Wilson-Gray YMCA
VACATION CAMP

When school is out, the Y is in! For youth development, all year.

Dear YMCA Family,

Thank you for choosing the Wison-Gray YMCA for your vacation planning needs. We are excited to welcome you and your family to our program!

The Y's focus is on youth development, healthy living, and social responsibility. At the YMCA of Greater Hartford, the goal of our child development program is to nurture young people by providing a safe place to learn foundational skills, develop healthy, trusting relationships, and build self-confidence during school breaks.

Our vacation camp program is licensed by the state and follows the State of Connecticut requirements and regulations for child care programs. In addition to meeting the state's expectations, we also collaborate with many local and state organizations to offer the highest quality enrichment experience for your child.

PROGRAM HIGHLIGHTS:

- Character Development
- Service Learning Projects
- STEM Learning
- Minute to Win it Games
- A Caring Adult in the Presence of Every Child
- Healthy Education on Food and Movement
- AMAZING STAFF!

Please review this registration packet carefully. Complete and accurate information helps us to provide the best possible care for your child. If you have questions or need any additional information, please feel free to call or to email us.

Sincerely,

Melody Santiago
melody.santiago@ghymca.org

To register, please complete the following:

Currently enrolled At Wilson-Gray YMCA
Part 1: Vacation Camp Registration

New Participants (not enrolled in our childcare programs):
Part 1: Vacation Camp Registration
Part 2: Contact Registration/Payment Forms
Part 3: Health Forms, full immunization record and allergy care plans.

Valencia Mack
860-241-9622
Valencia.mack@ghymca.org

Wilson-Gray YMCA
444Albany Ave.
Hartford, CT 06120

p: (860) 241-9622
f: (860) 293-2120
wilsongrayYMCA.org

REGISTRATION MADE EASY

keep this page for your records!

STEP one

REGISTRATION

- ☐ If you are enrolled in the YMCA After Care at Wilson-Gray YMCA, please confirm that we have all necessary medical records. You will only need to fill out pages 2 and 8 of this form if we have your childcare packet. We will use the payment form we have on file unless otherwise stated.

- ☐ If you are not enrolled in After Care at Wilson-Gray YMCA, complete this entire packet, including medical forms.

If you don't have a copy of the medical forms, use the forms we've provided; you can request copies of the physical and immunization record from your **school, but any medication authorization must be filled out and signed by the Dr. on the form in this packet.** If you need to contact your **Dr.** for a copy 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 **"NO"** on them, SIGN and submit.

****Your child is not ready for our program until this packet is 100% completed and submitted and your payment is made.**

- ☐ Notify the YMCA of any changes to this packet or your child's medical condition.

STEP two

SUBMIT YOUR FORMS

WHERE TO SUBMIT YOUR FORMS:

Wilson-Gray
444 Albany Avenue
Hartford, CT 06120

WAYS TO SUBMIT YOUR FORMS:

- ☐ Mail (send to address on left)
- ☐ Drop it off at the office in Wilson-Gray YMCA
- ☐ Fax: (860) 293-2120 (Please confirm your fax!)

All forms must be received **at least one week prior to your student's program. Registration is **based on availability** and you are not guaranteed a spot in the program.

STEP three

PAYMENTS

- ☐ If it applies, fill out a financial aid packet. Visit wilsongrayymca.org for more information.
- ☐ If you are applying for financial assistance, you MUST also apply to Care 4 Kids; whether you think you are eligible or not, you will be required to go through the application process. (More info on page 9)
- ☐ Notify the YMCA if there are ANY updates to your payment information, including new or cancelled cards, accounts, or billing address, change of payee/custody, etc.

PROGRAM LOCATION

Wilson-Gray
444 Albany Avenue
Hartford, CT 06120

CHILDCARE CONTACT INFORMATION and pick up authorization form

REQUIRED FORM

CHILD/FAMILY INFORMATION

Child's Name _____ Male _____ Female _____ D.O.B. ____/____/____ Age____

Home Address _____ Town/City _____ State _____ Zip_____

Home Phone (____) _____-_____ School child attends _____ Grade in September 2016 _____

In case of emergency, which parent/guardian listed should we contact first? _____

Parent/Guardian Name_____

Relationship to Child _____

Parent/Guardian D.O.B. ____/____/_____

Address_____

Town/City _____ State _____ Zip____

Home Phone (____) _____-_____ Work (____) ____-_____

Cell Phone (____) _____-_____ **Please * your Preferred #**

Place of Work _____

Business Address _____

Email Address _____

Parent/Guardian Name _____

Relationship to Child _____

Parent/Guardian D.O.B. ____/____/_____

Address _____

Town/City _____ State _____ Zip____

Home Phone (____) _____-_____ Work (____) ____-_____

Cell Phone (____) _____-_____ **Please * your Preferred #**

Place of Work _____

Business Address _____

Email Address _____

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

EMERGENCY INFORMATION (Must have at least one besides the names listed above.)

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 from the YMCA in case of emergency or early dismissal from the YMCA.

Name_____ Relationship to child_____

Home Phone (____) _____-_____ Work (____) _____-_____ Cell (____) _____-_____

Address_____

Name_____ Relationship to child_____

Home Phone (____) _____-_____ Work (____) _____-_____ Cell (____) _____-_____

Address_____

CHILD PICK UP AUTHORIZATION

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 releasing my child.

Name_____ Name_____ Name_____

Address_____ Address_____ Address_____

City, Zip_____ City, Zip_____ City, Zip_____

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). _____

_____

CHILD DEVELOPMENT
electronic payment form

REQUIRED FORM

Please retain all receipts for tax purposes.

BILLING PARTY INFORMATION

Billing Name_____Child's Name_____

Address _____Town _____State_____Zip_____

Home Phone (_____) _____-_____Work Phone (_____) _____-_____Place of Work _____

VACATION CAMP REFUND POLICY

1. Vacation Camp spots are ***first come, first serve***.
2. Care costs $40.00 per child per day or $200 for the week. Payment is due in full at the time of registration.
3. Registration closes two (2) days prior to the day of care for registrants who are not currently enrolled in the Wilson-Gray AFTERSCHOOL.
4. Registration closes for current AFTERSCHOOL enrollees one (1) day prior to the Vacation Camp day at 3pm.
5. The completed registration form must be fully completed prior to registration if you are a non AFTERSCHOOL enrollee.
6. **No walk-in registrations allowed.**
7. If you are registered for Vacation Camp in advance, but are not planning to use care, you must cancel ***two weeks*** in advance by email: Valencia. mack@ghymca.org. There are **no refunds** after this point.
8. Registration forms can be faxed to (860) 293-2120or emailed to WGSACC@ghymca.org
9. All participant registrations and changes to registration must be submitted **in writing.**

TERMS AND CONDITIONS

It is my complete understanding that if I terminate my child's enrollment I must submit a letter in writing canceling my Electronic Payment giving the YMCA **Two (2) week(s) written notice** prior to my child's withdrawal date. I understand that paying under the Electronic Payment method, I am subject to fee increases periodically by the Board of Directors, and the YMCA may adjust the monthly rate applicable to my child's enrollment category. I will be notified 30 days in advance of any increases. Should any pre-authorized electronic payment not be honored by my financial institution when received, I agree that the payment is to be made by me in the amount of said payment, and I agree that I am responsible for that payment plus a service charge (contact your branch for current fees). I understand that if two electronic payments are rejected my child's enrollment will be terminated. I understand that the YMCA may utilize third party companies to assist with its collection efforts. Any service charge from the YMCA or its third party agencies does not include possible fees imposed by my financial institution.

I, the undersigned, have read and agree to the above Refund Policy and Terms and Conditions. I agree that my child may fully participate in all activities outlined in the vacation day program.

Parent/guardian Signature _____ **Date Signed** _____

ELECTRONIC FUNDS TRANSFER (EFT) OR CREDIT/DEBIT CARD AUTHORIZATION

I authorize the YMCA of Greater Hartford to debit my account as indicated below. Should any preauthorized EFT or Credit/Debit Card payment not be honored by my financial institution at the time of the draft, I understand and agree to the YMCA re-submitting, at their discretion, the request for payment. CHOOSE ONE PAYMENT METHOD:

☐ **CREDIT/DEBIT CARD**

Card Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover Expiration Date: _____

Name on Card (print) _____Card Number _____

Authorized Signature _____ Date _____

☐ **EFT**

Financial Institution Name & Address _____

Name on Account (print) _____ ☐ Checking Account ☐ Savings Account

Routing Number (9 digits) _____ Account Number _____

Authorized Signature _____ Date _____

CHILDCARE
memorandum of understanding

REQUIRED FORM

Child Name_____

Parent/Guardian Name _____

1. The YMCA assumes responsibility for my child's well being during the hours of operation in which my child attends the program.
2. I am responsible for the cost of all medical treatment and care.
3. The information on this form is complete and accurate. I have provided the YMCA with all of the necessary information to properly care for my child's needs.
4. I must notify the YMCA staff in writing immediately of any changes to this form.
5. It is my responsibility to notify the YMCA my child will be absent from the program.
6. YMCA staff is not allowed to baby-sit or transport children at any time outside of the YMCA program.
7. Parents/guardians are required to sign child in & out of program every day. This includes the time of drop off & pick up as well as a signature.
8. Each child must be able to fully participate in all activities. If they are ill and cannot fully participate, a parent/guardian will be contacted to pick them up within one hour's time.
9. The YMCA promotes a safe environment for all children and staff. If a child acts inappropriately the behavior management policy lays out guidelines and the procedures that the YMCA will take.
10. The YMCA follows all State of CT guidelines when administering medications, including but not limited to: only certified staff may administer medication; collection of the appropriate forms signed by parents and physician where applicable; medication must be in original, labeled container.
11. The YMCA must have accurate, up-to-date health and medical information for each child according to CT Department of Public Health regulations. Children may not participate in child care programs if health and medical forms are absent or expired.
12. **A two-week written notice must be provided to the office when changing your child's schedule or withdrawing from program.**
13. Two-party payments are available upon request of the parent/guardian.
14. The YMCA agrees not to share information with non-regulatory outside agencies who have not been designated by the parent or guardian. All changes to this policy must be written and handed in to the YMCA.
15. The YMCA is required to collect copies of all court orders & custody agreements regarding the child's limited access to the parents and/or guardians.

Please check each additional statement with which you agree:

The YMCA has permission to use photographs of my child in promotional materials such as brochures, ads, televisions/videos, YMCA website, or newspaper releases. I will not be informed or reimbursed for such photographs.

☐ I give permission to the YMCA staff to administer First Aid in case of injury. In the event my child needs immediate attention and I cannot be contacted I give the YMCA staff permission to authorize medical treatment for my child.

☐ I give the YMCA permission to transport my child, in the event of an emergency and for field trips. Prior written notice will be given for all field trips.

☐ **As per State Regulations, a signed consent for the children to participate in activities outside of licensed child care space (i.e.: library or another classroom in the event the school needs the cafeteria) I give permission for my child to participate activities outside licensed child care space under the supervision of the YMCA Staff.**

☐ I have read and understand all policies and procedures including but not limited to the items outlined above.

Parent/Guardian Signature Date

Wilson-Gray YMCA
444Albany Ave.
Hartford, CT 06120

p: (860) 241-9622
f: (860) 293-2120
wilsongrayYMCA.org

CHILD GUIDANCE and discipline policies

REQUIRED FORM

It is YMCA procedure to use positive techniques of guidance with all children. Staff will set appropriate expectations and will have guidelines and environments that will minimize the need for discipline. Staff will be aware that all children are different and respond to different disciplinary techniques. The best results are achieved when parents and staff work together. Therefore, staff will communicate any behavior issues to parents promptly and be available for discussion.

Staff will be responsible for managing child behavior using techniques based on developmentally appropriate practice, including positive guidance, redirection, and setting clear limits that encourage children to develop self-control, self-discipline, and positive self-esteem.

The following are YMCA policies of positive guidance and discipline techniques:

1. Staff will divert attention away from any activity that they disapprove of by substituting another toy/game or leading the child to another activity.
2. Staff will offer children choices of activities/games they can participate in.
3. Staff will set limits for children that are consistently enforced and are based on reasons children can understand.
4. Children will be given warnings when they have done something wrong. Warnings are necessary to allow children to know in advance what to expect, reduce resistance and ease transitions.
5. Staff will structure the environment in such a way to help reduce misbehavior and accidents.
6. Staff will redirect behavior. It is necessary at times to move a child away from a behavior by suggesting an alternative acceptable behavior.
7. Staff will model appropriate behaviors for children.
8. Staff will be aware when a conflict between children arises. Staff will engage children in helping to solve the problem by analyzing the situation and all possible solutions, and work with the children to pick one they all agree is the best.
9. Staff will separate children if they are having difficulty getting along.
10. Staff will remain objective when there is a problem with a child.
11. Staff will give children positive attention, and will engage children in behaving positively.
12. Staff will encourage children to behave positively and to continue to behave in appropriate ways.
13. Staff will explain the consequences of misbehavior to all children, and will continually remind students of consequences.
14. No child will be physically restrained unless it is necessary to protect the health and safety of the child and others.
15. Site Directors and staff will discuss positive guidance techniques with parents, and will review these techniques as needed during the period of the child's enrollment.
16. If a child's behavior is determined by the Program Director and Executive Director to be a danger to the child, to other children or to the staff in a program, parents/guardians will be required to withdraw the child from the program.
17. Staff will report actual or suspected child abuse or neglect, or imminent risk of serious harm of any child to the Department of Children and Families as mandated by section 17a-101 to section 17a-101e inclusive, of the Connecticut General Statutes. Connecticut General Statutes identifies professionals who, because their work involves regular contact with children, are mandated by law to report suspected child abuse and neglect. All YMCA employees are considered Mandated Reporters by the State of CT. Mandated Reporters are required to report abuse or neglect based on a reasonable cause to suspect, such as what is observed, what is told or said.

I have read, understood, and discussed the Child Guidance and Discipline policies of the West Hartford YMCA.

Parent/Guardian Signature Date

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

REQUIRED FORM

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_____).
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 "releasees") 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 releasees 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 child off licensed property for 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.

Date: _____ Printed Name of Participant _____

Printed Name of Parent/Guardian _____

Signature of Participant or Parent/Guardian _____

Wilson-Gray YMCA
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Hartford, CT 06120

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wilsongrayYMCA.org

HEALTH CARE ASSESSMENT
instructions

REQUIRED FORM

STEP one

Complete State of CT Health Assessment Record (pages 8-10) or you may obtain a copy from your school or Doctor and submit it with your registration and step 2 if it applies to your child.

STEP two

If any of the health history questions on the State of CT Health Assessment Record are answered "YES" then the appropriate attached individual care plan must be completed and signed by the Dr. i.e. ASTHMA (page 15), ALLERGY (page 16) or GENERAL Form (page 19).

If your child has no asthma, no allergies, and takes no medications, check "NO" on the appropriate forms, SIGN and SUBMIT with rest of paperwork.

Parents are responsible for bringing medication to the vacation camp site in a labeled, clear plastic bag. All medication needs to be in its original container with original labels.

HEALTH AND INSURANCE INFORMATION

HEALTH - Indicate "yes" where it applies and explain as necessary.

						ALLERGIES	
Asthma	___	Convulsions	___	Emotional	___	Hay Fever	___
Diabetes	___	Hearing	___	Psychological	___	Poison Ivy	___
Special Diet	___	Vision	___	Learning Disability	___	Insect	___
Physical	___	Illness	___	ADD/ADHD	___	Medication	___
Restraints	___	Injury	___	Operations	___	Food	___
Other	___						

Please explain details of above "yes" answers _____

_____

Special health or emotional note _____

Is this child currently taking prescribed or over-the-counter medication? _____Yes_____No_____ Why? _____

Are you covered by any hospitalization/medical care policy? Yes ___ No ___ Preferred Hospital _____

Name of Insurance Company_____ Phone (____) _____-_____

Address _____ Town/City _____State _____Zip _____

Policy Holder's Name _____ Policy Holder's D.O.B. ____/____/____

Policy Number _____

Name of Physician _____ Phone (____) _____-_____

Name of Dentist _____ Phone (____) _____-_____

Special Services received through school or other agency:

_____

_____

HEALTH ASSESSMENT
step one

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

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

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

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

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

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

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

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

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

Signature of Parent/Guardian Date

HAR-3 REV. 4/2010

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

Wilson-Gray YMCA
444Albany Ave.
Hartford, CT 06120

p: (860) 241-9622
f: (860) 293-2120
wilsongrayYMCA.org

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					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**			***Auditory Screening**				Date
Type:	Right	Left	Type:	Right	Left	Lead:	
With glasses	20/	20/		❑ Pass ❑ Fail	❑ Pass ❑ Fail	***HCT/HGB:**	
Without glasses	20/	20/					
❑ Referral made			❑ Referral made			Other:	

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

*IMMUNIZATIONS

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

***Chronic Disease Assessment:**

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

Anaphylaxis 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

HEALTH ASSESSMENT
step one

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

ASTHMA CARE PLAN

REQUIRED FORM

step two **does your child have asthma?**

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

☐ YES
☐ NO

Student's Name: _____ **Birthday:** _____

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

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

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)

A. _____ No medication required while attending Camp. Physician initials required: _____

B. _____ Medication required at camp (Bring original prescription to first day of camp, label clearly showing student'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: _____ **Phone number:** (____) - _____

Physician's signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

ALLERGY CARE PLAN

step two **does your child have any allergy?**

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

REQUIRED FORM

☐ YES
☐ NO

Student's Name: _____ **Birth Date:** _____

Student 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#:_____
   Parent/Guardian:_____ Phone#:_____
5. If Parent/ Guardians 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 student's name, birthday, and expiration date)

Physician's Name: _____ **Phone number:** (____) - _____

Physician's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

Wilson-Gray YMCA
444Albany Ave.
Hartford, CT 06120

p: (860) 241-9622
f: (860) 293-2120
wilsongrayYMCA.org

GENERAL INDIVIDUAL CARE PLAN

REQUIRED FORM

step two will your child take any meds at the Y?

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:

MUST BE SIGNED ON FOLLOWING PAGE!

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GENERAL INDIVIDUAL CARE PLAN
step two continued

REQUIRED FORM

Dietary/Nutritional Restrictions:

Communication:

Gross Motor:

Social-Emotional:

Sleep:

Physician's Name: _____

Physician's Signature: _____

Phone number: (____) - _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

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MEDICATION AUTHORIZATION

REQUIRED FORM

step two **will your child take any meds at the Y?**

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

☐ YES
☐ NO

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____ Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered _____

Specific Instructions for Medication Administration _____

Dosage_____ Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: ____/____/____ End Date: ____/____/____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____ Town_____ State____

Home Phone # (____) _____-_____ Work Phone # (____) _____-_____ Cell Phone # (____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____ (Signature) _____ (Date)

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____ (Signature) _____ (Date)

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____ (Signature) _____ (Date)

Today's Date _____ Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

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THANK YOU FOR CHOOSING
Y VACATION CAMP!

When school is out, the Y is in! For youth development, all year.

We know it takes a lot of paperwork to ensure the safety of your children during our vacation camp program, but thanks for sticking with it. Now you can take a deep breath...

We can't wait to see you at the Y!

Remember to make sure to <u>submit this packet</u> and confirm your <u>payment.</u>

If at any time you'd like to speak with us, or if you need any information, please contact our main office at (860) 241-9622 or email **Valencia.mack@ghymca.org**.

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