



WELCOME TO YMCA CAMP CUTLER

Dear Campers/Families,

Summer is on the way which only means one thing.... CAMP is almost here!

We hope this letter finds you and your family well. As we begin the 2020 season, we would like to welcome back all our returning families and would also like to extend a great Camp Cutler welcome to all of you! We know that finding the right summer camp is important to you, and we can assure you that your child will have the most amazing experience at **Camp Cutler** this summer.

You should know that by making the decision to send your child to camp this summer, you are providing him/her with an experience that will have lasting impact. Committed to teaching the Y Core Values--caring, honesty, respect, and responsibility—and creating a camping community around excitement, Camp Cutler's culture and traditions are one of a kind.

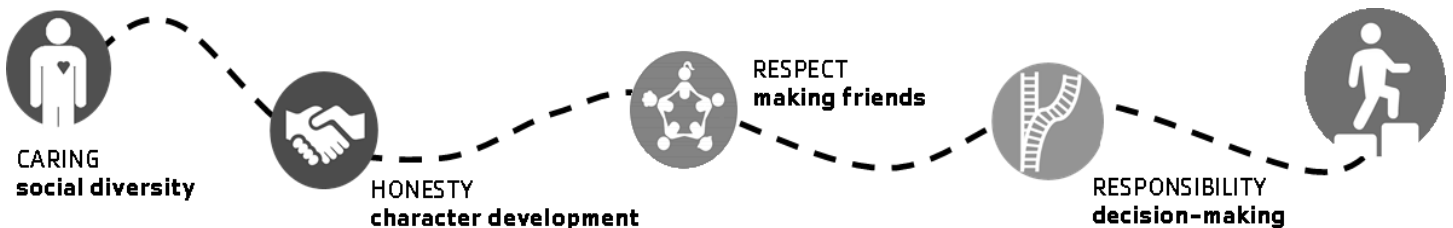
Along with these great highlights, this is what you'll experience at Camp Cutler!

Fun Weekly Themes
Swim/Water Safety Lessons
Teambuilding Exercises
Pre and Post Camp care available

Arts and Crafts
Structured Sports
Activities All-Camp Games
Lots and Lots of Fun!!

See you soon,

If at any time you'd like to speak with us, or if you need any information, please contact the Hale YMCA at (860) 315-9622 or email Camp.Cutler@ghymca.org.



Camp Cutler—Hale YMCA
9 Technology Park Drive
Putnam, CT 06260

p: (860) 315-9622
f: (860) 315-9798
ghymca.org/hale



CAMP DESCRIPTIONS

Pre School (Kiddie) Camp (Ages 3 – PreK)

This half day program gives preschoolers a chance to experience summer camp! Each day the campers in this program will enjoy swimming, arts and crafts, circle time and other age appropriate activities. Perfect for children who are preschool age, who have never tried summer camp before or had the opportunity to experience a school-like setting. *Please note, any child that is entering Kindergarten is recommended to participate in our traditional day camp.*

Monday – Friday 9:00am – 12:00pm

Traditional Camp (Grades K–5)

This traditional camp program provides students in grades K-5 theme-based camp experiences. Activities include swimming, water safety lessons, teambuilding exercises, arts and crafts, STEM activities, All-camp games, weekly projects and a whole lot of fun!

Full Day: 9:00 am – 4:00pm
Half Day: 9:00am – 12:00pm
3 Day: Monday, Wednesday, Friday

Tween Camp (Grades 6–8)

This traditional camp program provides middle school students in grades 6-8 theme-based camp experiences while focusing on the importance of self-esteem and self-confidence. Activities include swimming, water safety lessons, teambuilding exercises, arts and crafts, STEM activities, All-camp games, weekly projects and a whole lot of fun!

Full Day: 9:00 am – 4:00pm
Half Day: 9:00am – 12:00pm
3 Day: Monday, Wednesday, Friday

Pre and Post Camp Activities (Grades K–8)

We recognize that it is not always easy or convenient for our camper's families to accommodate transportation in conjunction with our scheduled camp times. For those families, we do offer both a pre (6:30am—9:00am) and/or post (4:00pm—6:00pm) camp care in order to help with those needs. Supervised activities will be run during these times in either the campsite, the teen center or the gymnasium. If pre or post care is necessary for your child, please register them for this option as well.



SELECT CAMP OPTIONS BELOW

(Please check all that apply)

Camper's Name: _____

		PRE-SCHOOL	1/2 DAY	3 DAY	FULL DAY	TWEEN	PRE CAMP	POST CAMP
Member Rates:		\$110	\$150	\$150	\$210	\$210		
Non-Member Rates:		\$160	\$200	\$200	\$260	\$260		
Week 1: Animals	June 15-19							
Week 2: Food	June 22-26							
Week 3: Wood Building	June 29-July 3							
Week 4: Nature	July 6-10							
Week 5: Water	July 13-17							
Week 6: Creations	July 20-24							
Week 7: Music and Theater	July 27-31							
Week 8: Olympics	August 3-7							
Week 9: Electricity	August 10-14							
Week 10: Astronomy and Geology	August 17-21							

Note: There may be different themes for our Tween Camps

Please review page 5 for our Refund Policy.

Signature _____

Date _____



REGISTRATION MADE EASY

keep this page for your records!

STEP one

REGISTRATION—Done in person, online or over the phone

- Reserve your spot & pay the deposit, plus the one-time \$20 registration fee
- If it applies, fill out a financial aid packet
Visit ghymca.org/hale for more information
- Make Your Payments

ALL CAMP WEEKS ARE TO BE PAID IN FULL BY THE WEDNESDAY BEFORE THE CAMP WEEK STARTS!

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

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Camper Contact Information and Pick Up Authorization Form <input type="checkbox"/> Payment Terms and Agreement Form <input type="checkbox"/> Waiver of Liability and Photo Release Agreement <input type="checkbox"/> Sunscreen Authorization Form | <ul style="list-style-type: none"> <input type="checkbox"/> Youth Camp Health Exam/Record (3 pages)
<i>- Dated no later than September 1, 2019</i> <input type="checkbox"/> Asthma Care Plan <input type="checkbox"/> Allergy Care Plan <input type="checkbox"/> General Individual Care Plan & Medication Requirements |
|--|---|

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 doctor for a copy dated no later than 9-1-2019, we advise that families reach out as soon as possible. If your child does not have asthma, allergies, or take medication, do not leave out those forms. Please check "NONE" on them and submit.

STEP three

SUBMIT ALL YOUR REQUIRED FORMS

WHERE TO SUBMIT YOUR FORMS:

**Hale YMCA Youth and Family Center
9 Technology Park Drive
Putnam, CT 06260**

WAYS TO SUBMIT YOUR FORMS:

- Snail Mail (send to address on left)
- Drop it off at the front desk at the Hale YMCA
- Fax: (860) 315-9798 (Please confirm your fax)
- Email: Camp.Cutler@ghymca.org

STEP four

STAY TUNED AND LEARN MORE!

OPEN HOUSES

When: TBD

Where: Hale YMCA Youth and Family Center — 9 Technology Park Drive, Putnam, CT 06260

Look out for emails from our Camp Director and pay special attention to your inbox for an email the week prior to camp!



PAYMENT SCHEDULE

All camp payments are due on the following dates:

	Dates of Session	Scheduled Payment Due Date
Week 1: Animals	June 15-19	Friday, June 5
Week 2: Food	June 22-26	Friday, June 12
Week 3: Wood Building	June 29-July3	Friday, June 19
Week 4: Nature	July 6-10	Friday, June 26
Week 5: Water	July 13-17	Friday, July 3
Week 6: Creations	July 20-24	Friday, July 10
Week 7: Music and Theater	July 27-31	Friday, July 17
Week 8: Olympics	August 3-7	Friday, July 24
Week 9: Electricity	August 10-14	Friday, August 31
Week 10: Astronomy and Geology	August 17-21	Friday, August 7



CAMPER CONTACT INFORMATION

and pick up authorization form

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 _____ Male _____ Female _____ D.O.B. ____/____/____ Age _____
Home Address _____ Town/City _____ State _____ Zip _____
Home Phone (____) _____ - _____ School _____ Grade in September 2019 _____
In case of emergency, which parent/guardian listed should we contact first? _____

Parent/Guardian Name _____	Parent/Guardian Name _____
Relationship to Child _____	Relationship to Child _____
Parent/Guardian D.O.B. ____/____/____	Parent/Guardian D.O.B. ____/____/____
Address _____	Address _____
Town/City _____ State _____ Zip _____	Town/City _____ State _____ Zip _____
Home Phone (____) _____ Work (____) _____	Home Phone (____) _____ Work (____) _____
Cell Phone (____) _____ <i>Please *primary contact #</i>	Cell Phone (____) _____ <i>Please *primary contact #</i>
Place of Work _____	Place of Work _____
Business Address _____	Business Address _____
Email Address _____	Email Address _____

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 _____

Unless informed otherwise, the YMCA assumes both parents listed above may pick up the child. We also assume both birth parents listed on their birth certificate are also eligible to pick up the child. If a parent may not pick up the child, legal documentation of that fact is required.

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

BILLING PARTY INFORMATION

PLEASE PRINT CLEARLY

Billing Name _____ Child's Name _____
Address _____ Town _____ State _____ Zip _____
Home Phone (____) _____ Place of Work _____ Work Phone (____) _____

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

Parent/ Guardian Signature _____

Date _____



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

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

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

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

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

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

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

Printed Name of Camper: _____

Signature of Participant or Parent/Guardian: _____

Hale YMCA
9 Technology Park Drive
Putnam, CT 06260

p: (860) 315-9622
f: (860) 315-9798
ghymca.org/hale



SUNSCREEN APPLICATION and authorization form

Connecticut Department of Public Health regulations require us to have written parental permission in order for YMCA Staff members to assist children in reapplying sunscreen throughout the day. Please complete this 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 supply your camper with **SPRAY ON SUNSCREEN**. We will assist all campers when reapplying sunscreen and educate them on remembering to do it as well. If sun exposure is ever a problem, please notify a director immediately so that the extra precautions can be made.

I give permission to
apply sunscreen

I do not give permission to
apply sunscreen

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

Name of Parent/Guardian (please print): _____

Signature of Parent/Guardian _____ Date: _____

Comments/Notes: _____

Reviewed by:

Name of staff (print): _____ Date: _____

Signature of Staff: _____



STATE HEALTH ASSESSMENT (AGES 5 AND UP)

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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)			
Parent/Guardian Name (Last, First, Middle)		Home Phone	Cell Phone
School/Grade		Race/Ethnicity	<input type="checkbox"/> Black, not of Hispanic origin
Primary Care Provider		<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> White, not of Hispanic origin
		<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian/Pacific Islander
		<input type="checkbox"/> Other	
Health Insurance Company/Number* or Medicaid/Number*			
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.

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
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HEALTH ASSESSMENT— Part 2 (All Ages)

HAR-3 REV. 4/2010

Part II — Medical Evaluation

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

Student Name _____ Birth Date _____ Date of Exam _____

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

Physical Exam

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

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

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

Screenings

*Vision Screening			*Auditory Screening			Date	
Type:	Right	Left	Type:	Right	Left	Lead:	
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass		*HCT/HGB:	
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail			
<input type="checkbox"/> Referral made			<input type="checkbox"/> 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 <i>Provider</i> Name and Phone Number
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IMMUNIZATION RECORD (All Ages)

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
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ASTHMA CARE PLAN

does your child have asthma?

CHECK ONE: If "yes" form must be signed by physician & care plan given to the YMCA. If "no" only parent signs.

REQUIRED FORM

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Camper's Name: _____ Birthday: _____

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

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

Steps to take during an asthma episode:

1. Give medications as listed below:

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

Medication Requirements: (check one)

- No medication required while attending Camp. Physician initials required: _____
- Medication required at camp (Bring original prescription to first day of camp, label clearly showing camper's name, birthday, and expiration date)

**Special Instructions _____

2. Observe for decreased symptoms

3. Contact Parent/Guardian if emergency medication is required

4. Call 911 if:

After receiving treatment, you observe the child:

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

Physician's name: _____

Physician's signature: _____

Phone number: (____) - _____ Date: _____

Parent's Signature: _____ Date: _____

Camp Director: _____	Date: _____
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ALLERGY CARE PLAN

does your child have any allergy?

CHECK ONE: If "yes" form must be signed by physician & care plan given to the YMCA. If "no" only parent signs.

REQUIRED FORM

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Camper's Name: _____ Birth Date: _____

Camper is Allergic to: _____

Steps to take during an allergy episode:

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

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

ACTION FOR MINOR REACTION:

If only symptom(s) are: _____, give _____

Then call: Parent/Guardian _____ Phone# _____

Action Steps for Major Reaction:

1. If symptom (s) are:

2. Give _____

3. Call 911

4. Call Parent/Guardian: _____ Phone#: _____

5. If Parent/ Guardian are unreachable, contact Emergency Contacts

Medication Requirements: (check one)

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

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

Physician's name: _____

Physician's signature: _____

Phone number: (____) - _____ Date: _____

Parent's Signature: _____ Date: _____

Camp Director: _____ Date: _____

First- Aid Director: _____ Date: _____



GENERAL INDIVIDUAL CARE PLAN

will your child take any meds at camp?

CHECK ONE: If "yes" form must be signed by physician & care plan given to the YMCA. If "no" only parent signs.

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Child's Name _____ Date of Birth _____

Parent/Guardian Name _____

Emergency Phone Numbers: Mother _____ Father _____

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

Primary Health provider's name: _____

Emergency Phone _____

Specialist's name & field _____

Emergency Phone _____

Specialist's name & field: _____

Emergency Phone _____

Diagnosis/Medical History: (please be specific) Daily Medications:

As Needed Medications:

(Bring original prescription to first day of camp, label clearly showing camper's name, birthday, and expiration date)

Minor Symptoms:

If you see these symptoms DO THIS:

Major Symptoms:

If you see these symptoms DO THIS:

Physician's Name: _____

Physician's Signature: _____

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

Parent's Signature: _____ Date: _____



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

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

PLEASE NOTE: We do not have a camp nurse or doctor on site. In the event your child needs medication administered, a trained and certified staff (First Aid Director or Camp Director) will administer the medication.

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 _____

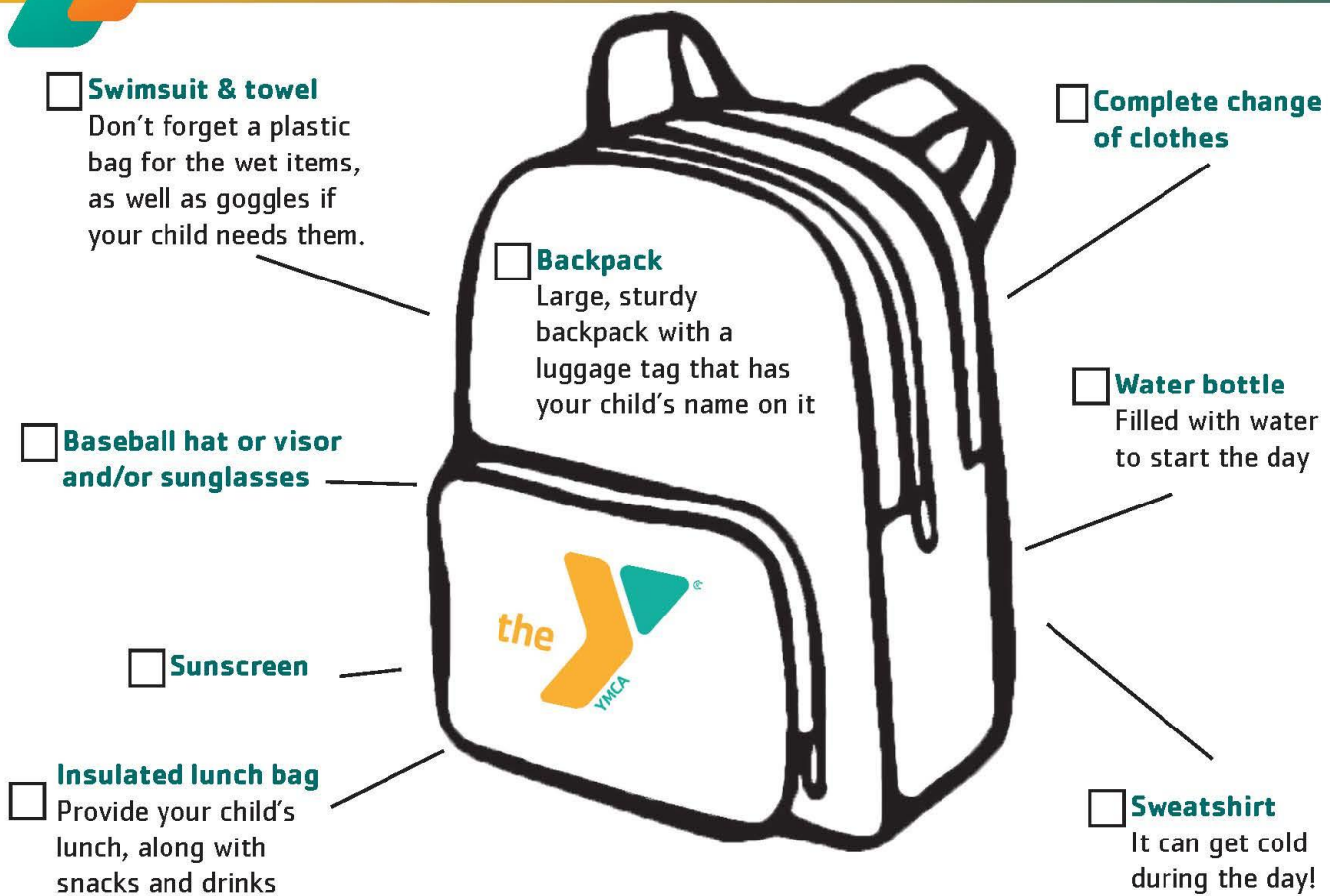
School nurse, if applicable, approval for self-administration: YES NO _____
Signature _____ Date _____

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.)

WHAT TO BRING TO CAMP



To help your child take full advantage of all we have to offer, please leave the following items at home:

- Personal toys
- Electronic equipment/toys (cell phones, gaming devices, tablets, etc.)
- Trading & game cards

FINANCIAL ASSISTANCE

Donate today to help! Every child deserves to go to camp!

Every year, hundreds of families across our region need financial assistance to send their children to camp. The Y's Annual Campaign provides that assistance so that all families can give their children a safe, enriching summer. Please give if you can help.

Give today at GHYMCA.org/hale. Thank you!



THANK YOU FOR CHOOSING CAMP CUTLER!

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

CONGRATS!

you've completed the registration packet!

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

Remember to make sure to submit this packet.

If at any time you'd like to speak with us, or if you need any information, please contact our main office at (860) 315-9622 or email camp.cutler@ghymca.org.