FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and School-Aged Child Care
Summer Camp 2026

Child's Name _____ D.O.B _____

Group Name_____ Start Date _____

Checklist Documentation

- o Registration & Release Form
- o Camp payment and Registration Information
- o Authorization and Acknowledgements
- o Behavior Management Plan
- o Authorization for Access/ Release of Information
- o Payment Authorization
- o Child Emergency Form (in-house form)
- o Child's Assessment/Medical Evaluation/Immunization
- o Medication Authorization Form (If Needed)
  Brand new medication unopened with RX information label
  Action Plan/Care Plan
- o Copy of Parent ID
- o Copy of Child Medical Card
- o Care 4 Kids Application (Provide all documents that are needed: proof of income 2 consecutive paystubs if you get paid bi-weekly and 4 consecutive paystubs if you get paid weekly. If you are paid by cash you must provide a letter how much you get paid and state whether if it's bi-weekly or weekly must be notarized and have the person information you work for on the letter).
- o Parent Fee Determination/ Financial Assistance Form

OFFICE STAFF ONLY

Please list missing documentation or note:

_____

_____

_____

_____

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CENTRAL CONNECTICUT COAST YMCA

Infant, Toddler, Preschool and SACC Summer Camp 2026

Registration & Release Forms

Member ID# _____

Camper's First Name _____ Last _____ Gender_____

Address _____ City _____ State ____ Zip _____

Date of Birth _____ Age entering camp yrs ___ mos ___ Grade entering in Sept _____ Child lives with _____

Office Use – Program Name _____ Start Date _____

Parent # 1 _____	Parent #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 _____	Email _____

Please check which phone number you would like used as Primary Contact number:

☐Home Phone # ( )_____	☐Home Phone # ( )_____
☐Cell Phone # ( )_____	☐Cell Phone # ( )_____
☐Work Phone # ( )_____	☐Work 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 <u>persons not authorized</u> to pick up this child and attach the original copy of the court order.

Name_____ Relationship _____

If parent cannot be reached, give name and relationship of person to be called in case of an emergency. Must be 18 & Older.

Name _____ Relationship _____

Home # ( ) _____ Work # ( ) _____ Cell # ( ) _____

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/Guardian _____ Date _____

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CENTRAL CONNECTICUT COAST YMCA

Infant, Toddler, Preschool and SACC Summer Camp 2026

Payment & Session Registration Form

Camper's First Name _____ Last _____ Gender _____

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 fees are $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 YMCA is a CACFP program participant. Breakfast, Lunch, and Snack will be provided.

(Refer to Day Camp Parent Handbook)

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

CIRCLE CAMPERS SHIRT SIZE*
Youth: ☐S ☐M ☐L ☐XL
Adult: ☐S ☐M ☐L *size not guaranteed

Camp Hours 8:00 am–4:00 pm			**Extended Camp 4:00–5:30 pm**
☐ Week 1 June 22–June 26	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 2 June 29–July 3*	Member $154	Program Participant $228	☐ Extended care $50/$75
☐ Week 3 July 6–July 10	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 4 July 13–July 17	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 5 July 20–July 24	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 6 July 27–July 31	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 7 August 3–August 7	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 8 August 10–August 14	Member $192	Program Participant $285	☐ Extended care $50/$75
☐ Week 9 August 17–August 21	Member $192	Program Participant $285	☐ Extended care $50/$75

* Week 3 – Summer Day Camp will be closed on Friday, July 3 in observance of the 4th of July (the week will be pro-rated).

Registration Fee (per camper) $50
Total Weeks ___ x $50 Deposit per week = _____
Total Due at Registration = _____

Parent/Guardian Signature _____ Date _____
Staff Initial _____ Date _____

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Authorization for Access/Release of Information

Camper's First Name _____ Last _____ Date_____

Parent Legal Guardian Authorizations and Acknowledgements

I hereby authorize the CCC Y Preschool and School Age Child Care 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.
  Initial ___
- I understand that this authorization that I have signed is in effect the length of the child's enrollment in our program.
  Initial ___
- 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.
  Initial ___

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 of Program Staff_____Date_____

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Information Sheet

Camper's First Name _____ Last _____ Gender _____

Authorized Pick Ups

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 & 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 _____

Special Social, Behavioral or Medical Needs

Does your child require an Individualized Education Plan? ☐Yes ☐No

Does your child require special accommodations (social,behavioral, medicine)? ☐Yes ☐No

If you chose Yes, please note the following:

- An Individual Care Plan (ICP), completed by parent/guardian, is required by May 1st.
- Authorization of Medication Forms and Care Plan provided by Physician, signed by a Physician and parent/ guardian are due by May 1st.
- We want to provide a positive and successful experience for all children. If your child has social, behavioral or developmental needs, please contact the Camp Director by May 1st to discuss their needs and required support.

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 with any information about your child that you think would benefit the staff from knowing to help ensure a successful/safe time at camp. We strongly encourage you to meet with the Director and visit the program prior to enrolling your child. _____

_____

_____

_____

Signature of Parent/Guardian _____ Date _____

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Infant, Toddler, Preschool and SACC Summer Camp 2026

Medical Information Sheet

Child Information

Child's Name _____ D.O.B _____

Address _____

Best Contact Phone _____ Email _____

Medical Information

Diagnosed with Asthma: ☐ YES ☐ NO Inhaler needed at School: ☐ YES ☐ NO

Individual Care Plan on File: ☐ YES ☐ NO

Diagnosed Allergies: _____

_____

_____

_____

Other Medical Information: _____

_____

_____

_____

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/Guardian _____ Date _____

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Infant, Toddler, Preschool and SACC Summer Camp 2026

Payment Authorization

Camper's First Name _____ Last _____ Gender _____

Summer Camp Payment Agreement

I, _____, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the Monday, two weeks prior to the session start date to act as payment for Child Care services. I understand the final payment for each session is due no later than the Monday, two weeks before each session begins. If the session balance is not paid by that date, I am aware that my child will not be able to attend camp until the balance has been paid in full. I understand that I must provide THIRTY DAYS notice, in writing, if I wish to discontinue this service. These fees will be automatically drafted from my Child Care account. *To set up a different payment arrangement, please reach out to the Camp Director.

Camp Fees/ Refund Policy

Camp fees are due, in full, the Monday, two weeks prior to the session start date. Deposit fees and registration fees are non-refundable and non-transferable. Session refund requests must be done in writing on a Refund Request Form a minimum of 2 weeks prior, if I wish to discontinue this service. Refunds will not be granted less than 2 weeks before the start of a session. Refunds may be issued for medical emergencies. A physicians note will be required. There is a $10 administration fee for all refunds.

Service Fees/ Late Fees

A $25 late camp payment fee will be applied to accounts not paid in full by the Monday, two weeks prior to the session start date. There will be a $30 charge for any EFT or charge returned by the bank. A $30 fee for credit card returns and returned checks will be applied to outstanding balances. These fees will be automatically drafted from the account associated with Summer Camp payments. Failure to pay this fee will jeopardize your child's enrollment in camp.

Camp Payments

I authorize my bank to honor preauthorized Electronic Funds or credit card charges against my account for Summer Camp tuition 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 from my ☐ Checking ☐ Savings account.

*A Voided Check must be attached to this form.

Bank Name_____ Name on Account _____

Routing Number_____ Account Number _____

☐ I choose to utilize a credit card on file at the Y. Card Type _____ Last 4 digits _____

☐ I choose to utilize the Credit Card Payment option for monthly payments (automatically charged to my card.).

Your credit card must be swiped at the YMCA Branch to save information.

Card Type: ☐American Express ☐Discover ☐MC ☐Visa

I understand that 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).

I understand the financial requirements, payment obligations, refund policy, fees and deadlines as outlined.

Print Name_____ Email _____

Billing Address _____ City _____ State _____ Zip _____

Authorized Signature _____Date _____

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CENTRAL CONNECTICUT COAST YMCA

Infant, Toddler, Preschool and SACC Summer Camp 2026

Waivers & Acknowledgements

Camper's First Name _____ Last _____ Gender _____

Parent/Guardian Permission

- 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 regard to the content of this handbook it is my responsibility to notify the YMCA at the earliest convenience. **Initial ___**
- 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. **Initial ___**
- I hereby give permission for my child to participate in all activities, including field trips, that are part of the camp program. I understand that there are risks associated with camp 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. **Initial ___**
- 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. **Initial ___**
- 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 hereby give permission for my child to be transported by the YMCA for emergency situations when the camp needs to be evacuated for the safety of the children. **Initial ___**
- I grant permission to have my child transported to one of the YMCA's other facilities in case of inclement weather. **Initial ___**
- I grant permission for any pictures taken of my child while at camp to be used for publicity and promotional purposes. **Initial ___**
- 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. **Initial ___**
- I hereby give permission for the YMCA to apply sunscreen and/or bug spray to my child. I will supply sunscreen and/or bug spray for my child, as well as apply to my child prior to camp. The YMCA is NOT responsible for lost or stolen bottles of sunscreen/bug spray (please label containers). **Initial ___**
- 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. **Initial ___**
- 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. **Initial ___**
- I understand that my weekly payment is due every Friday for the upcoming week. If I am on a bi-weekly payment plan, I understand that my payment must be made every two weeks, in advance. I understand that a $30 fee will be applied for any returned payments (e.g., insufficient funds). Furthermore, I understand that if payment is not received by the due date, my child will not be allowed to attend the program until my balance is paid in full. **Initial ___**
- I understand that ALL updated Physical Forms, signed by a physician, must be turned into the camp office at the time of registration or the latest May 1st. **Initial ___**

Authorization for Medical Attention:

- I give permission for the YMCA Certified First-Aid staff to treat my child, if needed. I authorize the camp staff to consent to emergency treatment, under the 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 expense incurred, through transportation and the treatment of my child are my responsibility. **Initial ___**

Physicians Name _____ Physicians Number (____) _____
Hospital of Choice _____

Signature of Parent/Guardian _____ Date _____

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CENTRAL CONNECTICUT COAST YMCA
Infant, Toddler, Preschool and SACC Summer Camp 2026
Behavior Contract

Camper's First Name _____ Last _____ Gender _____

EXPECTATIONS

- Show respect by treating other children and adults the way I would want to be treated.
- Be honest, will always tell the truth about actions and feelings.
- Be a friend that others can trust.
- Demonstrate caring by helping others and treating them kindly.
- Take responsibility for my own behavior and accept the consequences for my actions.
- To be free from cruel teasing and insults.
- Have a safe, calm, clean and orderly environment.
- Make mistakes without being ridiculed by others.
- Seek help from those that are there to help. Talk with Camp Staff when frustrated or feel mistreated.
- Be treated with dignity and respect by everyone.
- Use appropriate, acceptable language. Don't talk back or use obscene, threatening language or speak in an unkind manner.
- Avoid fights or verbal abuse.
- Be fair and accepting of others eager to join any activity.
- Work and play safely.
- Be kind, considerate, helpful, and respectful towards others.
- Follow directions and listen attentively while participating in activities.
- Share equipment and materials fairly and use them properly.
- Respect property, especially things that do not belong to me.
- Cooperate with others who are there to help.
- Speak up when witnessing unfairness or offensive language or behaviors of others.
- Be a good sport whether I win or lose.
- Be truthful with everyone.

CONSEQUENCES

- Report of discipline for talking back, destroying property, bullying children, disrupting the program, refusing to obey. Parent will be required to sign these reports acknowledging that they have read the report. After three reports, child and parent may be required to meet with the Camp Leadership staff.
- Letter of discipline and immediately suspended for a minimum of one day for hitting, kicking, biting, spitting, scratching, swearing, making degrading or racial remarks, or leaving the group. Parents may be required to meet with the Camp Director before the child can return to the program.
- Camp services may also be terminated if the parent is physically or verbally abusive to a staff member. It is our desire that every child enjoys his/her experience in the program.
- Participation in the Summer Camp Program may be limited or discontinued if this contract is not followed.

Some behaviors may warrant our skipping procedure depending upon the severity of the inappropriate behavior.

_____ _____

Parent/Guardian Signature **Child/Participant Signature**

_____

Date

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CENTRAL CONNECTICUT COAST YMCA
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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: _____

01/05/2026

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State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 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	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
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 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.

Signature of Parent/Guardian Date

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**_____/ _____

	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 * According to Bright Future's Periodicity Schedule

***Vision Screening**

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

❑ Referral made

***Auditory Screening**

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

❑ Referral made

***History of Lead Level** ≥**3.5** µg/dL ❑ No ❑ Yes **Results:**	Date
***Speech** (school entry only)	
***HCT/HGB:**	

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

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	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No
Risk Assessment	**Describe Risk Factors**		
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ 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 ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 3/2024

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 of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Religious Exemption: _____

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.

Medical Exemption: _____

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

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 the1st 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 the1st 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 through11th 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