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.
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.

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

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 = $ __________________________
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: ____________
Part 2: Registration and Payment Forms
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 ____________________________ Parent/Guardian Name ____________________________

Relationship to Child ____________________________ Relationship to Child ____________________________


Address ____________________________ Address ____________________________

Town/City __________________ State ________ Zip ________ Town/City __________________ State ________ Zip ________

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

Place of Work ____________________________ Place of Work ____________________________

Business Address ____________________________ Business Address ____________________________

Email Address ____________________________ Email Address ____________________________

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

EMERGENCY INFORMATION

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

Name________________________________________ Relationship to child________________________

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

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). ______________
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

- 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 ____________________________

Address ____________________________________________

Policy Holder’s Name ____________________________

Policy Number ____________________________

Name of Physician ____________________________

Phone (____) - __________

Policy Holder’s D.O.B. __________  /  /

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 ____________________________

Farmington Valley Vacation Days 2019-2020
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)
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
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. **RELEASE, 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 ________________________________

Farmington Valley Vacation Days 2019-2020
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.
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 in sports teams.

Please print

<table>
<thead>
<tr>
<th>Student Name (Last, First, Middle)</th>
<th>Birth Date</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, Town and ZIP code)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian Name (Last, First, Middle)</td>
<td>Home Phone</td>
<td>Cell Phone</td>
<td></td>
</tr>
<tr>
<td>School/Grade</td>
<td>Race/Ethnicity</td>
<td></td>
<td>White, not of Hispanic origin</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td></td>
<td>Asian/Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>Health Insurance Company/Number* or Medicaid/Number*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does your child have health insurance? Y N If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have dental insurance? Y N

* If applicable

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

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

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

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:

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 4/2019

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

Farmington Valley Vacation Days 2019-2020
# Part II — Medical Evaluation

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

### Physical Exam

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

<table>
<thead>
<tr>
<th><em>Height</em> (in.)</th>
<th><em>Weight</em> (lbs.)</th>
<th>BMI</th>
<th><em>Pulse</em></th>
<th><em>Blood Pressure</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Describe Abnormal</td>
<td>Ortho</td>
<td>Normal</td>
<td>Describe Abnormal</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Neck</td>
<td>Shoulders</td>
<td>Arms/Hands</td>
<td>Hips</td>
</tr>
<tr>
<td>H.E.N.T.</td>
<td>Arms/Hands</td>
<td>Hips</td>
<td>Knees</td>
<td>Feet/Ankles</td>
</tr>
<tr>
<td><em>Gross Dental</em></td>
<td><em>Postural</em> No spinal abnormality</td>
<td><em>Spine abnormality</em> Mild</td>
<td>Moderate</td>
<td>Marked</td>
</tr>
<tr>
<td>Lymphatic</td>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal/ hernia</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Screenings

<table>
<thead>
<tr>
<th><em>Vision Screening</em></th>
<th><em>Auditory Screening</em></th>
<th>History of Lead level</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: Right</td>
<td>Left</td>
<td>Type: Right</td>
<td>Left</td>
</tr>
<tr>
<td>With glasses 20/10</td>
<td>20/10</td>
<td>❑ Pass ❑ Fail</td>
<td>❑ Pass ❑ Fail</td>
</tr>
<tr>
<td>Without glasses 20/10</td>
<td>20/10</td>
<td>❑ Referral made</td>
<td>❑ Referral made</td>
</tr>
</tbody>
</table>

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 ❑ History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes
  
  If yes, please provide a copy of the Emergency Allergy Plan to School

- 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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Farmington Valley Vacation Days 2019-2020
**Immunization Record**

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

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

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Dose 4</th>
<th>Dose 5</th>
<th>Dose 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP/DTaP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DT/Td</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required for 7th grade entry</td>
</tr>
<tr>
<td>IPV/OPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required K-12th grade</td>
</tr>
<tr>
<td>Hib</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PK and K (Students under age 5)</td>
</tr>
<tr>
<td>Hep A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PK and K (born 1/1/2008 or later)</td>
</tr>
<tr>
<td>Hep B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required PK 12th grade</td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 doses required for K &amp; 7th grade as of 8/1/2011</td>
</tr>
<tr>
<td>PCV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PK and K (born 1/1/2008 or later)</td>
</tr>
<tr>
<td>Meningooccal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Required for 7th grade entry</td>
</tr>
<tr>
<td>HPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PK, students 24-59 months old — given annually</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Disease Hx ___________________________ (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**
- DTP: 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 days 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**
- DTP/DTdTd: At least 4 doses. The last dose must be given on or after 4th birthday; students who start the series at age 5 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*.

**GRADES 7-12**
- 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: 1 dose on or after the 1st birthday 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.

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Initial/Signature of health care provider  MD/ DO / APRN/ PA  Date Signed  Printed/Stamped Provider Name and Phone Number
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
___red face/pale or swollen
___gray or blue lips or fingernails
___persistent cough
___difficulty playing, eating, drinking, talking
___wheezing
___grunting
___gray or blue lips or fingernails
___sucking in chest/neck
___breathing faster
___other:_______________________________

Steps to take during an asthma episode:

1. Give medications as listed below:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Amount</th>
<th>When to use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

___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/fingernails
      - 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 ____________
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: ______________

Farmington Valley Vacation Days 2019-2020