



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

### CENTRAL CONNECTICUT COAST YMCA Summer Camp Registration & Release Form

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 \_\_\_\_\_

Parent # 1 \_\_\_\_\_ Parent # 2 \_\_\_\_\_

Home Address \_\_\_\_\_ Home address \_\_\_\_\_

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 # ( ) \_\_\_\_\_

Parent/Guardian E-Mail Address (camp info will be sent via e-mail) \_\_\_\_\_

If parent cannot be reached, give name and relationship of person to be called in case of emergency.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Does your child require special accommodations (social, behavioral, medicine)? Yes \_\_\_\_\_ No \_\_\_\_\_ An Individual Plan of Care for a Child and an authorization of medication form must be provided the week before the start of camp. Initials \_\_\_\_\_

**Parent/Guardian Permission:** I hereby give permission for my child to participate in all activities (including field trips) that are part of the camp program. I understand 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. I grant permission to have my child transported to one the YMCA's other facilities in case of inclement weather. I also grant permission for any pictures taken of my child while at camp to be used for publicity and promotional purposes.

**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 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.

**Sunscreen/Bug Spray Release:** 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 every morning. The YMCA is NOT responsible for lost or stolen bottles of sunscreen/bug spray. (Please label containers).

**Guardian Authorization:** In order to ensure the well-being of all our campers 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. 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 copy of a court order to the contrary. Please list below any **persons not authorized** to pick-up this camper and attach a copy of the court order.

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

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 Summer Camp Brochure.

I have read the above and agree to the terms and conditions.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



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**BRIDGEPORT YMCA**  
**2022 Summer Camp Payment and Registration Information**

**PAYMENT INFORMATION**

**A \$25 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**

<input type="checkbox"/>	<b>Week 1 June 20 – June 24</b>	Member \$165	Community Member \$225
<input type="checkbox"/>	<b>Week 2 June 27 – July 1</b>	Member \$165	Community Member \$225
<input type="checkbox"/>	<b>Week 3 July 5 - July 8</b>	Member \$165	Community Member \$225
<input type="checkbox"/>	<b>Week 4 July 11 – July 15</b>	Member \$165	Community Member \$225
<input type="checkbox"/>	<b>Week 5 July 18 – July 22</b>	Member \$165	Community Member \$225
<input type="checkbox"/>	<b>Week 6 July 25 - July 29</b>	Member \$165	Community Member \$225
<input type="checkbox"/>	<b>Week 7 August 1 – August 5</b>	Member \$165	Community Member \$225
<input type="checkbox"/>	<b>Week 8 August 8 – August 12</b>	Member \$165	Community Member \$225
<input type="checkbox"/>	<b>Week 9 August 15 – August 19</b>	Member \$165	Community Member \$225

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 Summer Camp Payment Authorizations

Child's First Name \_\_\_\_\_ Last \_\_\_\_\_ Gender \_\_\_\_\_

**Summer Camp Agreement (Check One)**

I \_\_\_\_\_, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the 1<sup>st</sup> of each month (March, April, May, and June) in the amount of \$\_\_\_\_\_ to act as payment for Summer Camp services. I understand that final payment for each session is due no later than 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 \_\_\_\_\_, hereby authorize the Central Connecticut Coast YMCA to charge the account listed on the Monday, two weeks prior to the session start to act as payment for Summer Camp services. I understand that 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 a minimum of 2 weeks' 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 prior to the first day of the session. These fees will be automatically drafted from my Summer Camp 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 summer camp) or credit card information/expiration date (if utilizing credit card for payment of summer camp).

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 (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 (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**

**SUMMER CAMP ONLY**

**Attach voided check here for EFT Accounts**



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## Bridgeport YMCA Summer Camp 2022 Summer Camp Transportation Permission Form

I hereby give permission for my child, \_\_\_\_\_, for emergency situations when the camp needs to be evacuated for the safety of the children.

In the event of an emergency and I cannot be reached please call:

\_\_\_\_\_ at \_\_\_\_\_  
(Emergency Contact) (Phone Number)

I prefer my child to be taken to \_\_\_\_\_ hospital and in the event that my child requires emergency medical attention the following physician should be notified.

\_\_\_\_\_  
(Physician's Name and number)

\_\_\_\_\_  
Signature of Parent/ Guardian

\_\_\_\_\_  
Date



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## CENTRAL CONNECTICUT COAST YMCA

### Summer Camp Behavior Contract for Participants, Parents, Families and Campers

#### 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 toward 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 behavior of others.
- Be a good sport whether I win or lose.
- Be truthful with everyone.

#### CONSEQUENCES

- Letter of discipline for talking back, destroying property, bullying children, disrupting the program, refusing 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 PROCEDURES DEPENDING UPON THE SEVERITY OF THE INAPPROPRIATE BEHAVIOR.**

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Parent/Guardian Signature

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Child/Participant Signature

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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, a physi-

cian 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 <b>1-877-CT-HUSKY</b>
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
<b>Family History</b>						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

## 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			*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	History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	Date
Type: <u>Right</u> <u>Left</u> With glasses 20/ 20/ Without glasses 20/ 20/ <input type="checkbox"/> Referral made	Type: <u>Right</u> <u>Left</u> <input type="checkbox"/> Pass <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Fail <input type="checkbox"/> Referral made	*HCT/HGB:	
		*Speech (school entry only)	
		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 <b>Provider</b> Name and Phone Number
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## 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

<b>Dental Examination</b> Completed by: <input type="checkbox"/> Dentist	<b>Visual Screening</b> Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	<b>Normal</b> <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	<b>Referral Made:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Risk Assessment</b> <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	<b>Describe Risk Factors</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <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 _____                 </td> <td style="width: 33%; border: none; vertical-align: top;"> <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 _____                 </td> <td style="width: 34%; border: none;"></td> </tr> </table>			<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 _____	
<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
<b>DTP/DTaP</b>	*	*	*	*		
<b>DT/Td</b>						
<b>Tdap</b>	*				Required 7th-12th grade	
<b>IPV/OPV</b>	*	*	*			
<b>MMR</b>	*	*			Required K-12th grade	
<b>Measles</b>	*	*			Required K-12th grade	
<b>Mumps</b>	*	*			Required K-12th grade	
<b>Rubella</b>	*	*			Required K-12th grade	
<b>HIB</b>	*				PK and K (Students under age 5)	
<b>Hep A</b>	*	*			See below for specific grade requirement	
<b>Hep B</b>	*	*	*		Required PK-12th grade	
<b>Varicella</b>	*	*			Required K-12th grade	
<b>PCV</b>	*				PK and K (Students under age 5)	
<b>Meningococcal</b>	*				Required 7th-12th grade	
<b>HPV</b>						
<b>Flu</b>	*				PK students 24-59 months old – given annually	
<b>Other</b>						

**Disease Hx** \_\_\_\_\_  
**of above** (Specify) \_\_\_\_\_ (Date) \_\_\_\_\_ (Confirmed by) \_\_\_\_\_

**Exemption:** Religious \_\_\_\_\_ **Medical:** Permanent \_\_\_\_\_ Temporary \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Renew Date:** \_\_\_\_\_

**Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.  
 Medical exemptions that are temporary in nature must be renewed annually.**

## Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

### 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 <i>Provider</i> Name and Phone Number
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