2020

FARMINGTON VALLEY YMCA CAMPS

Camp Farmington Valley, Fun in the Sun, Twisters Gymnastics Camp, Youth Sports & Fitness Camp

"We Build Lifetime Success"

CAMP FARMINGTON VALLEY LOCATION:

Farmington Valley YMCA
97 Salmon Brook Street, Granby, CT 06035
860-653-5524

Rev. 1.31.2020

REGISTRATION MADE EASY

STEP one

REGISTRATION—Done online, In person, or Over the phone

- **Reserve your spot & pay $58 deposit or $100 (2 week session)**
- Deposits are **non-refundable** and will go toward the total payment of camp .
- **A one -time Registration Fee $20** ***This is non-refundable & Financial Aid does not apply .***
- **If it applies, fill out a financial aid packet; please call us at 860-653-5524 or stop by our welcome desk**

Your child is not ready for camp until this packet is **100%** completed and submitted and your camp payments are made **on time.**

STEP two

COMPLETE ALL REQUIRED FORMS and MEDICAL FORMS

- **Camper Contact Information and Pick Up Authorization Form**
- **Refund Policy/Late Registration Fee/Payment Agreement Form**
- **Waiver of Liability and Photo Release Agreement**
- **Youth Camp Health Exam/Record (3 pages)**
  Dated no later than September 1, 2018
- **Asthma Care Plan**
- **Allergy Care Plan**

If you don't have a copy of the medical forms, use the forms we've provided, or you can request them from your **school.** If you need to contact your **Dr.** for a copy dated no later than 9-1-2018, we advise that families reach out as soon as possible. If your

STEP three

SUBMIT ALL YOUR REQUIRED FORMS

WHERE TO SUBMIT YOUR FORMS:

Attn: Camp Farmington Valley
Farmington Valley YMCA
97 Salmon Brook Street
Granby, CT 06035

WAYS TO SUBMIT YOUR FORMS:

- **Snail Mail (send to address on left)**
- **Drop it off at the front desk at the FV YMCA**
- **Fax: (860) 844-8074 (Please confirm your fax!)**
- **Scan to campfvy@ghymca.org**

STEP four

STAY TUNED!

open houses: FIND OUT MORE ABOUT CAMP!

When: Saturday, June 6th 10:00AM-12:00PM & Weds June 10th 6:00-8:00PM
Where: Farmington Valley YMCA
97 Salmon Brook Street

REQUIRED

CAMPER CONTACT INFORMATION

PLEASE PRINT CLEARLY

Each child that attends our summer camp is required by the State Department of Health to have this information on file.

Child's Name _____ Gender _____ D.O.B. ____/___/____Age _____
Home Address _____Town/City _____State _____Zip_____
Home Phone (____) _____School_____ Grade in Sept 2020_____
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 * primary contact #*
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 * primary contact #*
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 is required.

EMERGENCY INFORMATION

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

Name_____Relationship to child_____
Home Phone ( ) _____ Work ( ) _____ Cell ( ) _____

Name_____Relationship to child_____
Home Phone ( ) _____ Work ( ) _____ Cell ( ) _____

CHILD PICK UP AUTHORIZATION Other than Legal Custodians

I give permission for my child to be released from the YMCA program to the people listed below at any time. I understand that YMCA staff requires these people to furnish Photo Identification before releasing my child.

Name_____Name_____Name_____
Address_____Address_____Address_____

Home Phone ( ) _____Home Phone ( ) _____Home Phone ( ) _____
Work Phone ( ) _____Work Phone ( ) _____Work Phone ( ) _____
Relationship_____Relationship_____Relationship_____

REQUIRED FORM

REFUND/LATE PAYMENT POLICIES

There are **NO** for late payments. campers will not be permitted into camp if payments have not been made on time.

Refund Policy:

Our Refund Policy states that all **deposits** are **non-refundable and non-transferable**.
All refund requests must be made in writing. If withdrawing due to a medical reason, a signed doctor's note must be presented and a full refund less the 20% deposit will be issued. All schedule changes must be made **in writing** at least **two weeks** prior to session start date. After the camp session/ week is complete a refund may not be submitted unless for medical reasons.

Registration Fees:

In order to provide the best resources that go into preparing each session of camp, summer camp registration ends the **Wednesday** prior to the following session. A One -Time Registration Fee of $20 will be applied for each camper for the 2020 season. The one-time fee is non-refundable and FA cannot be applied to this fee.

Payment Options:

You will be automatically withdrawn the balance left for that week of camp the **Wednesday** before your camper attends that week of camp. If payment is not collected the child will not be able to attend camp until payment is made.

Automatic Payments : All camp payment will be automatically withdrawn from a checking, savings, debit or credit card.

It is my complete understanding that if I wish to terminate my child's enrollment, I must submit a letter in writing canceling my EFT transaction **two (2) weeks prior** to my child's withdrawal date. I understand that the monthly debit to my account will vary based on my child's session enrollment. An estimate of this charge is listed above; however it is subject to change based on enrollment changes that I request. Should any pre-authorized check/charge (EFT) not be honored by my financial institution when received by them, I understand that the payment is to be made by me in the amount of said payment, and I realize that I am responsible for that payment, plus a service charge. I understand that if two EFT payments are rejected my child's enrollment will be subject to termination. 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.

CREDIT/DEBIT CARD ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Name on Card: _____ Signature:_____

Credit/Debit Card Number _____ Expiration Date: _____/_____/_____

Billing Address: _____Zip Code: _____

CHECKING/SAVINGS ACCOUNT Checking Savings

Name on Account: _____Account Holder Signature: _____

Routing Number: _____Account Number: _____

☐ **YES I agree automatic payment will be drawn from my account the Wednesday before my camper attends that week of camp.**
I understand that payment is due in full by the Wednesday before the camp week in order to remain enrolled in program.

☐ **Pay in Full**
I have paid my balance in full at registration and understand the refund policies outlined above.

REQUIRED FORM

RELEASE/WAIVER OF LIABILITY/IDEMNITY

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

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

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

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

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

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

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

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

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

7. **INDEMNIFY AND SAVE AND HOLD HARMLESS** I hereby agree to indemnify and save and hold harmless the 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.

REQUIRED FORM

SUNSCREEN APPLICATION

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

Camper's Name: _____

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

☐ I give permission to apply sunscreen

☐ I do not give permission to apply sunscreen

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

Name of parent/ Guardian (please print):
_____

Signature of Parent/Guardian _____ Date: _____

Reviewed by:

Name of staff (print): _____ Date: _____

Signature of Staff: _____

PRESCHOOL HEALTH ASSESSMENT

REQUIRED FORM

fill out if your child is attending preschool camp

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N Does your child have HUSKY 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	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months	Y	N	Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place			6. Interaction with others	Y	N	Eating concerns	Y	N
to another	Y	N	7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

ED 191 REV. 3/2015 C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2)

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	❑ Black, not of Hispanic origin
	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
Primary Care Provider	❑ Hispanic/Latino	❑ Asian/Pacific Islander
		❑ 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. 4/2010

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

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**

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

❑ Referral made

***Auditory Screening**

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

❑ Referral made

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

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

*IMMUNIZATIONS

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

***Chronic Disease Assessment:**

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

Anaphylaxis ❑ 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

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

does your child have asthma?

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

REQUIRED FORM

☐ YES
☐ NO

Camper's Name: _____ **Birthday**: _____

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

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

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

___ wheezing
___ other:_____

Steps to take during an asthma episode:
1. Give medications as listed below:

- o Has sucking in of the skin (chest/neck) with breathing
- o Won't play
- o Has gray or blue lips/finger nails
- o Cries more softly and briefly
- o Is hunched over to breathe

Medication Requirements: (check one)

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

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

**Special Instructions

_____

Camp Director: _____ Date:

Farmington Valley YMCA
97 Salmon Brook Street
Granby, CT 06035

p: (860) 653-5524
f: (860) 844-8074
https://ghymca.org/campfarmingtonvalley

ALLERGY CARE PLAN

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

Campers Name: _____**Birth Date**_____

Camper is Allergic to:

_____

Steps to take during an allergy episode:

1. SIGNS OF AN ALLERGIC REACTION: (please check the following)

- ☐ **Mouth/Throat**: itching & swelling of tongue, mouth, throat, throat tightness, hoarseness or cough
- ☐ **Skin**: hives, itchy rash, or swelling
- ☐ **Gut**: nausea, abdominal cramps, vomiting, diarrhea
- ☐ **Lung**: shortness of breath, coughing, wheezing
- ☐ **Heart**: pulse is hard to detect, "passing out"

ACTION FOR MINOR REACTION:

If only symptom (s) are:_____,
give_____

Then call: Parent/Guardian_____
Phone#_____

Action Steps for Major Reaction:

1. If symptom (s) are:

_____
_____

2.Give_____
3. Call 911
4. Call Parent/Guardian:_____
Phone#:_____
5. If Parent/ Guardian are unreachable, contact Emergency Contacts

Medication Requirements: (check one)

1. _____ No medication required while attending Camp.

Physician initials required: _____

Camp Director: _____ Date: _____

First- Aid Director: _____ Date: _____

REQUIRED FORM

GENERAL INDIVIDUAL CARE PLAN

will your child take **any** meds at camp?

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

☐ YES
☐ NO

Child's Name_____

Date of Birth_____

Parent/Guardian Name _____

Emergency Phone Numbers: Name/Relation_____

Name/Relation_____

*****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:

Physician's Name:

_____

Physician's Signature:

_____

Farmington Valley YMCA
97 Salmon Brook Street
Granby, CT 06035

p: (860) 653-5524
f: (860) 844-8074
https://ghymca.org/campfarmingtonvalley

MEDICATION AUTHORIZATION

will your child take **any** meds at camp?

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

REQUIRED FORM

☐ YES
☐ NO

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

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

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

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

Address of Child/Student _____Town_____

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

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

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

Relevant Side Effects of Medication _____ ☐ None Expected

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

Plan of Management for Side Effects _____

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

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

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

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

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

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

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

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

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

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

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

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

****

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

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

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

THANK YOU FOR CHOOSING

Camps at the Farmington Valley YMCA

We know it takes a lot of paperwork to ensure the safety of your children during summer camp, but thanks for sticking with it.

CONGRATS!

you've completed the registration packet!

We can't wait to see you at Camp FV!

Remember to make sure to <u>submit this packet.</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) 653-5524 or email **campfvy@ghymca.org**.