fax!)
- ☐ Email: linda.mendelsohn@ghymca.org

STEP four

STAY TUNED!

Family Nights
When: June 27: 5:30 7:00 p.m.
August 1 5:30 7:00 p.m.
Where: J. B. Williams Park
Neipsic Road, Glastonbury, CT 06033

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

CAMPER CONTACT INFORMATION

REQUIRED FORM

pick up authorization form

Please inform us of your approximate drop off time so that we can staff accordingly______am

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______________________________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 ________________*Please * primary contact* Cell Phone ________________*Please * primary contact*

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 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):

____

REQUIRED FORM

2019 REGISTRATION FORM

	Glawackus K - Grade 5	Liger Grades 6-8	Leaders In Training Ages 14-15	High Street After Care	Ingersoll Before Care	Ingersoll After Care	Swim Lessons 2 week sessions
Session 1 June 17-21	☐ $240	☐ $245	☐ $220	☐ $68	☐ $57	☐ $74	☐ $56
Session 2 June 24-28	☐ $240	☐ $245	☐ $220	☐ $68	☐ $57	☐ $74	
Session 3 July 1-5	☐ $190	☐ $180	☐ $168	☐ $55	☐ $46	☐ $60	☐ $56
Session 4 July 8-12	☐ $240	☐ $245	☐ $220	☐ $68	☐ $57	☐ $74	
Session 5 July 15-19	☐ $240	☐ $245	☐ $220	☐ $68	☐ $57	☐ $74	☐ $56
Session 6 July 22-26	☐ $240	☐ $245	☐ $220	☐ $68	☐ $57	☐ $74	
Session 7 July 29-Aug 2	☐ $240	☐ $245	☐ $220	☐ $68	☐ $57	☐ $74	Lessons Not Offered
Session 8 August 5-9	☐ $240	☐ $245	☐ $220	☐ $68	☐ $57	☐ $74	Lessons Not Offered
Session 9 August 13-17	☐ $240	☐ $245	☐ $220	☐ $68	☐ $57	☐ $74	Lessons Not Offered
Session 10 August 20-24	☐ $240	☐ $245	☐ $220	☐ $68	☐ $57	☐ $74	Lessons Not Offered

	Girl Power Grades 3-5	Daring Camp for Boys Grades 3-5	Teen Empowerment Grades 6-8	Lego Camp Grades 1-4	Excursion Camp Grades 5-8	Daring Camp Grades 3-5	Adventure Camp Grades 5-8
Session 2 June 25-29	☐ $320	☐ $320					
Session 3 July 2-6							
Session 4 July 9-13			☐ $320				
Session 5 July 16-20				☐ $320			
Session 6 July 23-27					☐ $360		
Session 7 July 30-Aug 3						☐ $320	
Session 8 August 6-10							
Session 9 August 13-17							☐ $360

Camp Hours – 7:00am – 3:30pm
Please inform us of your approximate drop off time so that we can staff accordingly __________am
After Care Hours – 3:30pm – 6:00pm

Glastonbury Family YMCA
95 Oakwood Drive
Glastonbury, CT 06033

p: (860) 633-6548
f: (860) 659-3301
ghymca.org/glastonbury

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: ____

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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Glastonbury, CT 06033

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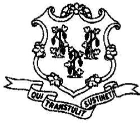
AGES 3 AND UP HEALTH ASSESSMENT

fill out if your child is three or older



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

AGES 5 & UP

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

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			***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	Lead:	
With glasses	20/	20/		❏ Pass ❏ Fail	❏ Pass ❏ Fail	***HCT/HGB:**	
Without glasses	20/	20/					
❏ 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

ALL AGES HEALTH ASSESSMENT

REQUIRED FORM

Please complete if your child is attending camp

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

ASHTMA CARE PLAN

Does your child have asthma?

CHECK ONE: If "yes" form must be signed by physician

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:

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

Physician's name: ____

Physician's signature: ____

Phone number: (_____) - ____________________ Date: _____________________

Parent's Signature: ____ **Date:** ____________________

Camp Director: ____ Date: __________________

ALLERGY CARE PLAN

Does your child have any allergy?

CHECK ONE: If "yes" form must be signed by physician

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: ________________

Glastonbury Family YMCA
95 Oakwood Dr
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p: (860) 633-6548
f: (860) 659-3301
ghymca.org/glastonbury

REQUIRED FORM

GENERAL INDIVIDUAL CARE PLAN

Will your child take any meds at camp?

CHECK ONE: If "yes" form must be signed by physician

☐ 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: ______________________________

MEDICATION AUTHORIZATION

Will your child take any meds at camp?

CHECK ONE: If "yes" form must be signed by physician

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

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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.)

THANK YOU FOR CHOOSING

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!

Remember to make sure to submit this packet.

If at any time you'd like to speak with us, or if you need any information, please contact our main office at (860) 633-6548 or email **Betsey.pitt@ghymca.org**.