FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CENTRAL CONNECTICUT COAST YMCA

Infant, Toddler, Preschool 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 <u>persons not authorized</u> 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_____

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CENTRAL CONNECTICUT COAST YMCA

Infant, Toddler, Preschool 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_____

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CENTRAL CONNECTICUT COAST YMCA

Infant, Toddler, Preschool 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: _____

2022-2023

CHILD CARE ONLY

Attach voided check here for EFT Accounts

05/05/2022

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CENTRAL CONNECTICUT COAST YMCA

Infant, Toddler, Preschool 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: _____

04/15/2021

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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

Early Childhood Health Assessment Record

(For children ages birth–5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑Male ❑Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑American Indian/Alaska Native ❑Native Hawaiian/Pacific Islander ❑Asian ❑White ❑Black or African American ❑Other ❑Hispanic/Latino of any race	
Primary Health Care Provider: Name of Dentist:		
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	
Does your child have HUSKY 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	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months?	Y	N	Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place			6. Interaction with others	Y	N	Eating concerns	Y	N
to another	Y	N	7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

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

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

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

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

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

Signature of Parent/Guardian Date

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑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.

***HT**____in/cm_____% ***Weight**____lbs._____oz /_____% **BMI**____/_____% ***HC**____in/cm_____% (Birth–24 months) ***Blood Pressure**____/ ____ (Annually at 3–5 years)

Screenings

***Vision Screening**
- ❑ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
- ❑ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

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

❑Unable to assess

❑Referral made to: _____

***Hearing Screening**
- ❑ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
- ❑ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

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

❑Unable to assess

❑Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑No ❑Yes

***TB:** High-risk group? ❑No ❑Yes

Test done: ❑No ❑Yes Date: _____

Results: _____

Treatment: _____

***Dental Concerns** ❑No ❑Yes

❑Referral made to: _____

Has this child received dental care in the last 6 months? ❑No ❑Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth–5 years) ❑No ❑Yes **Type:**

Results:

*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 an **Asthma Action Plan***
❑Rescue medication required in child care setting: ❑No ❑Yes

Allergies ❑No ❑Yes: _____
Epi Pen required: ❑No ❑Yes
History/risk of Anaphylaxis: ❑No ❑Yes: ❑Food ❑Insects ❑Latex ❑Medication ❑Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑No ❑Yes: ❑Type I ❑Type II

Seizures ❑No ❑Yes: Type: _____

Other Chronic Disease: _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑Vision ❑Auditory ❑Speech/Language ❑Physical ❑Emotional/Social ❑Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑No ❑Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑No ❑Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑No ❑Yes This child may fully participate in the program.

❑No ❑Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

_____

❑No ❑Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

_____

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	❑Dental or orthodontic appliance	❑Carious lesions
❑Moderate	❑Saliva	❑Restorations
❑High	❑Gingival condition	❑Pain
	❑Visible plaque	❑Swelling
	❑Tooth demineralization	❑Trauma
	❑Other _____	❑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

Child's Name: _____ **Birth Date:** _____ REV. 10/2018

Immunization Record

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

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2–3 years of age (24-35 mos.)	3–5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

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