



YOUR GUIDE TO  
**SUMMER CAMP**  
AT THE  
**YMCA OF GREATER HARTFORD**



[GHYMCA.org/Camping](http://GHYMCA.org/Camping)

# GENERAL CAMPING INFO

## How to register:

- Online at GHYMCA.org/camp for day camps, or GHYMCA.org/overnightcamp for overnight camps
- Over the phone: Use the number for the main office of the branch running the camp your child will be attending
- In person: Visit any YMCA of Greater Hartford branch

## Summer Camp Registration and Payments:

- A non-refundable deposit per a week is due at the time of registration to reserve your week(s). Deposits will go toward the total payment of the camp week.
- The balance of camp fees is due by the Wednesday before the week your child starts camp.

## Payment Options:

- **Pay in full:** Families can pay off the entire balance at the time of registration if they choose.
- **Payment Plan:** Using an EFT system, the YMCA will charge your account in equal payments over a set period of time. All payments for each session must be paid in full by the Wednesday before the week your child starts camp.
- **Invoices:** The YMCA of Greater Hartford will invoice you May 5, June 5, and July 5 for summer sessions.

## Registration Fee:

There is a one-time \$20 fee per camper to support general operations of the registration process. The registration fee is non-refundable and is paid one time during the summer upon initial registration.

## Well-Trained Staff:

At the YMCA of Greater Hartford, your camper's welfare is the number-one priority. The staff members are trained to understand the varying needs of children. In order to provide safe, quality experiences for children, the screening, training, and supervising of the staff is imperative. The team of directors works closely with applicants to ensure that camp has quality individuals who demonstrate a mature attitude, sound judgment and an ability to relate well to children. Upon joining our team, staff members receive comprehensive, on-site training, which includes certifications in first aid, CPR, and basic water safety.

## High Standards:

The safety of each camper is our primary concern. The Greater Hartford YMCA camps meet the 300 standards-of-excellence of the American Camp Association, as well as all state licensing standards. Make sure you ask your camp about the ACA standards and what they are!

## Quality Programs:

The YMCA of Greater Hartford has over 60 years of experience providing fun, safe camping programs that teach leadership, team-building, and sportsmanship. Each week your child will be encouraged to learn new skills and try new activities. The possibilities of fun and adventure are endless with each camp's property designed and programmed to meet your campers needs. Through programs and modeling, children come to a better understanding of the core values of the YMCA: Caring, Honesty, Respect, and Responsibility.



## Age Group Ratios:

In accordance with State of Connecticut policy, as well as the American Camping Association Accreditation, all YMCA of Greater Hartford camps strive to maintain the best staff-to-camper ratio possible. It is important to mention that ratios are typically smaller at the waterfronts, as well as when we take field trips or leave camp for any reason.

Age	Camper-to-Staff Ratio
4-5	6-1
6-8	8-1
9-15	12-1

# CAMP WHEELER, Plainville, CT

Day Camp at the Wheeler Regional Family YMCA

Serving: Avon, Bristol, Farmington, Plainville

For ages 3-15

Camp at the Wheeler Regional Family YMCA in Plainville is where ALL the fun happens! Our branch offers a beautiful outdoor play space, Gaga and basketball court, wooded area, and more, in addition to all the comforts of a full-facility branch, such as a pool, gymnasium, and indoor play rooms. Campers will swim, play archery, sports, Gaga, arts and crafts and have fun while making friends.

		Session 1 6/17-6/21	Session 2 6/24-6/28	Session 3 7/1-7/5	Session 4 7/8-7/12	Session 5 7/15-7/19	Session 6 7/22-7/26	Session 7 7/28-8/2	Session 8 8/5-8/9	Session 9 8/12-8/16	Session 10 8/19-8/23
	Theme	Preview Week	Aloha Week	Holiday Week	Color Games	Back to the Future	Adventure Camp	Gaming-a-Palooza	Survivor Week	Y-Tube	Camp Favorites
	Hours* for full day camps	9am-4pm	9am-4pm	9am-4pm	9am-4pm	9am-4pm	9am-4pm	9am-4pm	9am-4pm	9am-4pm	9am-4pm
<b>Traditional Camp (grades K-8)</b>	Price	\$250	\$250	\$230	\$250	\$250	\$250	\$250	\$250	\$250	\$250
<b>Specialty Camps (varies based on camp)</b>	Type	Jedi Camp	Swim Camp	Girl Power	Gymnastics/Cheer/Dance	Music & Theater	Builders Club	Gymnastics/Cheer/Dance	Animal Planet		
	Price	\$285	\$230	\$285	\$285	\$285	\$285	\$285	\$285		
	Type	Myth Busters		All Sports	Jedi Camp	Spy Kids	Music & Theater	Myth Busters	All Sports		
	Price	\$285		\$285	\$285	\$285	\$285	\$285	\$285		
<b>Teen Camp</b>	Theme	Game Day Challenge	Construction Camp	Challenger Camp	Young Chefs	Destination Fun	Film & Photo Camp	Advanced Art Camp	Bakery Boss		
	Price	\$330	\$305	\$330	\$330	\$330	\$330	\$330	\$330		
<b>Leadership Camp (CITs) (grade 9)</b>	Price	\$400		\$400		\$400		\$400		\$400	
<b>Preschool Camp 1/2 Day (age 3)</b>	Hours	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm
	Price	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
<b>Preschool Camp 1/2 Day (age 4)</b>	Hours	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm	9am-12pm
	Price	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150
<b>Preschool Camp Full Day (age 4)</b>	Price	\$300	\$300	\$240	\$300	\$300	\$300	\$300	\$300	\$300	\$300

\*No camp on July 4

## Specialty Camps:

- Jedi Camp:** While traveling to a galaxy far, far away campers will learn the way of the force, light-saber battling, and mysteries of the Empire.
- Girl Power:** Join us for an all-girl summer adventure. Led by female staff, this camp will focus on building confident young ladies who will learn about female leadership and develop "girls can do anything" attitudes. This camp will build friendships that will last a lifetime!
- Gymnastics/Cheer/Dance:** Campers will focus on three events, including beam, vault, and floor. This action-packed week will also include cheer and dance formations, and building skills. Campers will organize an exhibition for the entire camp and a parent show on Friday!
- Music/Theater:** Write, direct, produce! Campers put together their own production while learning about acting and working behind the scenes.
- Builders Club:** Campers will spend the week exploring different mediums of fort building.
- Animal Planet:** Learn about your favorite animals! Campers investigate where animals live, sounds they make, foods they eat and more. Creativity and imagination are needed as you go on an animal safari.
- Myth Busters Camp:** Ever wonder why Mentos make soda explode, or whether you can cook an egg on the black top? Come to our fun, science-led week of discovery.
- All Sports:** Ready to fulfill your dreams of playing in front of cheering fans? Campers will be taught the necessary skills in a new sport every day! Campers will focus on having fun playing the games, sportsmanship and what it means to be a part of a team!
- Spy Kids Camp:** Campers will break secret codes, solve puzzles, discover invisible messages, and develop detective skills in a race to solve the many mysteries of camp!

\*Before and after camp is available starting at 7am and ending at 6pm.



# REGISTRATION MADE EASY

## keep this page for your records!

### STEP one

#### REGISTRATION—Done In person or over the phone

- Reserve your spot & pay a \$50 deposit per week per child  
\*\$20 registration fee per child is due at registration.
- If it applies, fill out a financial aid packet  
Visit [ghymca.org/wheelerymca](http://ghymca.org/wheelerymca) for more information
- Make/schedule your Payments

#### PAYMENT SCHEDULE

**EACH CAMP WEEK IS TO BE PAID IN FULL THE WEDNESDAY BEFORE THE CAMP WEEK BEGINS**

Your child is not ready for camp until this packet is 100% completed and submitted and your camp payments are scheduled.

### STEP two

#### COMPLETE ALL REQUIRED FORMS and MEDICAL FORMS

- Camper Contact Information and Pick Up Authorization Form
- Youth Camp Health Exam/Record (3 pages)  
Dated no later than September 1, 2016
- Waiver of Liability and Photo Release Agreement
- Asthma Care Plan
- Sunscreen Authorization Form
- 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 doctor for a copy dated no later than 9-1-2017, 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

### STEP three

#### SUBMIT ALL YOUR REQUIRED FORMS

##### WHERE TO SUBMIT YOUR FORMS:

WHEELER REGIONAL FAMILY YMCA  
149 FARMINGTON AVE  
PLAINVILLE CT, 06062

##### WAYS TO SUBMIT YOUR FORMS:

- Snail Mail (send to address on left)
- Drop it off at the front desk at the Wheeler YMCA
- Fax: (860) 793-2092 (Please confirm your fax!)
- Email: [kelly.houston@ghymca.org](mailto:kelly.houston@ghymca.org)

### STEP four

#### STAY TUNED!

#### open houses

#### FIND OUT MORE ABOUT CAMP!

When: Friday, May 31  
Friday, June 7

##### MORE INFORMATION T

Where: Wheeler Regional Family YMCA  
149 Farmington Ave. Plainville, CT 06062

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



Child's Name: \_\_\_\_\_

# PLEASE SELECT CAMP OPTIONS

Week	Preschool Camp Ages 3-4 HALF DAY 9-12	Preschool Camp Age 4 FULL DAY	Traditional Camp Grades K-5	Specialty Camp Grades 1-5	Teen Camp Grades 6-8	CIT Grades 9-10 2 week sessions	Total Each Week
Week 1 6/17-6/21	<input type="checkbox"/> \$150	<input type="checkbox"/> \$300	\$65 Per Day <input type="checkbox"/> Fri 6/14 <input type="checkbox"/> Mon 6/17 <input type="checkbox"/> Tues 6/18 <input type="checkbox"/> Wed 6/19 <input type="checkbox"/> Thurs 6/20 <input type="checkbox"/> Fri 6/21	N/A	N/A	<input type="checkbox"/> \$400	\$ _____
Week 2 6/24-6/28	<input type="checkbox"/> \$150	<input type="checkbox"/> \$300	<input type="checkbox"/> \$250	<input type="checkbox"/> \$285 Jedi <input type="checkbox"/> \$285 Myth Busters	<input type="checkbox"/> \$330		\$ _____
Week 3 7/1-7/5	<input type="checkbox"/> \$150	<input type="checkbox"/> \$240	<input type="checkbox"/> \$230	<input type="checkbox"/> \$230 Swim Camp	<input type="checkbox"/> \$305	<input type="checkbox"/> \$400	\$ _____
Week 4 7/8-7/12	<input type="checkbox"/> \$150	<input type="checkbox"/> \$300	<input type="checkbox"/> \$250	<input type="checkbox"/> \$285 All Sports <input type="checkbox"/> \$285 Girl Power	<input type="checkbox"/> \$330		\$ _____
Week 5 7/15-7/19	<input type="checkbox"/> \$150	<input type="checkbox"/> \$300	<input type="checkbox"/> \$250	<input type="checkbox"/> \$285 Gym/Cheer/Dance <input type="checkbox"/> \$285 Jedi	<input type="checkbox"/> \$330	<input type="checkbox"/> \$400	\$ _____
Week 6 7/22-7/26	<input type="checkbox"/> \$150	<input type="checkbox"/> \$300	<input type="checkbox"/> \$250	<input type="checkbox"/> \$285 Music & Theater <input type="checkbox"/> \$285 Spy Kids	<input type="checkbox"/> \$330		\$ _____
Week 7 7/29-8/2	<input type="checkbox"/> \$150	<input type="checkbox"/> \$300	<input type="checkbox"/> \$250	<input type="checkbox"/> \$285 Music & Theater <input type="checkbox"/> \$285 Builders Club	<input type="checkbox"/> \$330	<input type="checkbox"/> \$400	\$ _____
Week 8 8/5-8/9	<input type="checkbox"/> \$150	<input type="checkbox"/> \$300	<input type="checkbox"/> \$250	<input type="checkbox"/> \$285 Gym/Cheer/Dance <input type="checkbox"/> \$285 Myth Busters	<input type="checkbox"/> \$330		\$ _____
Week 9 8/12-8/16	<input type="checkbox"/> \$150	<input type="checkbox"/> \$300	<input type="checkbox"/> \$250	<input type="checkbox"/> \$285 All Sports <input type="checkbox"/> \$285 Animal Planet	<input type="checkbox"/> \$330	<input type="checkbox"/> \$400	\$ _____
Week 10 8/19-8/23	<input type="checkbox"/> \$150	<input type="checkbox"/> \$300	<input type="checkbox"/> \$250	N/A	N/A		\$ _____
Registration							\$ 20
GRAND TOTAL							\$ _____

**I have agreed to select the following options for camp for my child. I understand that a nonrefundable \$50 deposit will be required upon registration for each week enrolled, and the remainder of the balance will be scheduled and drafted from a checking/savings account or credit/debit card on the Wednesday before each camp week begins. Cancellations to camp weeks less than one (1) week in advance are nonrefundable.**

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_



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 2017 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

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 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).

BILLING PARTY INFORMATION PLEASE PRINT CLEARLY

Billing Name Address Home Phone Place of Work Child's Name Town State Zip Work Phone

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

Parent/ Guardian Signature Date



# 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:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<p>Reviewed by:</p> <p>Name of staff (print): _____ Date: _____</p> <p>Signature of Staff: _____</p>
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**AGES 5 AND UP HEALTH ASSESSMENT**  
**fill out if your child is five years 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)			
Parent/Guardian Name (Last, First, Middle)		Home Phone	Cell Phone
School/Grade	Race/Ethnicity <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other		
Primary Care Provider			
Health Insurance Company/Number* or Medicaid/Number*			
Does your child have health insurance? Y N		If your child does not have health insurance, call 1-877-CT-HUSKY	
Does your child have dental insurance? Y N			

\* If applicable

**Part I — To be completed by parent/guardian.**

**Please answer these health history questions about your child before the physical examination.**

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y N	Hospitalization or Emergency Room visit	Y N	Concussion	Y N
Allergies to food or bee stings	Y N	Any broken bones or dislocations	Y N	Fainting or blacking out	Y N
Allergies to medication	Y N	Any muscle or joint injuries	Y N	Chest pain	Y N
Any other allergies	Y N	Any neck or back injuries	Y N	Heart problems	Y N
Any daily medications	Y N	Problems running	Y N	High blood pressure	Y N
Any problems with vision	Y N	"Mono" (past 1 year)	Y N	Bleeding more than expected	Y N
Uses contacts or glasses	Y N	Has only 1 kidney or testicle	Y N	Problems breathing or coughing	Y N
Any problems hearing	Y N	Excessive weight gain/loss	Y N	Any smoking	Y N
Any problems with speech	Y N	Dental braces, caps, or bridges	Y N	Asthma treatment (past 3 years)	Y N
<b>Family History</b>				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
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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**

**Part II — Medical Evaluation**

HAR-3 REV. 4/2010

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

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date of Exam \_\_\_\_\_

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

**Physical Exam**

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

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

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

**Screenings**

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

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

**\*IMMUNIZATIONS**

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

**\*Chronic Disease Assessment:**

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

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

**Allergies** *If yes, please provide a copy of the Emergency Allergy Plan to School*

History of Anaphylaxis  No  Yes Epi Pen required  No  Yes

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

**Seizures**  No  Yes, type: \_\_\_\_\_

This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.

*Explain:* \_\_\_\_\_

Daily Medications (*specify*): \_\_\_\_\_

This student may:  **participate fully in the school program**

participate in the school program with the following restriction/adaptation: \_\_\_\_\_

This student may:  **participate fully in athletic activities and competitive sports**

participate in athletic activities and competitive sports with the following restriction/adaptation: \_\_\_\_\_

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

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped <b>Provider</b> Name and Phone Number
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**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 <i>Provider</i> Name and Phone Number
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# ASTHMA CARE PLAN

## does your child have asthma?

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

REQUIRED FORM

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Camper's Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

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

- |  |   |
|--|---|
| <input type="checkbox"/> fatigue                                       | <input type="checkbox"/> restlessness/agitation             |
| <input type="checkbox"/> flaring nostrils, mouth opens (panting)       | <input type="checkbox"/> red face/pale or swollen           |
| <input type="checkbox"/> dark circles under eyes                       | <input type="checkbox"/> grunting                           |
| <input type="checkbox"/> gray or blue lips or fingernails              | <input type="checkbox"/> sucking in chest/neck              |
| <input type="checkbox"/> persistent cough                              | <input type="checkbox"/> complains of chest pains/tightness |
| <input type="checkbox"/> difficulty playing, eating, drinking, talking | <input type="checkbox"/> breathing faster                   |
| <input type="checkbox"/> wheezing                                      | <input type="checkbox"/> 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)**

- No medication required while attending Camp. Physician initials required: \_\_\_\_\_
- 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:

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

REQUIRED FORM

<input type="checkbox"/>	YES
<input type="checkbox"/>	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: _____



**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

REQUIRED FORM

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  
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.)**