FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CENTRAL CONNECTICUT COAST YMCA

School Aged Child Care Registration & Release Form

Site Location/Program_____ Child's School_____

# of Days_____ M☐ T☐ W☐ T☐ F☐ Before☐ After☐ Start Date_____ End Date_____

Child's First Name_____ Last_____ Gender_____

Address_____ City_____ State Zip_____

Date of Birth _____Age as of Sept 1, yrs._____ mos.___ 2026-2027 Grade_____ Child resides with_____

Parent/Guardian #1_____ Parent/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 accommodations (social, behavioral, medicine)? No☐ Yes☐ Will an individualized care plan be provided? Yes☐ 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_____

Insurance Company_____ Policy Number_____

Policy Holder_____ Relationship to Child_____

Signature of Parent/Guardian _____ Date_____

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. I authorize the YMCA to release my child to the custody of the following people other than Parents/Guardians listed above:

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/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, refund policy and deadlines as outlined in the School Age Child Care Parent Handbook.

Signature of Parent/Guardian _____ Date_____

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CENTRAL CONNECTICUT COAST YMCA

School Aged Child Care Authorizations and Acknowledgements

Site Location_____ Child's School_____

Child's First Name_____ Last_____ Gender_____

Parent 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 have received, read and understand the Central Connecticut Coast YMCA SACC Safety Policy. **Initials** _____
- I hereby give permission for my child to participate in all activities (including field trips) that are part of the program. **Initials** _____
- I hereby give my consent for my child to participate in activities that involve water while under the supervision of the YMCA staff or their representatives. **Initials** _____
- I hereby give my consent for my child to be transported by the YMCA staff or their representatives. I grant permission to have my child transported to one of the YMCA's other facilities in case of inclement weather. **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 grant permission for photographs taken of my child while at school aged child care to be used for publicity and promotional purposes. **Initials** _____
- I acknowledge that the school district is not responsible for incidents/accidents that occur during after-school hours. **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 on time. 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 30th 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. 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 answer the following questions:

Please explain if there are certain situations that may cause your child difficulty. How can we best work with your child in these situations?

What limitations does your child have?

Are special provisions required to enable your child to participate in our program? (Including all food allergies).

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).

Other comments:

Signature of Parent/Guardian _____ Date_____

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SOUNDVIEW FAMILY YMCA

School Aged Child Care Payment Authorizations

Site Location_____ Child's School_____

Child's First Name_____ Last_____ Gender_____

Child Care Agreement

The School-Age Child Care Programs are tuition based. The yearly cost per child for the program is based on the number of calendar days in the school year and divided into 10 monthly equal payments. 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 School Aged Child Care services. I understand that I must provide two weeks' notice, in writing, to discontinue this service. This agreement is for the current school year plan only and the last draft will occur on May 20, 2027 . **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 before the first of the month. These fees will be automatically drafted from my School Aged 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 childcare).

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 (child care service) 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 monthly 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 the Credit Card Payment option for monthly payment (automatic direct charge to credit card)

Credit Card Type ☐ American Express ☐ Discover ☐ MC ☐ Visa Card Holder Name _____
Credit Card needs to be scanned at the branch. Card Holder Address _____
Authorized Signature: _____ Date: _____

2026-2027

SCHOOL AGED CHILD CARE ONLY

Attach voided check here.

03/18/26

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CENTRAL CONNECTICUT COAST YMCA

Parent Statement of Understanding

The following information is important for the safety of your child. Please read the information and sign below. Please keep and refer to your copy of the YMCA Child Care Parent Handbook which outlines our program policies and procedures. Your signature below indicates that you have received, read, and understand the Parent Handbook.

I understand that the YMCA staff and volunteers are not allowed to baby-sit or transport children at any time outside of the YMCA program. Immediate disciplinary action will be taken by the YMCA towards staff and volunteers if a violation is discovered.

I understand that I am not to leave my child at the program site unless a YMCA staff or volunteer is there to receive and supervise my child.

I understand that my child will not be allowed to leave the program with an unauthorized person. A court order is required to restrict a legal parent/guardian from pick-up. Any person authorized to pick up my child must either be listed with the YMCA or other arrangements must be made by calling the YMCA Child Care office to inform them of a change.

Do not release my child to any of the following individuals_____, if any of these individuals are biological parents, a court order is required to not release.

I understand that should a person arrive to pick-up my child who appears to be under the influence of drugs or alcohol, for the child's safety, staff may have no recourse but to contact the police. Please do not put staff in the position where they have to make this judgment call.

I understand that the YMCA is mandated, by state law, to report any suspected cases of child abuse or neglect to the appropriate authorities of investigation.

Managing a Child's Behavior

The Central Connecticut Coast YMCA staff are trained based on the following disciplinary policies and are reviewed during staff development and upon new hire orientation. The goal of discipline is to help the child to develop inner control so that he/she may move toward appropriate social behavior.

1. In order to work effectively with children, we must first try to understand his or her motives for inappropriate behavior. Straight forward rules and clear guidelines have been established for a uniform set of appropriate behavior. Consistency is paramount in effective discipline and is stressed throughout our programs. Positive guidance and the use redirection as an initial technique to change negative behavior is used by staff in addition to providing a clear explanation of the inappropriate behavior displayed.

2. Staff will not be abusive, neglectful, or use corporal, humiliating or frightening punishment to discipline children in our programs. A child will not be hit, spanked, slapped, pinched, shook or struck by any staff. Nor will any child be handled roughly. Staff will not shove or shake any child nor pull their ears or hair at any time as form of discipline. No child shall be physically restrained unless it is necessary to protect the safety and health of the child or another child or adult.

3. If a child does not respond to redirection and continues to display inappropriate behavior the child may be removed from the activity for a "Time Out". The child remains within full view of the staff and may not be able to see the activity during this period. The limit on "time out" is five minutes and is determined by the amount of time the child takes to display appropriate behavior or on the severity of the inappropriate act. During the "time out" the staff will ask the child what they think they did to be put in "time out", why did they behave that way, and what will they do next time to avoid the situation happening again.

4. If redirection of the child and the time out and counseling is ineffective and serious behavioral problems continue to disrupt the class the parent may be called to pick-up their child early. The YMCA also reserves the right to remove or suspend a child without tuition reimbursement if the parents, Head Teacher, Director of School Age Child Care, Child Care Coordinator and/or Youth Director cannot mutually get the child to behave in an appropriate manner.

I have read and understand the statements above and have been informed of the YMCA Parent Policies and Procedure.

Parent Signature: _____ Date: _____

Child's Name: _____ Program: _____

CENTRAL CONNECTICUT COAST YMCA
1240 Chapel Street, New Haven, CT 06511
P 203 777 9622 **F** 203 773 8950 **W** cccymca.org

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CENTRAL CONNECTICUT COAST YMCA
School Age Child Care Behavior Contract for Participants, Parents and Families

EXPECTIONS

- Show respect by treating other children and adults the way I would want to be treated.
- Be honest, I 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 YMCA 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 for 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 YMCA 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 YMCA SACC Director before the child can return to the program.
- SACC 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 YMCA 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

CENTRAL CONNECTICUT COAST YMCA
1240 Chapel Street, New Haven, CT 06511

P 203 777 9622 **F** 203 773 8950 **W** cccymca.org

03/18/26

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CENTRAL CONNECTICUT COAST YMCA School Age Child Care 2026-2027 Transportation Permission Form

I hereby give permission for my child _____, for daily transportation to and from his/her school as indicated on my child's enrollment form as well as for emergency situations when the program 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 Other than Parent/Guardian) (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

School Age Child Care Field Trip (on school site) Permission Form

I, _____, the parent/guardian of _____, give permission for my child to participate in supervised on-site field trips and activities conducted by the program on school grounds. These activities may include use of areas such as playgrounds, basketball courts, fields, classrooms and other spaces that are not licensed by OEC. I understand that no transportation is required, that my child will remain on school property at all times, and that all activities will be supervised by qualified staff in accordance with Connecticut Office of Early Childhood (OEC) regulations.

_____

Signature of Parent/ Guardian Date

CENTRAL CONNECTICUT COAST YMCA
1240 Chapel Street, New Haven, CT 06511

P 203 777 9622 **F** 203 773 8950 **W** cccymca.org

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