



CENTRAL CONNECTICUT COAST YMCA

Preschool and School Age Child Care Summer Camp Registration & Release Form

Child's First Name _____ Last _____ Gender _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Child resides with _____

Office Use – Program Name: _____ Start Date: _____

Parent/Legal Guardian #1 _____ Parent/Legal Guardian #2 _____

Relationship to Child _____ Relationship to Child _____

Home Address _____ Home Address _____

City/State/Zip _____ City/State/Zip _____

Place of Employment _____ Place of Employment _____

Employment Address _____ Employment Address _____

City/State/Zip _____ City/State/Zip _____

Info will be sent via email
Email Address _____ Email Address _____

Home Phone # () _____ Home Phone # () _____

Cell Phone # () _____ Cell Phone # () _____

Work Phone # () _____ Work Phone # () _____

Does your child require special accommodations (social, behavioral, medicine)? No ___ Yes ___ Will you be providing an individualized care plan? Yes ___ No ___
Does your child require and Individualized Education Plan? Yes ___ or No ___

Authorization for medical attention:

I give permission for the YMCA Certified First-Aid staff to treat my child, if needed. I authorize the child care staff to consent to emergency treatment (under advice of a Connecticut licensed physician) for my child when the need for such treatment is immediate and when efforts to contact me are unsuccessful. My child will be transported to the nearest emergency facility. I understand that any expenses incurred, through transportation and the treatment of my child, are my responsibility.

Name of Physician _____ Address/Phone _____

Legal Guardian Authorization:

In order to ensure the well-being of all our participants and our ability to help you with picking up your child, please include every person that could assume the custody of your child for any unforeseen circumstances. The YMCA WILL require photo I.D. to release any child to an authorized pick up person listed on this form. Individuals picking up your child must be 18 years old or older. I authorize the YMCA to release my child to the custody of the following people other than me:

Name: _____ Relationship: _____ Phone: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____ Phone: _____

The YMCA is required to permit either parent to pick up the child unless the YMCA is furnished with a court order to the contrary. Please list below any persons not authorized to pick-up this child and attach the original copy of the court order.

Name: _____ Relationship _____

Parent/ Legal Guardian Permission:

I understand that the Central Connecticut Coast Young Men's Christian Association, Inc. (the "Parent Company") and all of its branches are a charitable organization that makes its programs and facilities available to persons only on the condition that they agree to assume full responsibility for injury and damage. Therefore in exchange for acceptance of the child in the YMCA programs, I release, on behalf of the child, myself and members of the child's family, the YMCA, the Parent Company, and officers, directors, employees and volunteers from all claims of damage or loss to the child's property and claims of personal injury or property damage caused to others by the child, including injury or damage to YMCA property or personnel.

I understand the financial requirements, registration, payment obligations and deadlines as outlined in the Preschool Handbook. By signing this document, I affirm that I am the person legally responsible by law to make decisions for the well-being of the above named child.

Signature of Parent/Legal Guardian _____

Date _____



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

BRIDGEPORT YMCA

2025 Preschool, School Age Summer Camp Payment and Registration Information

PAYMENT INFORMATION

A \$50 non-refundable registration fee is required per camper

A \$50 non-refundable deposit is required to secure a session. *(Deposits are non-transferrable and non-refundable)*

Session must be paid in full prior to the start of each session.

All families must apply for Care 4 Kids.

Credit card returns and returned check fee is \$30.00.

Refunds may be issued for medical emergencies. (Physician notes will be required).

Failure to remit balance and signed medical form by due date will delay your child's enrollment.

The **Summer Food Program** begins Week 3. Parents must provide lunch for Week 1 and Week 2. *(refer to Day Camp Parent Handbook)*

REGISTRATION INFORMATION

Child Name: _____

Check boxes (X) that you are interested in registering your child.

Camp Shirt Size: _____

Camp Hours 8:00 am – 4:00 pm

Extended Camp 4:00-5:30 pm

<input type="checkbox"/> Week 1 June 16 – June 20	Member \$192	Program Participant \$285	<input type="checkbox"/> Extended care \$50/\$75
<input type="checkbox"/> Week 2 June 23– June 27	Member \$192	Program Participant \$285	<input type="checkbox"/> Extended care \$50/\$75
<input type="checkbox"/> Week 3 June 30 - July 4	Member \$154	Program Participant \$228	<input type="checkbox"/> Extended care \$50/\$75
<input type="checkbox"/> Week 4 July 7 – July 11	Member \$192	Program Participant \$285	<input type="checkbox"/> Extended care \$50/\$75
<input type="checkbox"/> Week 5 July 14 – July 18	Member \$192	Program Participant \$285	<input type="checkbox"/> Extended care \$50/\$75
<input type="checkbox"/> Week 6 July 21 - July 25	Member \$192	Program Participant \$285	<input type="checkbox"/> Extended care \$50/\$75
<input type="checkbox"/> Week 7 July 28 – August 1	Member \$192	Program Participant \$285	<input type="checkbox"/> Extended care \$50/\$75
<input type="checkbox"/> Week 8 August 4 – August 8	Member \$192	Program Participant \$285	<input type="checkbox"/> Extended care \$50/\$75
<input type="checkbox"/> Week 9 August 11 – August 15	Member \$192	Program Participant \$285	<input type="checkbox"/> Extended care \$50/\$75
<input type="checkbox"/> Week 10 August 18 – August 22	Member \$192	Program Participant \$285	<input type="checkbox"/> Extended care \$50/\$75

Drop off or mail completed, signed forms to:

BRIDGEPORT YMCA

850 Park Avenue

Bridgeport CT 06604

P 203 334 5551 **F** 203 334 2847 **W** bridgeportymca.org



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CENTRAL CONNECTICUT COAST YMCA

Preschool and School Age Child Care Summer Camp Authorizations and Acknowledgements

Child's First Name _____ Last _____ Gender _____

Parent Legal Guardian Authorizations and Acknowledgements

I understand there are risks associated with activities and programs in which my child is a participant. I hold the Y Branch, the Central Connecticut Coast YMCA, its employees, representatives, agents, and assigns from any and all claims whatsoever against said parties resulting from or caused by my child's participation. _____ Initials

I acknowledge that I have received a copy of the YMCA Child Care Parent Handbook which covers the following information: general policies, accounting policies, days program is closed and complaint procedure. I understand that if I have any questions in regards to the content of this handbook it is my responsibility to notify the YMCA at the earliest convenience. _____ Initials

I hereby give permission for my child to participate in all activities (including walks and field trips) that are part of the program. _____ Initials

I agree to arrange for my child to be picked up from the program if they become ill and to keep the child home until their condition is considered safe and appropriate for participation. _____ Initials

I hereby give my consent for my child to participate in activities that involve water and recreational swimming while under the supervision of the YMCA staff or their representatives where it applies. _____ Initials

I hereby give my consent for my child to be transported by the YMCA staff or their representatives in a YMCA Vehicle or contracted Bus Transportation. I grant permission to have my child transported to one of the YMCA's other facilities in case of an emergency situation when this center needs to be evacuated for the safety of the children. _____ Initials

I understand that neither the YMCA nor any of its paid or volunteer workers can be held responsible in the events of an accident. I understand that all precautions will be taken to ensure the safety and health of my child. _____ Initials

I also grant permission for photographs taken of my child while at preschool to be used for publicity and promotional purposes. _____ Initials

I understand that if I am receiving Care 4 Kids, my contract for child care and all associated fees is on file with the YMCA. If for any reason Care 4 Kids fails to pay, I, as a client of the YMCA, will be held responsible for the full child care tuition. By initialing, I agree with these terms. _____ Initials

I understand that the Site Location, the Y branch and the Central Connecticut Coast YMCA are not responsible for personal property lost, damaged, or stolen while members and/or program participants are using the facilities, on the premises, or involved in Y programs. _____ Initials

I understand that my monthly payment is due on the 20th of the month for the upcoming month and that a \$25 late fee will be charged if my payment is not received by the 1st of the current month. I understand that there will also be a \$30 fee for any returned payments. Furthermore, I understand that if payment is not received by the 1st of the month, my child will not be allowed to attend the program until my balance is paid in full. _____ Initials

Getting to know your child

The YMCA believes that *every* child in our care is a unique individual with special needs. Help us to provide the best care for your child by providing us as much information as possible. We strongly encourage you to meet with the Director and visit the program prior to enrolling your child.

Please list all medications and/or medical conditions affecting your child. (Must complete medication administration form, individual care plan and supply site with appropriate medication prior to starting the program).

By signing this document, I affirm that I am the person legally responsible by law to make decisions for the well-being of the above named child.

Signature of Parent/Legal Guardian _____

Date _____

05/26/2023



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CENTRAL CONNECTICUT COAST YMCA Preschool and School Age Child Care Summer Camp Payment Authorizations

Child's First Name _____ Last _____ Gender _____

Child Care Agreement

I _____, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the 20th of each month in the amount of \$ _____ to act as payment for Child Care services. I understand that I must provide THIRTY DAYS notice, in writing, if I wish to discontinue this service. **There will be a \$30.00 charge for any EFT or charge returned by the bank. Also a \$25.00 late payment fee will be added to the account if not paid by the first of the month. These fees will be automatically drafted from my Child Care account.**

I understand it is my responsibility to notify the YMCA of any change in address, bank account information (if utilizing bank draft for payment of child care) or credit card information/expiration date (if utilizing credit card for payment of child care).

Please print your name _____

Address _____

Email _____

Signature _____ Date _____

I authorize my bank to honor preauthorized Electronic Funds Transfers (or credit card charges) against my account for payments as indicated below. When the bank honors the EFT (or credit card) by charging my account, such transfer shall constitute notice of payment due and my receipt for the payment. Should any preauthorized EFT (or credit card) not be honored by said bank when received by them, then it is understood that the payment is to be made by me in the amount of said payment plus service charge. It is further understood that if such payment is not honored by the bank (or credit card institution), then the YMCA, at its discretion, may resubmit the amount due for payment on a future date.

I choose to utilize the EFT option for payment (direct debit from my Checking Savings account)

Bank Name _____ Name on Account _____

Routing/Transit Number _____ Account Number _____

Authorized Signature: _____ Date: _____

I choose to utilize a credit card on file at the Y. Reference _____

Authorized Signature: _____ Date: _____

I choose to utilize the Credit Card Payment option for monthly payment (automatic direct charge to credit card)

Your Credit Card must be swiped at the YMCA Branch. Card Type American Express MC Visa

Card Holder Name _____

Card Holder Address _____

Authorized Signature: _____ Date: _____

2025

Preschool and School Age Child Care Summer Camp

Attach voided check here for EFT Accounts



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CENTRAL CONNECTICUT COAST YMCA Preschool and School Age Child Care Summer Camp Behavior Management Plan

From time to time it may be necessary to discipline a child who continually exhibits a lack of respect or concern for the safety and well-being of their peers and/or staff.

Behavior management is used in the form of RE-DIRECTION or POSITIVE GUIDANCE and is done while the child is still in the program, not sent home with them, unless it is a serious matter. Behaviors considered inappropriate are, but not limited to:

- Fighting, Throwing things, Inappropriate language, Disrespect for others
- Refusing to listen to the teacher, Hitting, Biting or Kicking, children or teachers

A staff member will give positive guidance, redirection, setting clear limits to the child while maintaining good supervision of all areas. This allows the children to get control of their behavior and be able to continue to participate in classroom activities.

We do not use abusive, neglectful, physical restraint, unless such restraint is necessary to protect the health and safety of the child or others.

In the even that re-direction or positive guidance is not effective and /or the child has severely injured another child or teacher, a parent/guardian will be called in to discuss the situation and to develop a plan of action and /or 211 Info line may be called in for professional assistance depending on the severity of the behavior being exhibited.

I have read and understand the policy. The Behavior Management Plan has been discussed with me.

Child's First / Last Name _____

By signing this document, I affirm that I am the person legally responsible by law to make decisions for the well-being of the above named child.

Parent/Legal Guardian's Name/Signature _____ Date: _____

05/26/2023



FOR YOUTH DEVELOPMENT®
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CENTRAL CONNECTICUT COAST YMCA
Authorization for Access/Release of Information

Child's First Name _____ Last _____ Date _____

Parent Legal Guardian Authorizations and Acknowledgements

I hereby authorize the CCC Y Preschool program and related entities to release and obtain (in either verbal or written form) information on my child to:

Name _____

Name _____

Name _____

I understand that these transactions may include: standard reports, child/family history, physical reports, discharge summaries, growth charts, development continuum, immunization/lab reports and assessments. _____ Initials

I understand that this authorization that I have signed is in effect the length of the child's enrollment in our program. _____ Initials

I understand that if anyone other than those listed on this form request information, I will be notified by the program of this request and will have to provide authorization for any additional entities that are not listed above. This form will also need to be updated. _____ Initials

By signing this document, I affirm that I am the person legally responsible by law to make decisions for the well-being of the above named child.

Signature of Parent/Legal Guardian _____ Date _____

Relationship to Child: _____

Signature Classroom Teacher: _____ Date _____



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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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, physician assistant, licensed pursuant to chapter 370, a school medical

advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	<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 1 — 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.	Date
Signature of Parent/Guardian	

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

Part 2 — 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 1 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 _____ / _____

Table with columns for Normal and Describe Abnormal for Neurologic, HEENT, *Gross Dental, Lymphatic, Heart, Lungs, Abdomen, Genitalia/ hernia, and Skin. Includes Ortho section for Neck, Shoulders, Arms/Hands, Hips, Knees, Feet/Ankles, and *Postural assessment.

Screenings * According to Bright Future's Periodicity Schedule

Table for Screenings including Vision Screening, Auditory Screening, History of Lead Level, and Speech/HCT/HGB results.

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, Anaphylaxis, Allergies, Diabetes, Seizures assessment questions with checkboxes and instructions.

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 or participate with restriction/adaptation:

This student may: participate fully in athletic activities and competitive sports or participate with 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

Part 3 — Oral Health Assessment/Screening
Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: <input type="checkbox"/> Dentist	Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No
Risk Assessment <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Describe Risk Factors <input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____		
		<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	

Recommendation(s) by health care provider: _____

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 _____

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	Date Signed	Printed/Stamped <i>Provider</i> Name and Phone Number
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Immunization Record

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

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

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx _____

<p>of above _____ (Specify)</p> <p>Religious Exemption: _____</p> <p>Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.</p>	<p>(Date) _____ (Confirmed by) _____</p> <p>Medical Exemption: _____</p> <p>Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf</p>
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KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See “HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES” column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See “HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES” column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE

REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

**** Verification of disease:** Confirmation in writing by an 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 nationwide shortage of supply for such vaccine.

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