FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CAMP YANKEE TRAILS & INDIAN VALLEY REGISTRATION PACKET

Registration Instructions:

INITIAL REGISTRATION: In order to be added to a camp roster, simply…

- ☐ Turn in the completed registration packet. This includes:
  - ☐ Camper Registration Form
  - ☐ Financial Assistance & Care 4 Kids Paperwork (If necessary)
  - ☐ Pick-Up Authorization Form
  - ☐ Release/Waiver Form
  - ☐ Sunscreen Application Authorization
  - ☐ Health Assessment – Completed by Parent
  - ☐ Immunization Record and Physical within last 18 months OR Medical Evaluation – Completed by Physician
  - ☐ Related Medical Care Plans – Completed by physician (If necessary)
  - ☐ Medication Authorization (If necessary)
- ☐ Pay $50 deposit per week to hold your spot and a $20 one-time registration fee

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

ADDING ADDITIONAL SESSIONS: Once you've turned in your paperwork, adding is easy!

- ☐ Call: 860-871-0008
  E-Mail: Greg.Baker@GHYMCA.org
  Register online: www.ghymca.org
  Come in to the Y: 11 Pinney St, Ellington
- ☐ Pay $50 deposit per week to hold your spot.

Important Deadlines:

Session Dates	Financial Assistance & Care4Kids Deadline In order to apply for FA or Care 4 Kids, we ask for your paperwork to be completed **Four Wednesdays Prior to Session Start Date**	Pay-in-Full & Registration Deadline In order to register for a session of camp and be included on the roster, we require complete registration paperwork and payment by the **Wednesday Prior to Session Start Date**
June 24-28	5/29/2019	6/19/2019
July 1-5	6/5/2019	6/26/2019
July 8-12	6/12/2019	7/3/2019
July 15-19	6/19/2019	7/10/2019
July 22-26	6/26/2019	7/17/2019
July 29–Aug 2	7/3/2019	7/24/2019
Aug 5-9	7/10/2019	7/31/2019
Aug 12-16	7/17/2019	8/7/2019
Aug 19-23	7/24/2019	8/14/2019

INDIAN VALLEY & YANKEE TRAILS

Camper Registration Form

*This packet must be completed and returned to the YMCA before your camper will be added to a roster. This includes doctor's signatures on pages if necessary as well as immunization records and physical within last 18 months.

Camper Name: _____ Birthdate: __/__/__

Grade next school year: ____ Email: _____

Check off the sessions for which you'd like to register. A $50 deposit is due for all sessions at time of registration.

Camp Indian Valley

11 Pinney Street, Ellington
AM Care starting 7AM | PM Care until 6PM

Traditional (Gr. K-8)	Specialty (Various ages)	Sports (Gr. 3-8)	Preschool 1/2 Day (Ages 3 & 4)	Dates
$225	$245	$245	$110	
☐ Spirit Week	☐ Farm Camp (Gr. 2-6)	☐ Basketball	☐ Farm Week	June 24-28
☐ Strange Holiday Week	☐ Nature Camp (Gr. 2-6)	☐ Baseball	☐ Holiday Week	July 1-5*
☐ Time Travel	☐ Survivor (Gr. 3-8)	☐ Soccer	☐ Dinosaur Week	July 8-12
☐ Around the World	☐ Make-a-Diff. Camp (Gr. 3-8)	☐ Flag Football	☐ Nature Week	July 15-19
☐ Cinema Classico	☐ Girl Power (Gr.3-8)	☐ Basketball	☐ Mini Mad Scientists	July 22-26
☐ Mystery Week	☐ Archery Week (Gr. 3-6)	☐ Baseball	☐ Earth Week	July 29 -Aug 2
☐ Wet & Wild Week	☐ Drama Perf. (Gr. 2-8)	☐ Flag Football	☐ Galaxy Week	Aug 5-9
☐ Color Games	☐ Arts Week (Gr. K-6)	☐ Soccer	☐ Stay Safe Week	Aug 12-16
☐ Camp Favorites			☐ Ocean Animal Week	Aug 19-23

Camp Yankee Trails

343 Plains Road, Tolland, just 5 Minutes from Stafford Springs
Busing from Ellington, Vernon, Rockville, Tolland, Somers, Stafford, Enfield

Traditional (Gr. K-8) 2-week	Traditional (Gr. K-8) 1-week	Specialty Opt. 1 (Gr. 3-8)	Specialty Opt. 2 (Gr. 3-8)
$520	$280	$560	$560
☐ Sess. 1	☐ 1A ☐ 1B	☐ Outdoor Sports W1: Boating W2: Fishing	
☐ Sess. 2	☐ 2A ☐ 2B	☐ Survival Skills W1: Outdoor Cooking W2: Wilderness Survival	☐ Arts Camp W1: Wacky Arts W2: Drama Performance
☐ Sess. 3	☐ 3A ☐ 3B	☐ Sports Camp W1: Soccer W2: Flag Football	☐ Nature Camp W1: Nature Exploration W2: Outdoor Cooking
☐ Sess. 4	☐ 4A ☐ 4B	☐ Outdoor Sports W1: Boating W2: Archery	

*All camp prices are discounted the week of July 4th to account for the holiday.

Will you need extended care at the Indian Valley YMCA?

AM Care	PM Care	No extended care needed
7:00AM-9:00AM	4:00PM-6:00PM	Regular Camp Hours
☐	☐	☐

*For Yankee Trails campers, AM and PM care are available for those who are signed up for bus 1-A from the Indian Valley YMCA

Buddy Request:
We understand that it is important for campers to be with close friends, some of whom they do not see all year. List your buddy requests and we will do our best to meet them. However, requests are not guaranteed.

_____

Select your bus stop (Yankee Trails campers only)

Bus#	Town	Stop	AM Depart	Check one	PM Return	Check one
1-A**	Ellington**	Indian Valley YMCA**	8:15	☐	4:50	☐
1-B	Ellington	Subway, West Rd	8:23	☐	4:39	☐
1-C	Somers	Somers Senior Center	8:38	☐	4:22	☐
2-A	Vernon	375 Hartford Tpke	8:25	☐	4:38	☐
2-B	Rockville	Rockville Park & Ride	8:33	☐	4:29	☐
2-C	Tolland	Big Y	8:44	☐	4:16	☐
3-A*	Enfield*	Brookside Plaza*	8:22	☐	4:37	☐
3-B	Stafford	CVS	8:50	☐	4:10	☐
Parent Pickup/Drop off		Camp Yankee Trails	8:45	☐	3:45	☐

*A minimum of 10 campers is required for bus 3-A to run. If that minimum is not met, campers will be transferred to bus 1-C in Somers.
**In order to use the AM and PM care offered for Camp Yankee Trails, camper must be signed up for bus 1-A from the Indian Valley YMCA

Special paperwork being submitted with this registration packet is:

☐ Financial Assistance Paperwork
☐ Care 4 Kids Paperwork
☐ Asthma Care Plan (signed by physician)
☐ Allergy Care Plan (signed by physician)
☐ General Care Plan (signed by physician)
☐ Medication Authorization

CAMPER CONTACT INFORMATION and pick up authorization form

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

Camper Name _____ Gender_____ D.O.B. ___/___/____Age _____

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. ___/___/___

Child lives with this parent Yes No Child lives with this parent Yes No

Address_____ Address _____

Town/City _____State____ Zip_____ Town/City _____State___ Zip_____

Preferred Phone ( )_____ Preferred Phone ( )_____

Secondary Phone ( ) _____ Secondary Phone ( ) _____

Email Address _____ Email Address _____

EMERGENCY CONTACTS / ADULTS AUTHORIZED TO PICK-UP

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_____

Cell Phone ( ) _____ Work ( ) _____ Home ( ) _____

Name_____ Relationship to child_____

Cell Phone ( ) _____ Work ( ) _____ Home ( ) _____

ADDITIONAL ADULTS AUTHORIZED TO PICK-UP

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_____

Relationship_____ Relationship_____ Relationship_____

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

DO NOT RELEASE THIS CAMPER TO:_____

(Please attach legal documents for parents/guardians who are not authorized to pick up this camper)

THIRD PARTY BILLING PARTY INFORMATION *PLEASE PRINT CLEARLY*

In order to for the YMCA to bill a 3rd party AGENCY (i.e. DCF), we must have a written document confirming the amount the agency is willing to pay and for whom.

Billing Agency Name_____

Contact Name/Case Worker_____ Town _____ Phone ( )_____

PARENT/GUARDIAN SIGNATURE

I understand the above mentioned policies and verify that all of the information listed above is true and accurate to the best of my knowledge. I understand that ONLY ADULTS LISTED ABOVE AS AUTHORIZED TO PICK UP WHO PRESENT A VALID PHOTO ID AT PICK UP TIME WILL BE ALLOWED TO SGN OUT THIS CAMPER.

_____ _____

Parent/Guardian Signature Date

Indian Valley Family YMCA
11 Pinney St
Ellington, CT 06029

p: (860) 871-0008

ghymca.org/camp

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

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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: _____

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

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**			***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 ❑ 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

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
If "no" only parent must sign

☐ 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: _____

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

☐ 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: _____

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:** _____

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

☐ 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.)

FINANCIAL ASSISTANCE APPLICATION
instructions and information

To qualify for Financial assistance, this application must be submitted by the deadline indicated on the front of the registration packet (four Wednesdays before the start of the session). One application per family is acceptable.

Once the required application and documents are provided, you will receive an approval or denial letter within 14 days. You MUST return a signed copy of this letter by the date indicated in order to accept your scholarship. If the letter is not returned, your financial assistance will be cancelled may be given away to another camper.

If you decline the scholarship and wish to terminate the enrollment in our camps, your initial deposit will be returned to you. You must request this refund PRIOR TO JUNE 15th, 2018 IN WRITING via email to greg.baker@ghymca.org or mail to the YMCA administration offices.

Step 1: Complete the chart below to tell us which sessions you would like for your campers to attend.
Step 2: Complete Financial Assistance Application on the back side of this page.
Step 3: Attach all necessary additional paperwork:

- A copy of your 2018 1040 Tax Return Form. Please note, if you are unable to supply a tax return we must receive proof of non-filing status. You may call the IRS at 1-800-829-1040 to request this.
- Two consecutive pay stubs for each income-earning member of the household.
- Proof of public assistance if applicable.

Step 4: Submit this application along with your registration packet.
Step 5: Complete the CT Care 4 Kids application found at **www.CTCare4Kids.com**. This is required in order to be eligible for any YMCA FA award.

IMPORTANT:
The summer care version of Care4Kids forms are usually not made available until April each year. Campers may apply for financial assistance prior to these forms being made available, and will typically still receive their award in 14 days. However, if you are offered an award from the YMCA prior to the Care4Kids forms being made available, we will contact you once they are available in order to have you fill them out. Your eligibility for any award will still require that you complete the Care 4 Kids application.

Which sessions are you interested in having your camper(s) attend?

Dates	Camp Indian Valley	Camp Yankee Trails	Preschool 1/2 Day Camp
June 24-28	☐	☐	☐
July 1-5*	☐	☐	☐
July 8-12	☐	☐	☐
July 15-19	☐	☐	☐
July 22-26	☐	☐	☐
July 29–Aug 2	☐	☐	☐
Aug 5-9	☐	☐	☐
Aug 12-16	☐	☐	☐
Aug 19-23	☐	NO CAMP	☐

YMCA of Greater Hartford
Financial Assistance Application

A. About you:

Your Name: _____ (first) _____ (MI) _____ (last)

Address: _____

Town/City: _____ State: _____ Zip Code: _____

Email Address: _____ Preferred Phone: _____ Birthdate: _____

Employer Name: _____

Employer Address: _____

Town/City: _____ State: _____ Zip Code: _____

Job Title: _____ Business Phone: _____

B. Spouse/Partner Name: _____ (first) _____ (MI) _____ (last)

Employer Name: _____

Employer Address: _____

Town/City: _____ State: _____ Zip Code: _____

Job Title: _____ Business Phone: _____

C. Number of Dependent Children: _____

Name: _____ Birthdate: _____ Name: _____ Birthdate: _____

Name: _____ Birthdate: _____ Name: _____ Birthdate: _____

Name: _____ Birthdate: _____ Name: _____ Birthdate: _____

D. Financial Assistance is Requested For:

☐ Membership ☐ Programs ☐ Child Care ☐ Camp ☐ Other

E. Other Information:

Your Gross Annual Salary: $ _____ Spouse/Partner's Gross Annual Salary: $ _____

Other Income (list source & amount): _____

Housing: ☐Own ☐ Rent Monthly Mortgage/Rent: _____

Do you receive a housing subsidy? ☐Yes ☐ No Amount per Month: $ _____

Please list any special circumstances that affect your reason for need: _____

To qualify for financial assistance, you must submit the following documents within 2 weeks of application:

- Your most recently filed tax return
- Two current paycheck stubs or other proof of your current combined total income
- Proof of any other income - i.e. child support, social security benefits, etc.

The information listed on this form is correct to the best of my knowledge. I understand that if I do not provide the required documentation within 2 weeks, my membership rate will revert to the full fee. I understand that I must re-apply for financial assistance every 12 months from the date of this application. If I do not re-apply for financial assistance, my fees will revert the full published rate.

F. Applicant Signature: _____ Date: _____

G. YMCA of Greater Hartford Staff to Complete this Section

Member Account Number _____ Branch _____

Percent of Subsidy _____ Begin Date _____ Review Date _____

Approved By _____ Date Entered _____