FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

2019- 2020 Vacation Camp Days
Registration Form

Thank you for choosing the Farmington Valley YMCA for your child care needs. Here at the FV-YMCA, we are excited to build and continue this relationship with you and your family.

Following a very successful and innovative Summer Camp, the 2019-2020 Vacation Days is poised to be even better. Each vacation camp week will involve individual and group activities, and challenges aimed at igniting your child's creativeness. Staff will develop activities surrounding the daily themes as well as working towards building confidence in each participant all while providing you the peace of mind knowing your child is in a safe, caring atmosphere.

To register, please complete the following:
Currently enrolled School Age Childcare Participants must complete:

- Part 1: Vacation Camp Registration

New Participants (not enrolled in our childcare programs) must complete:

- Part 1: Vacation Camp Registration
- Part 2: Contact Registration/ Payment Forms
- Part 3: Health Forms with full immunization record and/ or allergy care plans.

Please feel free to contact us if you have any questions or concerns.

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Child's Name: _____

Is your child **registered** for the YMCA SACD program? _____ Site Location: _____

Please check all days that you will be registering your child for. Registration closes **two (2)** day prior to the vacation camp for SACD parents and **three (3)** days prior for **non** SACD children. . All Vacation club days will meet at the Farmington valley YMCA unless otherwise communicated. Snow Days follow Granby Public School schedule only. Your participant is welcome to join regardless of school district; however, the program is only staffed when Granby Schools are off.

Date	Holiday / Day Off	Payment Deducted Date	Check To Register
12/23	Winter Vacation	December 20, 2019	
12/24	Winter Vacation	December 21, 2019	
12/26	Winter Vacation	December 23, 2019	
12/27	Winter Vacation	December 24, 2019	
12/30	Winter Vacation	December 27, 2019	
12/31	Winter Vacation	December 28, 2019	
1/20	MLK Day	January 17, 2020	
2/17	Presidents' Day	February 14, 2020	
2/18	February Vacation	February 15, 2020	
4/10	Good Friday	April 7, 2020	
4/13	Spring Vacation	April 10, 2020	
4/14	Spring Vacation	April 11, 2020	
4/15	Spring Vacation	April 12, 2020	
4/16	Spring Vacation	April 13, 2020	
4/17	Spring Vacation	April 14, 2020	

Total Vacation Days_____ X $50 per child = $

SNOW DAYS

Please fill out the information below for the total number of snow days you would like to pre purchase. All unused snow days will be refunded in May 2019.

Total Snow Days_____(max of 3) X $45 per child = $_____

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Vacation Camp Refund Policy

1. Vacation Camp spots are ***first come, first serve***.
2. Care costs $50 per child per day.
3. Snow Days cost $45 per child per day.
4. Registration closes three (3) days prior to the day of care for registrants who are not currently enrolled in SACC.
5. Registration closes for current SACC enrollees two (2) day prior to the Vacation Camp day.
6. The completed Child Development Electronic Payment form must be fully completed prior to registration only if you are a non SACC enrollee.
7. The account listed will be charged three (3) days prior to the day of care.
8. **No walk- in registrations allowed.**
9. If you are registered for Vacation Days in advance, but are not planning to use care, you must cancel ***72 hours*** in advance by email: beth.garza@ghymca.org. There are **no refunds** after this point.
10. Registration forms can be faxed to (860) 844-8074 or emailed to beth.garza@ghymca.org
11. All participant registrations and changes to registration must be submitted **in writing.**

Permission to Participate

This page must be completed and attached to the registration form before registration is complete.

I agree that my child _____ may fully participate in all activities outlined in the vacation day program. Also, I agree and understand the Vacation Camp Refund/ Payment Policies.

Parents/ Guardian (print name): _____

Parent Signature: _____ Date: _____

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Part 2: Registration and Payment Forms

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Farmington Valley YMCA Child Care Registration Form 2019-2020

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 (____) ____-_____
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 (____) ____-_____
Place of Work _____
Business Address _____
Email Address _____

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

EMERGENCY INFORMATION

In case of emergency, and the YMCA is unable to reach the parents/guardians listed above, the following individuals have permission to make decisions regarding the care of my child, including permission to pick up my child from the YMCA in case of emergency or early dismissal from the YMCA.

Name_____ Relationship to child_____

Home Phone (____) _____-_____Work (____) _____-_____ Cell (____) _____-_____
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 before releasing my child.

Name_____ Name_____ Name_____
Address_____Address_____Address_____

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

Special Orders for picking up child (Please enclose legal documents if specified people are named). _____

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BILLING PARTY INFORMATION

Billing Name_____ Child's Name_____
Address _____ Town _____ State_____ Zip_____
Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Place of Work _____

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

HEALTH						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:

_____

PARENT/GUARDIAN AGREEMENT

I understand:

1. Any registration or deposit fee is non-refundable, non-transferable and for administration purposes only.
2. The YMCA assumes responsibility for my child's well-being during the hours of operation in which my child attends the program.
3. I am responsible for the cost of all medical treatment and care.
4. 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.
5. I must notify the YMCA staff in writing immediately of any changes to this form.
6. It is my responsibility to notify the YMCA my child will be absent from the program.
7. YMCA staff is not allowed to baby-sit or transport children at any time outside of the YMCA program.

I have read the YMCA Child Care Handbook and agree to these policies and procedures. Initial here _____

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.

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

_____

Parent/Guardian Signature *Date*

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Child Guidance and Discipline Policies: 2019-2020 School Year

Child's Name Age Date

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 working with the children to pick one they all agree as the best one.
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 the 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.

(Continued on next page)

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Child Guidance and Discipline Policies: 2018-2019 School Year (continued)

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 Farmington Valley YMCA.

Parent/Guardian Signature Date

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YMCA of GREATER HARTFORD
RELEASE and WAIVER OF LIABILITY and INDEMNITY
And PHOTO/TALENT RELEASE AGREEMENT

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_____). **(ONLY initial if you do not want photos taken)**
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. 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.
10. 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 _____

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Part 3:
Health Assessments and Care Plans

If a health assessment is marked "YES" for any allergies/ medications a care plan must be filled out and signed by a medical professional.

Medication must be presented the morning of drop off at Vacation Camp. Children will not be accepted if medication is not provided.

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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, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base 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	❑ Black, not of Hispanic origin
	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
Primary Care Provider		❑ Asian/Pacific Islander
	❑ Hispanic/Latino	❑ Other
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. 4/2012

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

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HAR-3 REV. 4/2012

Part II — Medical Evaluation

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

Student Name _____ Birth Date _____ Date of Exam _____

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

Physical Exam

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

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

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

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

Screenings

***Vision Screening**			***Auditory Screening**			Date
Type:	Right	Left	Type:	Right	Left	History of Lead level ≥ 5µg/dL ❑ No ❑ Yes
With glasses	20/	20/		❑ Pass ❑ Fail	❑ Pass ❑ Fail	***HCT/HGB:**
Without glasses	20/	20/				***Speech** (school entry only)
❑ Referral made			❑ Referral made			Other:

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

*IMMUNIZATIONS

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

***Chronic Disease Assessment:**

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

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

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

Seizures ❑ No ❑ Yes, type:

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

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

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

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

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

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Student Name: _____ **Birth Date:** _____ HAR-3 REV. 4/2012

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	*				Required for 7th grade entry	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
HPV						
Flu	*				PK students 24-59 months old – given annually	
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: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 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 of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart- 1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart- 1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 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 or verification of disease*.

* **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.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nation-wide shortage of supply for such vaccine.

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

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YMCA of Greater Hartford
Asthma Special Care Plan

Child's Name _____ Date of Birth _____

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.		

__No medication required while attending child care program
**Doctors initials are required*
__Medication form and medication on site
***Special Instructions _____
_____

2. **Observe for decreased symptoms**
3. **Contact Parent/Guardian if emergency medication is required**
4. **Call 911 if:**
   a. **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 name: _____ **Parent's signature:** _____ **Date**_____

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA of Greater Hartford
Allergies Care Plan

Child is allergic to:_____

Steps to take during an allergy episode:

(Physicians, please check all that apply)

1. **SIGNS OF AN ALLERGIC REACTION:**
   - **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"**

***If child has asthma, asthma symptoms may also need to be treated.**
The severity of symptoms can change quickly. All above symptoms can potentially be life threatening.

ACTION FOR MINOR REACTION:

1. **If only symptom(s) are:_____, give_____**
2. **Then call: Parent/Guardian_____Phone#_____**

ACTION FOR MAJOR REACTION:

1. **If Symptom(s) are:_____**
   Give_____IMMEDIATELY!
2. **Then Call 911**
3. **Parent/Guardian:_____ Parent Guardian:_____**
   Or emergency contacts
4. **Dr. _____ Phone number_____**

__No medication required while attending child care program
******Doctors initials are required***
__Medication form and medication on site
****Special Instructions: _____**
_____
_____

Physician's name: _____

Physician's signature: _____

Phone number: (____) - _____ Date: _____

Parent's name: _____ Parent's signature: _____