



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

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.

- Make Your Payments

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 2019 _____

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):



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	<input type="checkbox"/> \$240	<input type="checkbox"/> \$245	<input type="checkbox"/> \$220	<input type="checkbox"/> \$68	<input type="checkbox"/> \$57	<input type="checkbox"/> \$74	Lessons Not Offered
Session 2 June 24-28	<input type="checkbox"/> \$240	<input type="checkbox"/> \$245	<input type="checkbox"/> \$220	<input type="checkbox"/> \$68	<input type="checkbox"/> \$57	<input type="checkbox"/> \$74	<input type="checkbox"/> \$56
Session 3 July 1-5	<input type="checkbox"/> \$190	<input type="checkbox"/> \$200	<input type="checkbox"/> \$180	<input type="checkbox"/> \$55	<input type="checkbox"/> \$46	<input type="checkbox"/> \$60	
Session 4 July 8-12	<input type="checkbox"/> \$240	<input type="checkbox"/> \$245	<input type="checkbox"/> \$220	<input type="checkbox"/> \$68	<input type="checkbox"/> \$57	<input type="checkbox"/> \$74	<input type="checkbox"/> \$56
Session 5 July 15-19	<input type="checkbox"/> \$240	<input type="checkbox"/> \$245	<input type="checkbox"/> \$220	<input type="checkbox"/> \$68	<input type="checkbox"/> \$57	<input type="checkbox"/> \$74	
Session 6 July 22-26	<input type="checkbox"/> \$240	<input type="checkbox"/> \$245	<input type="checkbox"/> \$220	<input type="checkbox"/> \$68	<input type="checkbox"/> \$57	<input type="checkbox"/> \$74	<input type="checkbox"/> \$56
Session 7 July 29-Aug 2	<input type="checkbox"/> \$240	<input type="checkbox"/> \$245	<input type="checkbox"/> \$220	<input type="checkbox"/> \$68	<input type="checkbox"/> \$57	<input type="checkbox"/> \$74	
Session 8 August 5-9	<input type="checkbox"/> \$240	<input type="checkbox"/> \$245	<input type="checkbox"/> \$220	<input type="checkbox"/> \$68	<input type="checkbox"/> \$57	<input type="checkbox"/> \$74	Lessons Not Offered
Session 9 August 13-17	<input type="checkbox"/> \$240	<input type="checkbox"/> \$245	<input type="checkbox"/> \$220	<input type="checkbox"/> \$68	<input type="checkbox"/> \$57	<input type="checkbox"/> \$74	Lessons Not Offered
Session 10 August 20-24	<input type="checkbox"/> \$240	<input type="checkbox"/> \$245	<input type="checkbox"/> \$220	<input type="checkbox"/> \$68	<input type="checkbox"/> \$57	<input type="checkbox"/> \$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 24-28	<input type="checkbox"/> \$320	<input type="checkbox"/> \$320					
Session 3 July 1-5							
Session 4 July 8-12			<input type="checkbox"/> \$320				
Session 5 July 15-19				<input type="checkbox"/> \$320			
Session 6 July 22-26					<input type="checkbox"/> \$360		
Session 7 July 29-Aug 2						<input type="checkbox"/> \$320	
Session 8 August 5-9							
Session 9 August 13-17							<input type="checkbox"/> \$360
There will be a one time \$20 Registration Fee assessed at time of registration for each camper							

Camp Hours 7:00am - 3:30pm

After Care Hours 3:30pm - 6:00pm

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

Arrival Time _____ am



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 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: _____



AGES 3 AND UP HEALTH ASSESSMENT
fill out if your child is three or older

REQUIRED FORM



State of Connecticut Department of Education
Health Assessment Record



To Parent or Guardian:

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

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

Please print

Student Name (Last, First, Middle)		Birth Date	<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
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

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 Provider Name and Phone Number
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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.

Table with 7 columns: Vaccine, Dose 1, Dose 2, Dose 3, Dose 4, Dose 5, Dose 6. Rows include DTP/DaP, DT/Td, Tdap, IPV/OPV, MMR, Measles, Mumps, Rubella, HIB, Hep A, Hep B, Varicella, PCV, 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

<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?

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: _____



GENERAL INDIVIDUAL CARE PLAN

Will your child take any meds at camp?

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

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

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.