

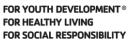


Signature of Parent/Guardian

CENTRAL CONNECTICUT COAST YMCASummer Camp Registration & Release Form

Member ID#				-	
Camper's First Name		Last			Gender
Address		City		State Zip_	<u></u>
Date of Birth	Age entering camp yrs mos	s Grade entering	in Sept	_ Child lives with_	
Parent # 1		Parent # 2			
Home Address		Home address			
Email		Email			
Please Check Which Phone N	umber You Would Like Used As Primary Conta	act Number			
☐ Home Phone # ()	Home Phone	# ()	
Cell Phone # ()	Cell Phone #	()	
☐ Work Phone # ()	Work Phone	# ()	
Name:	ed, give name and relationship of person Work # (to be called in case of Relationship:			_
Home # ()	Work # ()		Cell # ()	
inclement weather. I also Authorization for Media staff to consent to emergimmediate and when effor expenses incurred, throug Sunscreen/Bug Spray R and/or bug spray for my ospray. (Please label conta Guardian Authorization every person that could a an authorized pick up per	In order to ensure the well-being of all assume the custody of your child for any son listed on this form. I authorize the '	of my child while at car YMCA Certified First-Ai- ecticut licensed physicia child will be transported ny child, are my respons YMCA to apply sunscre norning. The YMCA is NO our campers and our al unforeseen circumstanc YMCA to release my chil	mp to be used staff to treen) for my chill to the neare ibility. The same and/or but to help tes. The YMO do to the customers.	ed for publicity and peat my child, if needs all when the need fo est emergency facilities are spray to my child. It for lost or stolen you with picking up CA WILL require photody of the following tody of the following are my child.	oromotional purposes. ed. I authorize the camp r such treatment is ty. I understand that any I will supply sunscreen bottles of sunscreen/bug your child, please include to I.D. to release any child to g people other than me:
Name:		Phone:			one:
Name:	Relationship:	Phone:		Ph	one:
Name:	Relationship:	Phone:		Ph	one:
-	permit either parent to pick up the child ot authorized to pick-up this camper ar			copy of a court ord	er to the contrary. Please
Name:				Relationship	
Name:				Relationship	
makes its programs and facil for acceptance of the child in officers, directors, employee	I Connecticut Coast Young Men's Christian As lities available to persons only on the condition In the YMCA programs, I release, on behalf of t Is and volunteers from all claims of damage or Or damage to YMCA property or personnel.	on that they agree to assur the child, myself and memb	me full respons ers of the chil	sibility for injury and d d's family, the YMCA, t	amage. Therefore, in exchange the Parent Company, and
	ial requirements, registration, payme andbook. I have read the above and ag				ned in the Summer Camp

Date_





SOUNDVIEW FAMILY YMCA

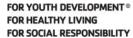
Camp HAYS Session Registration Form 2024

Child's Name	
· · · · · · · · · · · · · · · · · · ·	

Camp Unit	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week10
Member Rate/ Participant Rate	6/17-6/21	6/24-6/28	7/01-7/05 (No Camp on 4 th)	7/8-7/12	7/15-7/19	7/22-7/26	7/29-8/02	8/05-8/09	8/12-8/16	8/19-8/23
Discovery (Full Day) \$85										
Greenhorns \$85										
Explorers \$85										
Pioneers \$85										
Adventurers \$85										
CIT \$85										
AM Care \$52\$85										
PM Care \$56/\$89										

Quick Guide: Discovery Ages 3, 4, 5 Gr Explorers Ages 7, 8 Pic Adventurers Ages 11, 12, 13 CIT Ages 14, 15 **Greenhorns** Ages 5, 6 Pioneers Ages 9, 10

REGISTRATION FEE (PER CHILD)	\$25
	+
NUMBER OF WEEKS X \$50 DEPOSIT=	\$
TOTAL DUE AT REGISTRATION	\$
All deposits and registration fees are non-refundable and non-trans	ferable.
Sta	iff Initial





CENTRAL CONNECTICUT COAST YMCASummer Camp Payment Authorizations

Child's First Name	Last	Gender
Summer Camp Payment Agreement (Check One)	
to the session start to act as payment	, hereby authorize the Central Connecticut Coast YMCA to cha t for Summer Camp services. I understand that final payment for each sessi ance is not paid by that date, I am aware that my child will not be able to at	ion is due no later than the Monday two weeks before
April, May, and June) in the amount of	, hereby authorize the Central Connecticut Coast YMCA to char to act as payment for Summer Camp services. I und on begins. If the session balance is not paid by that date, I am aware that m	derstand that final payment for each session is due no
refund requests must be done in writin	, two weeks prior to the session start date. Deposit fees and registration fe g on a Refund Request Form. I understand that I must provide a minimum of d less than 2 weeks before the start of a session. Refunds may be issued fo Il refunds.	f 2 weeks' notice, in writing, if I wish to discontinue
EFT or charge returned by the bank. A	oplied to accounts not paid in full the Monday, two weeks prior to the session \$30 fee for credit card returns and returned checks will be applied to outsout with Summer Camp payments. Failure to pay this fee will jeopardize your continuation.	tanding balances. These fees will be automatically
	notify the YMCA of any change in address, bank account information (if utiliz lizing credit card for payment of summer camp).	zing bank draft for payment of summer camp) or credit
	equirements, payment obligations, refund policy, fees and dea	
Address		
Signature	Date	
below. When the bank honors the EFT Should any preauthorized EFT (or credi	rized Electronic Funds Transfers (or credit card charges) against my account (or credit card) by charging my account, such transfer shall constitute notice t card) not be honored by said bank when received by them, then it is under harge. It is further understood that if such payment is not honored by the bue for payment on a future date.	e of payment due and my receipt for the payment. stood that the payment is to be made by me in the
•	or payment (direct debit from my \square Checking \square Savings account)	
	Name on Account	
	Account Number	
Authorized Signature:	Dat	e:
$\hfill \square$ I choose to utilize a credit card on	file at the Y. Reference	
Authorized Signature:	Dat	e:
Your Credit Card must be swiped at the Card Holder Name	Payment option for monthly payment (automatic direct charge to credit card e YMCA Branch. Card Type 🗆 American Express 🗆 Discover 🗆 MC 🗅 Visa)
Card Holder Address		o.
Authorized Signature:	Dati	e:

2024

SUMMER CAMP ONLY

Attach voided check here for EFT Accounts

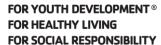


FOR YOUTH DEVELOPMENT® FOR HEALTHY LIVING FOR SOCIAL RESPONSIBILITY

SOUNDVIEW FAMILY YMCA CAMP HAYS

2024 Summer Camp Transportation Permission Form

I hereby give permission for my child, when the camp needs to be evacuated for the safety	
In the event of an emergency and I cannot be reached	d please call:
	at
(Emergency Contact)	at (Phone Number)
I prefer my child to be taken to my child requires emergency medical attention the fol	
(Physician's Name and number)	
Signature of Parent/ Guardian	
- Date	

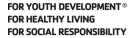




SOUNDVIEW FAMILY YMCA CAMP HAYS

2024 Summer Camp Fieldtrip Permission Form

I hereby give permission for my child, the Vernon Hays School to/from Kennedy Field for Spo weeks my child is attending camp: (For Explorers, Pior initial all weeks that apply.	
Week 1: June 17-21, 2024 Week 2: June 24-28, 2024 Week 3: July 1-5, 2024 (No Camp July 4th) Week 4: July 8-12, 2024 Week 5: July 15-19, 2024 Week 6: July 22-26, 2024 Week 7: July 29-Aug 1, 2024 Week 8: August 5-9, 2024 Week 9: August 12-16, 2024 Week 10: August 19-23, 2024	Parent/Guardian Initials
Date	





CENTRAL CONNECTICUT COAST YMCA Summer Camp Behavior Contract for Participants, Parents, Families and Campers

EXPECTIONS

- 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, threating 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.	
Parent/Guardian Signature	Child/Participant Signature
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, aphysi-

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	e)			Birth Dat	e	☐ Male ☐ Fema	ale	
Address (Street, Town and ZIP cod	ie)		I			I		
Parent/Guardian Name (Last, F	irst, Midd	lle)		Home Ph	one	Cell Phone		
School/Grade				Race/Eth	•	☐ Black, not of Hispan ian/ ☐ White, not of Hispan		
Primary Care Provider				Alaska □ Hispar			er	
Health Insurance Company/N	umber*	or M	edicaid/Number*					
Does your child have health in Does your child have dental in * If applicable	nsurance	e? Y	N If your c			ve health insurance, call 1-877-CT	 Γ-HUS	SKY
Please answer these	healtl	n his	tory questions about v	your cl	ild b	efore the physical examii	natio	n.
			or N if "no." Explain all "ye					
Any health concerns	Y	N	Hospitalization or Emergency Ro	om visit Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocati		N	Fainting or blacking out		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		N
Any daily medications	Y	N	Problems running	Y		High blood pressure	Y 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 bridge		N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden	unexplai	ned de	eath (less than 50 years old)	Y	N	Diabetes	Y	N
Any immediate family members	have hig	h chol	esterol	Y	N	ADHD/ADD	Y	N
Please explain all "yes" answe	ers here.	For i	llnesses/injuries/etc., include	he year a	nd/or y	our child's age at the time.		
Is there anything you want to	discuss	with t	he school nurse? Y N If yes, e	xplain:				
Please list any medications yo child will need to take in school relations taken in school re	ol:	separa	ute Medication Authorization Fo	rm signed	by a he	alth care provider and parent/guardia	un.	
					<i>y</i> 1.00	, , , , , , , , , , , , , , , , , , ,		
I give permission for release and exch between the school nurse and health use in meeting my child's health and	care pro	vider fo	or confidential	 t/Guardia	n			Date

HAR-3 REV 1/2022 Part 2 — Medical Evaluation Health Care Provider must complete and sign the medical evaluation and physical examination 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 Hips Lymphatic Knees Heart Feet/Ankles Lungs Abdomen *Postural ☐ No spinal ☐ Spine abnormality: Genitalia/ hernia ☐ Moderate abnormality ☐ Mild ☐ Marked ☐ Referral made Skin **Screenings** Date *Vision Screening *Auditory Screening History of Lead level $\geq 5\mu g/dL \square$ No \square Yes Left Type: Right Left Type: Right □ Pass □ Pass 20/ *HCT/HGB: With glasses 20/ ☐ Fail ☐ Fail Without glasses 20/ *Speech (school entry only) ☐ Referral made Other: ☐ Referral made ☐ Yes PPD date read: **TB:** High-risk group? □ No Results: Treatment: *IMMUNIZATIONS □ Up to Date or □ Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED *Chronic Disease Assessment: ☐ Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise induced **Asthma** 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 □ No ☐ Yes: ☐ Type I ☐ Type II **Diabetes** 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: \Box participate fully in the school program

☐ 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

This student may: \Box participate fully in athletic activities and competitive sports

participate in the school program with the following restriction/adaptation:

☐ participate in athletic activities and competitive sports with the following restriction/adaptation:

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

To Parent(s) or Guardian(s):

Signature of health care provider

DMD / DDS / MD / DO / APRN / PA/ RDH

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, M		Birth Date		Date of Exam		
School			Grade		☐ Male ☐ Female	
Home Address			ı		_	
Parent/Guardian Name (Las	st, First, Middle)		Home Phone	e	Cell Phone	
Dental Examination Completed by: ☐ Dentist	Visual Screening Completed by: MD/DO APRN PA Dental Hygienist		·	Referral Made: Yes No		
Risk Assessment		Γ	Describe Risk 1	L Factors		
☐ Low☐ Moderate☐ High	☐ Dental or orthodom ☐ Saliva ☐ Gingival condition ☐ Visible plaque ☐ Tooth demineraliza ☐ Other	ation		☐ Carious lesion ☐ Restorations ☐ Pain ☐ Swelling ☐ Trauma ☐ Other	ns	
Recommendation(s) by hea	ılth care provider:					
I give permission for releas use in meeting my child's h			between the se	chool nurse and hea	Ith care provider for confidentia	
Signature of Parent/Guar	dian				Date	

Date Signed

Printed/Stamped Provider Name and Phone Number

Student Name:	Birth Date:	HAR-3 REV. 1/2022

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 7	th-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)		
Нер А	*	*			See below for specific grade requirement		
Нер В	*	*	*		Required PK-12th grade		
Varicella	*	*			Required K-12th grade		
PCV	*				PK and K (Stud	ents under age 5)	
Meningococcal	*				Required ?	7th-12th grade	
HPV							
Flu	*				PK students 24-59 mor	nths 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 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