FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CAMP NOWASHE 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
  - ☐ 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)
  - ☐ Financial Assistance & Care 4 Kids Paperwork (If necessary)
- ☐ Pay $40 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 Register online: www.ghymca.org
  E-Mail: Greg.Baker@GHYMCA.org Come in to the Y: 770 Main Street, E. Hartford
- ☐ Pay $40 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

FOR YOUTH DEVELOPMENT®
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YMCA CAMP NOWASHE

*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: ___/___/___

*Please complete a separate registration packet for each camper.

Grade next school year:____ E-mail:______________________

Step 1– SESSION SELECTION

Check off the sessions for which you'd like to register. A $40 deposit is due for all sessions at time of registration. Please only select sessions for which you are prepared to pay the $40 at this time.

Dates	Traditional Camp $215/session K-8th Grade	Enrichment Camp $225/session 3rd-8th Grade	Sports Camp $225/session 3rd-8th Grade	CIT Program $215/session 9th-10th Grade
	With a different theme every week, we put a new spin on traditional camp fun. The focus at these camps is on making life long friendships and giving campers the chance to feel a sense of belonging and achievement in a uniquely caring community. Field trips each week keep campers excited to learn more and experience new things each and every week!	For campers interested in expanding their horizons and achieving new things, these camps focus on a unique activity area for the mornings, then traditional camp activities in the afternoons. *20 spaces per camp	Each day, sports camp spends the mornings learning new skills, then putting them to work with a scrimmage. Other active games will be incorporated as well. Traditional camp activities in the afternoons. *20 spaces per camp	Learn to be a great leader and set yourself up to be a counselor at camp someday with this 2-week leadership development program. *5 CITs/session
6/24-6/28	☐ Spirit Week	☐ Survivor: Nowashe	☐ Soccer	☐ CIT Session A
7/1-7/5**	☐ Strange Holiday Week	☐ Arts Week	☐ Basketball	
7/8-7/12	☐ Time Travel Week	☐ Galaxy Camp	☐ Flag Football	☐ CIT Session B
7/15-7/19	☐ Around the World	☐ Drama Performance	☐ Baseball	
7/22-26	☐ Cinema Classics	☐ Supreme Queens	☐ Basketball	☐ CIT Session C
7/29–8/2	☐ Mystery Week	☐ Lego Builders	☐ Flag Football	
8/5-8/9	☐ Wet and Wild	☐ *Make-a-Difference Camp	☐ Soccer	☐ CIT Session D
8/12-8/16	☐ Color Games	☐ Movie Makers	☐ Baseball	
8/19-8/23	☐ Camp Favorites	NO ENRICHMENT CAMP	NO SPORTS CAMP	☐ CIT Session E

** Make-a-Difference Camp is $285 instead of $225 due to the extra transportation costs involved.
*There is no camp on Thursday July 4th. All camp weeks are prorated that week to accommodate the 4-day week.
Camp drop off is at 8:45AM and pick up is by 4:15PM

Step 2 - EXTENDED CARE NEEDS

Normal drop off times are 8:45-9:00AM and pick up happens each day from 4:00-4:15PM. **Check off the extended care options you will need for your camper.**

Early Drop Off 7:00-8:45	Late Pick Up 4:15-6:00	No Extended Care Needed (8:45-4:15 works)
☐ $5/Week	☐ $5/week	☐ $0

Step 3 - BUDDY REQUEST

Camp Nowashe uses small groups to enhance bonds. This means that not all campers see each other every day unless they are grouped together. In order to enhance their experience, we try to pair campers with friends from past summers. **Does your camper have a buddy request?**

____

REQUIRED FORM

CAMPER CONTACT INFORMATION and pick up authorization form

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

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

Each family participating in YMCA programs or camps must have a waiver of liability on file with the office prior to arrival at camp. If your family has more than one child attending camp, one Waiver of Liability Form will suffice.

IN CONSIDERATION of being permitted to utilize the facilities, services and programs of the YMCA for any purpose, including, but not limited to observation or use of facilities, or equipment, or participation in any off-site program affiliated with the YMCA, the undersigned, for himself or herself, or on behalf of a minor child under age 18, and for any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has, inspected and carefully considered, or will immediately upon entering and/or participating, inspect and carefully consider, such premises and facilities or the affiliated program. It is further warranted that such entry into the YMCA constitutes an acknowledgement that that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use or participation.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE YMCA FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY OFF-SITE PROGRAM AFFILIATED WITH THE YMCA, **THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING ON HIS OR HER BEHALF AND/OR BEHALF OF HIS/HER CHILDREN OR GUESTS** (herein referred to as "the undersigned"):

1. **MEMBER CONDUCT** I agree to abide by all rules and regulations of the YMCA of Metropolitan Hartford (hereafter "YMCA"), and I understand that failure to act in accordance with the rules may result in expulsion from the YMCA and cancellation of membership.

2. **INSURANCE** I understand that the YMCA does not provide any accident or health insurance for its members or participants and it is my responsibility to provide such coverage.

3. **PROPERTY LOSS** I understand that the YMCA is not responsible for personal property lost, damaged or stolen while using YMCA facilities or participating in YMCA programs.

4. **ASSUME FULL RESPONSIBILITY** I hereby assume full responsibility for and risk of bodily injury, death or property damage while in about or upon the premises of the YMCA and/or while using the premises, or any facilities or equipment thereon or participating in any program affiliated with the YMCA.

5. **PHOTO/TALENT RELEASE** I hereby irrevocably release, consent and allow the YMCA and its agents to use my photograph, likeness, voice, as it pertains to my participation with the YMCA, in any manner for promotional efforts without expectation of any reimbursement for its use. *(My initials here **revoke** photo/talent release_______________). Pictures are used to show you what they are doing!*

6. **RELEASEE, WAIVE, DISCHARGES** I hereby release, waive, discharge and covenant not to sue the YMCA, its directors, officers, employees, and agents (hereinafter referred to as "releases") from all liability to the undersigned, his personal representatives, assigns, heirs, and next of kin for any loss or damages, and any claim or demands therefore on account of injury to the person or loss of property while the undersigned is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with the YMCA.

7. **INDEMNIFY AND SAVE AND HOLD HARMLESS** I hereby agree to indemnify and save and hold harmless the releases from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about the YMCA premises or in any way observing or using any facilities or equipment of the YMCA or participating in any program affiliated with the YMCA.

8. **MEDICAL RELEASE** I authorize the YMCA, as my agent, to give consent to medical treatment by a licensed physician or hospital when such treatment is deemed necessary by the physician, and I am unable to give such consent. I authorize a qualified YMCA staff member to administer CPR or first aid if necessary. I understand that it may be necessary for me to provide a release form from my physician regarding my current health status.

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

THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of Connecticut and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding continue in full legal force and effect.

THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AND PHOTO/TALENT RELEASE AGREEMENT, and further agrees that no oral representations, statement or inducement apart from the foregoing written agreement have been made. I HAVE READ THIS RELEASE

Printed Name of Camper: ____

Signature of Participant or Parent/Guardian: ____

SUNSCREEN APPLICATION and authorization form

Connecticut Department of Public Health regulations require us to have written parental permission in order for YMCA Staff members to assist children in reapplying sunscreen throughout the day. Please complete the enclosed form and return to the office if your child will need our assistance. Campers must label and supply their own sunscreen.

Camper's Name: ____

Your camper will be spending a lot of the time at camp running around in the sun. It is imperative that the children reapply sunscreen throughout the day. The sunscreen is always a concern for us. We want you to know that we are committed to making sure your child is safe from the sun. We strongly encourage you to your camper with **SPRAY ON SUNSCREEN**. We will assist all campers when reapplying sunscreen and educate them on remembering to do it as well. If sun exposure is ever a problem please notify a director immediately so that the extra precautions can be made.

☐ I give permission to apply sunscreen

☐ I do not give permission to apply sunscreen

I give permission to designated YMCA staff to assist my child in applying sunscreen throughout the camp day. I understand that it is my responsibility to provide sunscreen for my child each day and to apply sunscreen prior to their arrival at camp. Furthermore, I will assist the staff in educating my child in the importance of applying and reapplying sunscreen throughout the day.

Name of parent/ Guardian (please print): ____

Signature of Parent/Guardian ____ **Date:** ________________

Comments/Notes: ____

____

____

____

____

Reviewed by:

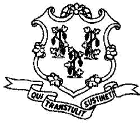
Name of staff (print): ____ Date: ______________

Signature of Staff: ____

AGES 3 AND UP HEALTH ASSESSMENT

REQUIRED FORM

fill out if your child is three or older



State of Connecticut Department of Education

Health Assessment Record

To Parent or Guardian:

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

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

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

AGES 5 & UP

Part I — To be completed by parent/guardian.

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

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

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

HAR-3 REV. 4/2010

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

ASHTMA CARE PLAN

does your child have asthma?

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

REQUIRED FORM

☐ YES

☐ NO

Camper's Name: ___________________________________ **Birthday:** _______________

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

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

Steps to take during an asthma episode:

1. Give medications as listed below:

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

Medication Requirements: (check one)

1. __________ No medication required while attending Camp. Physician initials required: _________________

2. __________ Medication required at camp (Bring original prescription to first day of camp, label clearly showing camper's name, birthday, and expiration date)

**Special Instructions ____

____

2. Observe for decreased symptoms

3. Contact Parent/Guardian if emergency medication is required

4. Call 911 if:

After receiving treatment, you observe the child:

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

Physician's name: ____

Physician's signature: ____

Phone number: (_____) - ____________________ **Date:** _____________________

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

Camp Director: ____ Date: _________________

East Hartford YMCA
770 Main St.
East Hartford, CT 06108

p: (860) 289-6612
f: (860) 289-6659
ghymca.org/camp

ALLERGY CARE PLAN

does your child have any allergy?

REQUIRED FORM

☐ YES

☐ NO

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

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: _______________

REQUIRED FORM

GENERAL INDIVIDUAL CARE PLAN

will your child take any meds at camp?

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

☐ YES
☐ NO

Child's Name____ Date of Birth____________________

Parent/Guardian Name ______________________________________

Emergency Phone Numbers: Mother________________________________ Father________________________________

*****See emergency contact information for alternate contacts if parents are unavailable

Primary Health provider's name: ____

Emergency Phone ________________________

Specialist's name & field ____

Emergency Phone ________________________

Specialist's name & field: ____

Emergency Phone ________________________

Diagnosis/Medical History: (please be specific)

Daily Medications:

As Needed Medications:

Minor Symptoms: **If you see these symptoms DO THIS:**

Major Symptoms: **If you see these symptoms DO THIS:**

Physician's Name: ____

Physician's Signature: ____

Phone number: (____) - ____________________ Date: ____________________

Parent's Signature: ____ Date: ____________________

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ghymca.org/camp

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.)

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 and may be allocated 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, 2019 IN WRITING via email to greg.baker@ghymca.org or mail to the YMCA office, 770 Main St, E. Hartford, CT 06108.

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	Traditional Camp $215/week K-8th Grade	Enrichment Camp $225/week 3rd-8th Grade	Sports Camp $225/week 3rd-8th Grade
June 24-28	☐ Spirit Week	☐ Survivor: Nowashe	☐ Soccer
July 1-5*	☐ Strange Holiday Week	☐ Arts Week	☐ Basketball
July 8-12	☐ Time Travel Week	☐ Galaxy Camp	☐ Flag Football
July 15-19	☐ Around the World	☐ Drama Performance	☐ Baseball
July 22-26	☐ Cinema Classics	☐ Supreme Queens	☐ Basketball
July 29–Aug 2	☐ Mystery Week	☐ Lego Builders	☐ Flag Football
Aug 5-9	☐ Wet and Wild	☐ Make a Difference Camp	☐ Soccer
Aug 12-16	☐ Color Games	☐ Movie Makers	☐ Baseball
Aug 19-23	☐ Camp Favorites	NO ENRICHMENT CAMP	NO SPORTS 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 ______

HAR-3 REV. 4/2010

Part II — Medical Evaluation

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

Student Name ______________________ Birth Date __________ Date of Exam __________

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

Physical Exam

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

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

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

Screenings

***Vision Screening**

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

❑ Referral made

***Auditory Screening**

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

❑ Referral made

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

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

*IMMUNIZATIONS

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

***Chronic Disease Assessment:**

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

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

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

Seizures ❑ No ❑ Yes, type:

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

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

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

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

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

ALL AGES HEALTH ASSESSMENT

fill out if your child is attending camp

REQUIRED FORM

HAR-3 REV. 4/2010

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx of above ______________ (Specify) ______________ (Date) ______________ (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date _________ Recertify Date _________ Recertify Date ________

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6

DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12

Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

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

East Hartford YMCA
770 Main St.
East Hartford, CT 06108

p: (860) 289-6612
f: (860) 289-6659
ghymca.org/camp

care4kids
MAKING CHILD CARE AFFORDABLE

Care 4 Kids Application

Care 4 Kids ▪ 1344 Silas Deane Highway ▪ Rocky Hill, CT 06067
Phone: 1-888-214-5437
Fax: 1-877-868-0871

Care 4 Kids (C4K) is the child care assistance program for the State of Connecticut. This form will give us the information we need to see if you are eligible for child care assistance from Care 4 Kids.

1. **Fill out this Application.** If you need help, call 1-888-214-5437 or visit www.ctcare4kids.com.
2. **Fill out the Parent Provider Agreement (PPA)** with your child care provider. New providers to the Care 4 Kids program must complete a W-9 form and return it with the completed PPA. Applications can be submitted even if you have not picked a child care provider. If you need help finding a licensed child care provider, call 2-1-1 Child Care at 2-1-1 or 1-800-505-1000.
3. Please make sure you sign and date your Application and PPA. **Incomplete forms may not be accepted and <u>will delay</u> processing.**
4. **Provide all necessary information.** Submit a copy of the requested information with your Application.

Information that you provide on this form must be checked before you can receive Care 4 Kids assistance. The following documents can be submitted.

- **Income from Employment** – Copy of your most recent pay stubs or a letter from your employer.
- **Self-Employment** – Recent tax records and tax returns, or receipts of business income and expenditures.
- **Social Security Income** – Current award notice, copy of current check or statement from social security.
- **Child Support Paid** – Cancelled check, money order, or wage stub showing deduction.
- **Foster Care Payment** – Foster care stipend check or award letter from Department of Children and Families.
- **Rental Income You Receive From Someone Else** – Business records or income tax records.

SECTION 1: APPLICANT INFORMATION/HEAD OF HOUSEHOLD

The applicant is the parent or adult legally responsible for the child(ren). If the parent is under the age of **18** and living with an adult, the adult is considered the applicant and must fill out and sign this Application.

_____ FIRST NAME _____ M.I. _____ LAST NAME ___/___/___ DATE OF BIRTH

_____ STREET ADDRESS _____ FLOOR/APARTMENT NUMBER

_____ CITY _____ STATE _____ ZIP (   ) _____ PRIMARY PHONE (   ) _____ WORK PHONE

___–___–___ SOCIAL SECURITY NUMBER (OPTIONAL)

Gender: ☐ Female ☐ Male **Marital Status:** ☐ Married ☐ Single ☐ Separated ☐ Divorced

Race: ☐ **A** (Asian) ☐ **B** (Black/African) ☐ **C** (White) ☐ **N** (American Indian/Alaska Native) ☐ **P** (Native Hawaiian/Other Pacific Islander)

Hispanic/Latino: ☐ YES ☐ NO

Is this Application for child care assistance for a foster child? ☐ YES ☐ NO

Are you living in a temporary housing situation? ☐ YES ☐ NO

Have you experienced 3 or more moves in the past year? ☐ YES ☐ NO

Are you an active member of the United States Military? ☐ YES ☐ NO (If **YES**, check box below)

☐ Active Duty U.S. Military ☐ National Guard Military Reserve

Do you have an impairment that requires an accommodation or extra help? ☐ YES ☐ NO

What is the primary language spoken in your home? _____________

☐ Marque aquí si desea recibir cartas y formularios en español. *(Check here to receive letters and forms in Spanish)*

NAME (First/Last):______________________________

SECTION 2: CHILDREN INFORMATION

To be eligible, children must be under age 13. Children with special needs may be eligible up to age 19.

CHILDREN IN THE HOME WHO NEED CHILD CARE ASSISTANCE

KEY: A (Asian) **B** (Black/African Decent) **C** (White) **N** (American Indian/Alaskan Native) **P** (Native Hawaiian/Other Pacific Islander)

Child's Name (*First Name, Middle Initial, Last Name*)	Date of Birth	Relationship to Applicant	Gender	Race (*circle all that apply*)	Is child Hispanic/ Latino?	Social Security Number (*optional*)	Is child a U.S. citizen?	Is child up to date with shots? (*immunizations*)
1.	___/___/___		❑ M ❑ F	A B C N P	❑ YES ❑ NO	_____-_____-_____	❑ YES ❑ NO	❑ YES ❑ NO
2.	___/___/___		❑ M ❑ F	A B C N P	❑ YES ❑ NO	_____-_____-_____	❑ YES ❑ NO	❑ YES ❑ NO
3.	___/___/___		❑ M ❑ F	A B C N P	❑ YES ❑ NO	_____-_____-_____	❑ YES ❑ NO	❑ YES ❑ NO
4.	___/___/___		❑ M ❑ F	A B C N P	❑ YES ❑ NO	_____-_____-_____	❑ YES ❑ NO	❑ YES ❑ NO
5.	___/___/___		❑ M ❑ F	A B C N P	❑ YES ❑ NO	_____-_____-_____	❑ YES ❑ NO	❑ YES ❑ NO

Do any of the above children have special needs? ❑ YES ❑ NO If **YES**, provide name(s):______________________

Do you share joint custody with any of the children listed above? ❑ YES ❑ NO

If **YES**, provide name(s): ______________________________

CHILDREN UNDER 18 IN THE HOME WHO DO NOT NEED CHILD CARE ASSISTANCE

First Name, Middle Initial, Last Name	Date of Birth	Gender	Relationship of Child to Applicant	Social Security Number (*optional*)
1.	____/____/____	❑ M ❑ F		_______-______-_______
2.	____/____/____	❑ M ❑ F		_______-______-_______
3.	____/____/____	❑ M ❑ F		_______-______-_______

Do any of the children listed above have their *own* children living in your home? ❑ YES ❑ NO If **YES**, list the names of the minor parents (under age 18) and the name(s) of their child(ren):

Parent(s) Under Age 18: ______________________________ ______________________________

Child(ren) of Parent Under Age 18: ______________________________ ______________________________

SECTION 3: INFORMATION ON OTHER ADULTS LIVING IN YOUR HOME

List <u>all</u> other adults **18 and over** living in your home. Include your spouse and any relatives and non-relatives who live in your home.

First Name, Middle Initial, Last Name	Date of Birth	Gender	Relationship to Applicant	Social Security Number (*optional*)	Is this person a parent of child living in the home?
1.	___/___/___	❑ M ❑ F		_____-_____-_____	❑ YES ❑ NO Name of Child
2.	___/___/___	❑ M ❑ F		_____-_____-_____	❑ YES ❑ NO Name of Child

Are any of the other adults listed above an active member of the United States Military? ❑ YES ❑ NO If **YES**, check the box and provide the name of the other adult(s): ❑ Active Duty U.S. Military ❑ National Guard Military Reserve

____

NAME (First/Last): ______________________________

SECTION 4: WORK/EDUCATION/TRAINING ACTIVITIES

List all parents and other adults, including yourself, who are working, in training, or in school. Include parents or other persons legally responsible for the children in the home and their spouses. Fill out the information for each activity/parent/other adult. **If there are more than 2 activities, make a copy of this page or download and print another copy of this page from the Care 4 Kids website at www.ctcare4kids.com.**

1. ______________________________
NAME OF PARENT OR OTHER ADULT IN THE HOME

Type of Activity: ☐ Work ☐ Education ☐ High School ☐ Self-Employed ☐ Training ☐ Disabled

Name of Employer/Program/School ______________________________

Address ______________________________ City ______________ State ________ Zip ________

Start Date ______________________________ Phone (______) ______________

PARENT/ADULT – TYPICAL WEEKLY SCHEDULE

Enter start time and end time, and circle AM or PM. If this activity has more than one schedule, please indicate below.

Day of the Week	Schedule 1 Begin Time	Schedule 1 End Time	Schedule 2 Begin Time	Schedule 2 End Time
Sunday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Monday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Tuesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Wednesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Thursday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Friday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Saturday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM

If your work schedule or activity is flexible or varies, please explain: ______________________________

____

Daily commute to/from child care setting/activity? __________ minutes Do you use public transportation? ☐ YES ☐ NO

2. ______________________________
NAME OF PARENT OR OTHER ADULT IN THE HOME

Type of Activity: ☐ Work ☐ Education ☐ High School ☐ Self-Employed ☐ Training ☐ Disabled

Name of Employer/Program/School ______________________________

Address ______________________________ City ______________ State ________ Zip ________

Start Date ______________________________ Phone (______) ______________

PARENT/ADULT – TYPICAL WEEKLY SCHEDULE

Enter start time and end time, and circle AM or PM. If this activity has more than one schedule, please indicate below.

Day of the Week	Schedule 1 Begin Time	Schedule 1 End Time	Schedule 2 Begin Time	Schedule 2 End Time
Sunday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Monday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Tuesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Wednesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Thursday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Friday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Saturday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM

If your work schedule or activity is flexible or varies, please explain: ______________________________

____

Daily commute to/from child care setting/activity? __________ minutes Do you use public transportation? ☐ YES ☐ NO

NAME (First/Last): ____________________

SECTION 5: CHILD SUPPORT PAID

If you or another adult living in your home pays child support, that amount may be deducted from your income. If **YES**, payment is made to ____________________. Submit verification of child support paid.

What is/are the name(s) of the child(ren) for whom you pay support? ____________________

How much is paid? $__________ How often? ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

SECTION 6: INCOME INFORMATION

Send verification of all earned and unearned income for parents, parents of children under 18, step-parents, and children under 18. These family members are part of your household and their income will be counted when deciding eligibility. Send at least 2 weeks of your MOST RECENT paycheck stub(s) or a letter from your employer. If you are self-employed, submit a copy of your most recent tax records and returns, including the schedules or receipts of business income and expenditures.

Persons with Income →	**Name**	**Name**	**Name**	**Name**
Gross Wages *(before taxes)* **and Frequency**	$ ______ *per wk bwk sm mo *(circle one)*	$ ______ *per wk bwk sm mo *(circle one)*	$ ______ *per wk bwk sm mo *(circle one)*	$ ______ *per wk bwk sm mo *(circle one)*
Self-Employment	$ ______ per week or month *(circle one)*	$ ______ per week or month *(circle one)*	$ ______ per week or month *(circle one)*	$ ______ per week or month *(circle one)*
DCF Stipend	$ ______ per month	$ ______ per month	$ ______ per month	$ ______ per month
Social Security Income	$ ______ per month	$ ______ per month	$ ______ per month	$ ______ per month
Unemployment Compensation	$ ______ per month	$ ______ per month	$ ______ per month	$ ______ per month
Other Income *(i.e. alimony, pensions, worker's compensation, veterans benefits, rental income)*	$ ______ Type: ______ *per wk bwk sm mo *(circle one)*	$ ______ Type: ______ *per wk bwk sm mo *(circle one)*	$ ______ Type: ______ *per wk bwk sm mo *(circle one)*	$ ______ Type: ______ *per wk bwk sm mo *(circle one)*

*KEY: per: **wk** (weekly), **bwk** (bi-weekly), **sm** (semi-monthly), **mo** (monthly)

Does your household have assets that exceed $1 million in value? ☐ YES ☐ NO

Do you get child care assistance from another source? ☐ YES ☐ NO

If **YES**, from whom? __________ How much? $__________ How often? __________

SECTION 7: PARENTS RIGHTS AND RESPONSIBILITIES

Please read the following section carefully. If there is anything you do not understand, call **Care 4 Kids** at **1-888-214-5437** and ask that it be explained to you.

- When you have read this section, please sign and date the next page.
- You have certain rights and there are certain rules you need to follow.
- You have the right to file an Application, withdraw an Application, or discontinue your participation in Care 4 Kids at any time.
- You have the right to be treated fairly by Care 4 Kids without regard to race, color, religion, sex or sexual orientation, marital status, national origin, ancestry, age, political beliefs, or disability. You have the right to request forms and notices in Spanish. All non-English speaking participants have the right to the services of an interpreter.
- You have the right to ask for a review of any decision made by Care 4 Kids on your Application. You have the right to speak to a supervisor or mediator and the right to request a hearing from the State of Connecticut.

I understand and agree that:

- I must report changes in my situation to Care 4 Kids **within 10 days** of the change for the following: change in address, household income over 85% of the State Median Income, if the child receiving Care 4 Kids benefits is no longer in the home, child care provider, and loss of employment or stopping an approved activity. For the current State Median Income Chart, please visit the Care 4 Kids website www.ctcare4kids.com.
- Care 4 Kids may verify the information I have given on this form. I understand that if I am eligible for Care 4 Kids, benefits will not begin any earlier than 15 days before the date the Application is received.

NAME (First/Last): ____________________

SECTION 7, CONTINUED: PARENTS RIGHTS AND RESPONSIBILITIES

- The Department of Labor will share unemployment compensation and wage information for applicants and household members for determination of eligibility for Care 4 Kids. The Office of Early Childhood (OEC) may disclose to its contractor confidential information from the Department of Labor concerning unemployment compensation benefits and quarterly wage information pertaining to individuals who have signed the Application, only as necessary, to determine eligibility for the Care 4 Kids program.
- The information on this form is confidential. The OEC or its contractor will only use this information to administer a State of Connecticut program. Information may be shared with others as permitted by law.
- Care 4 Kids will disclose information about my eligibility for Care 4 Kids to my provider.
- Care 4 Kids may be required to provide information about program applicants and participants to law enforcement officials.
- The child care arrangement is between my provider and me. The OEC and Care 4 Kids are not responsible for the child care arrangement.
- The State of Connecticut may conduct unscheduled visits to verify any household, employer, or provider circumstances.
- Care 4 Kids may not pay the full amount charged by my provider. I am responsible for paying all additional provider charges.
- I have the right to choose any eligible child care provider that meets all applicable health, training, and licensing requirements.
- I may be required to repay any benefits received in error, including administrative errors. I may be subject to criminal prosecution for fraud if I knowingly supply any false information to Care 4 Kids or fail to report changes on time. I also may be disqualified from the program. In order to remain eligible, I must cooperate with the Care 4 Kids and State of Connecticut quality control process.

PLEASE READ AND SIGN: I have read my rights and responsibilities or have had them read to me in a language I understand. I certify, under penalty of perjury, that all of the information provided is true and correct to the best of my knowledge.

Applicant Signature: ____________________ Date: ____________

Signature of other legally responsible adult living with you (i.e. spouse, child's parent, etc.)

Other Signature: ____________________ Date: ____________

RETURN THIS APPLICATION TO:

Care 4 Kids ▪ 1344 Silas Deane Highway ▪ Rocky Hill, CT ▪ 06067

FAX: 1-877-868-0871

Parent Name: C4K Case Number:

Si quiere recibir este formulario en español, llame al 1-888-214-5437.

Summer 2019 Parent-Provider Agreement Form

Step 1: This form must be completed by the parent and the child care provider.
- **Parent** – Complete Sections 1, 3 and 5.
- **Child Care Provider** – Complete Sections 2, 3 and 4.

Step 2: Make sure all sections have been filled in and the information is correct. Answer all Yes or No questions by checking the right box. Once you have filled out and checked this form, make sure the parent and provider sign and date this form. If you need help, call 1-888-214-5437 or visit www.ctcare4kids.com. **Incomplete forms may not be accepted and will delay processing.**

Step 3: The law requires us to report all payments to the Internal Revenue Service (IRS) for income tax purposes. If you are a new child care provider with Care 4 Kids (C4K), you must provide us with your Social Security Number or Federal Employer Identification Number and fill out an IRS W-9 form. To get a W 9 form by mail, call 1-888-214-5437, or download the form at www.ctcare4kids.com. If you have already submitted a W-9 form to us, you do not need to fill out a new form unless your information has changed. Care 4 Kids does not withhold income taxes. Providers are responsible for paying taxes to the IRS and the State of Connecticut.

Step 4: Submit the filled out form to: **Care 4 Kids, 1344 Silas Deane Highway, Rocky Hill, CT 06067** or fax it to: **1-877-868-0871.**

SECTION 1: PARENT INFORMATION *(To be completed by Parent)*

Parent Name: ____________________ C4K Case Number: ____________
Last Name, First Name, Middle Initial

Parent Address: ____________________ City, State, Zip Code: ____________

Telephone Number: (Primary) ____________________ (Secondary) ____________

Reason for submitting this form: ☐ Part of my Application or Redetermination ☐ Reporting changes or a new provider

SECTION 2: CHILD CARE PROVIDER INFORMATION *(To be completed by Provider)*

What type of child care provider are you?

- ☐ Unlicensed Individual (relative)
- ☐ Licensed Family Child Care Home
- ☐ Licensed Child Care Center
- ☐ Licensed Group Child Care Home
- ☑ Licensed Youth Camp
- ☐ Exempt Youth Camp
- ☐ Exempt Center Based Program

Are you accredited by any of the following? (*check if yes*)

- ☐ National Assoc. for the Education of Young Children (NAEYC)
- ☐ Council on Accreditation (COA)
- ☐ New England Assoc. of Schools and Colleges (NEASC)
- ☐ National Assoc. for Family Child Care (NAFCC)

SECTION 2A: LICENSED CHILD CARE PROVIDERS/EXEMPT PROGRAMS *(To be completed by Provider)*

PROVIDER NAME

Center Name: East Hartford YMCA Licensed Home: ____________ *(Last)* *(First)*

Address where child care is provided: Camp Nawashe 450 Forbes St East Hartford CT 06108
Street City State Zip Code

Telephone Number: (860) 289-6612

Date of Birth: ____________ C4K Provider ID: 91991C License Number: 191
Family Home Providers Only

Family Home Providers Only: ☐ **I understand I must complete the pre-service training requirement prior to becoming eligible for payment. For more information, visit www.ctcare4kids.com.**

Please list the address you would like notices to be mailed if different from the address where child care is provided.

Street Address: 770 Main St. City, State, Zip Code: East Hartford, CT. 06108

Parent Name:	C4K Case Number:

SECTION 2B: UNLICENSED RELATIVE CHILD CARE PROVIDERS *(To be completed by Provider)*

You must be related to the child by blood, marriage, or adoption. This means the child is your grandchild, great grandchild, niece, nephew, or sibling. If you are not related, you must have a license from the Office of Early Childhood Division of Licensing to provide child care.

Provider Name:______________________________________
Last Name, First Name, Middle Initial

Home Address:______________________________ City, State, Zip Code:______________________

Telephone Number:___________________________ C4K Provider ID:__________________________

Date of Birth:_____/_____/_____ Gender: ☐ Male ☐ Female

☐ **I understand I must complete the pre-service training requirement prior to becoming eligible for payment. For more information, visit www.ctcare4kids.com.**

Are you self-employed or do you have another job? ☐ YES ☐ NO If yes, list your work schedule at your other job in the table below.

Name, Address, and Telephone Number of your other job:_____________________________________

Providers: Use this table to list the hours and days you normally work your other job (circle AM or PM).

TIME	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Start	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM
End	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM	___:___ AM PM

Where do you provide child care for the children listed on this agreement form? ☐ Child's home ☐ Provider's home ☐Other_______

Is there a working telephone at this care location? ☐ YES ☐ NO Telephone number: (_____)_______________

Is there a working smoke detector? ☐ YES ☐ NO Do you have immediate access to a fire extinguisher? ☐ YES ☐ NO

What is the total number of children in your care at the same time on any day, including your own children?__________

How many of these children are under the age of 2, including your own children?__________

Are you under investigation by the Department of Children and Families (DCF) for child abuse or child neglect or do you have a record of child abuse or child neglect in Connecticut or any other state? ☐ YES ☐ NO

Were you ever arrested or do you have an arrest warrant or criminal charge pending against you? ☐ YES ☐ NO

What crime(s) were you charged with? When and where?_______________________________

Have you ever been convicted of any of the crimes listed below? ☐ YES ☐ NO

- Abandonment, injury or risk of injury to a minor.
- Cruelty to persons or animals, stalking, obscenity, public indecency, reckless endangerment, arson, robbery, burglary, home invasion.
- Use of force against another person, including murder, assault, manslaughter, kidnapping, unlawful restraint.
- Crimes involving a weapon, explosives, or a firearm.
- Sex crimes including sexual assault, rape, prostitution, child pornography, and other related sex crimes.
- Sale, manufacture, or possession of narcotics or other illegal drugs or controlled substances.

For a complete crime list please visit www.ctcare4kids.com

NOTE: All Unlicensed Relative Providers are subject to child abuse/neglect, sex offender, and criminal background checks. If the results of the background check confirms you are ineligible, you will be required to repay Care 4 Kids benefits issued to you.

Parent Name:	C4K Case Number:

SECTION 3: CHILDREN IN CARE *(To be completed together by Parent and Provider)*

Complete for each child needing Care 4 Kids assistance. *If there are more than 3 children in your care, make a copy of this page or download and print another copy of this page from the Care 4 Kids website at www.ctcare4kids.com.*

CHILD #1

_______________ _______________ _____ ___/___/___
LAST NAME *FIRST NAME* *M.I.* *DATE OF BIRTH*

Summer Care: Date care started:_________ Date care ended:_________ How much is the parent charged per week? $________

Will Child 1 stay with this provider in the fall and will the before/after school hours of care remain the same? ☐ **Yes** ☐ **No**

Are you related to this child? ☐ YES ☐ NO If related, specify your relationship to the child:

☐ Grandparent/Great Grandparent ☐ Aunt/Uncle ☐ Sibling ☐ Other: ______________

CHILD'S CARE SCHEDULE: Fill in the time the child is in your care (circle AM or PM)

Day of the Week	Schedule 1 Begin Time	Schedule 1 End Time	Schedule 2 Begin Time	Schedule 2 End Time
Sunday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Monday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Tuesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Wednesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Thursday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Friday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Saturday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM

Is this child care schedule the same each week? ☐ YES ☐ NO If no, explain how the care schedule varies:______________

CHILD #2

_______________ _______________ _____ ___/___/___
LAST NAME *FIRST NAME* *M.I.* *DATE OF BIRTH*

Summer Care: Date care started:_________ Date care ended:_________ How much is the parent charged per week? $________

Will Child 1 stay with this provider in the fall and will the before/after school hours of care remain the same? ☐ **Yes** ☐ **No**

Are you related to this child? ☐ YES ☐ NO If related, specify your relationship to the child:

☐ Grandparent/Great Grandparent ☐ Aunt/Uncle ☐ Sibling ☐ Other: ______________

CHILD'S CARE SCHEDULE: Fill in the time the child is in your care (circle AM or PM)

Day of the Week	Schedule 1 Begin Time	Schedule 1 End Time	Schedule 2 Begin Time	Schedule 2 End Time
Sunday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Monday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Tuesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Wednesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Thursday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Friday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Saturday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM

Is this child care schedule the same each week? ☐ YES ☐ NO If no, explain how the care schedule varies:______________

CHILD #3

_______________ _______________ _____ ___/___/___
LAST NAME *FIRST NAME* *M.I.* *DATE OF BIRTH*

Summer Care: Date care started:_________ Date care ended:_________ How much is the parent charged per week? $________

Will Child 1 stay with this provider in the fall and will the before/after school hours of care remain the same? ☐ **Yes** ☐ **No**

Are you related to this child? ☐ YES ☐ NO If related, specify your relationship to the child:

☐ Grandparent/Great Grandparent ☐ Aunt/Uncle ☐ Sibling ☐ Other: ______________

CHILD'S CARE SCHEDULE: Fill in the time the child is in your care (circle AM or PM)

Day of the Week	Schedule 1 Begin Time	Schedule 1 End Time	Schedule 2 Begin Time	Schedule 2 End Time
Sunday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Monday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Tuesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Wednesday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Thursday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Friday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM
Saturday	____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM

Is this child care schedule the same each week? ☐ YES ☐ NO If no, explain how the care schedule varies:______________

Parent Name:	C4K Case Number:

SECTION 4: PROVIDER CERTIFICATION *(To be completed by Provider)*

I certify that:

1) I am the individual or program that is providing care to the children listed on this form. I am at least 20 years of age and capable of providing safe and competent child care services. I do not have a disability, impairment or health problem that would prevent me from caring for the children.
2) Care will be given at the location specified on the form. I am responsible for reporting changes in the hours of care, the amount I charge for services, if the child stops attending care, and changes in the location where care is given. I must also inform Care 4 Kids of any changes in my criminal or child abuse/neglect history. Changes must be reported within 10 days.
3) For each child in my care, I have the name of the child's primary care physician and health insurance provider and proof that each child is up to date with his or her immunizations and health screening exams.
4) I understand and agree that the Office of Early Childhood and Care 4 Kids may verify information listed on this form independently without prior authorization, including criminal and child abuse/neglect background checks.
5) I understand that this agreement is between the parent and the provider. It is not a contract with Care 4 Kids or the State of Connecticut. Neither Care 4 Kids nor the State of Connecticut employ me. I am an independent contractor and will receive a 1099 tax form for monies received from Care 4 Kids.
6) Care 4 Kids may not cover my total charges. The parent is responsible for any costs that are not paid by Care 4 Kids.
7) I may be required to repay benefits that were paid to me in error. I may also be subject to criminal or civil charges if I knowingly omit, misrepresent or provide false information to Care 4 Kids or if I do not report changes in a timely manner that affect payments or my eligibility for this program. I may be liable for all penalties associated with crimes, including, but not limited to, larceny by defrauding a public community, conspiracy to commit larceny by defrauding a public community, vendor fraud, forgery, false statement and other relevant crimes pursuant to Title 53a of the Connecticut General Statutes.
8) I must submit a completed invoice to receive payment. Invoices are issued to me when payment is approved and monthly thereafter. I will have **120 days** to submit the completed invoice in order to be paid.
9) To be eligible for payments, (1) I will abide by State of Connecticut health and safety regulations as applied to me (either as a licensed or unlicensed provider), and (2) I will cooperate with the State of Connecticut and its designees in program audits and fraud prevention activities, including any site visits that may be conducted to my home, child care site or place of employment.
10) I understand I must complete the orientation and annual training requirements in order to be eligible for payment. For more information on specific provider requirements, visit www.ctcare4kids.com.
11) I have read and understand the information contained in this form and certify that all of the information I have provided is true and correct to the best of my knowledge.
12) I understand that if I am licensed, I must report any child fatalities and any injuries that result in a child being admitted to a hospital that occur while a child is in my care to The Office of Early Childhood, Licensing Division at 1-800-282-6063.

Provider Name ***(please print)*****:** ____________________ ____________________ ______
LAST NAME *FIRST NAME* *M.I.*

Provider Signature: ____ ____/____/____
DATE

SECTION 5: PARENT CERTIFICATION *(To be completed by Parent)*

I certify that:

1) I have selected the provider identified above to care for my children while I work or attend an approved activity.
2) I will report any changes in child care arrangements, household income that exceeds 85% of the State Median Income guidelines, loss of a job or ending of an approved activity, if the child receiving Care 4 Kids benefits is no longer in the home, or my residential address to Care 4 Kids within 10 days of a change.
3) I am responsible to pay the provider any costs not covered by Care 4 Kids.
4) I understand and agree that Care 4 Kids may contact the provider listed above and the provider may contact Care 4 Kids concerning my eligibility and payment amounts.
5) I may be required to repay benefits that were paid in error on my behalf. I may also be subject to criminal or civil charges if I knowingly omit, misrepresent or provide false information to Care 4 Kids or if I do not report changes in a timely manner that affect payments or my eligibility for this program. I may be liable for all penalties associated with crimes, including, but not limited to, larceny by defrauding a public community, conspiracy to commit larceny by defrauding a public community, vendor fraud, forgery, false statement and other relevant crimes pursuant to Title 53a of the Connecticut General Statutes.

Parent Name ***(please print)*****:** ____________________ ____________________ ______
LAST NAME *FIRST NAME* *M.I.*

Parent Signature: ____ ____/____/____
DATE