



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.

Concussion Information: I have read the CDC Concussion Fact Sheet and will talk to my child about the information. (<http://www.cdc.gov/headsup/>)

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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WOODRUFF FAMILY YMCA
2019 Summer Camp Session Registration Form

Child's Name _____ MEMBER ID # _____ Shirt Size _____

CAMPER UNIT	Grades	WEEK 1 6/17-6/21	WEEK 2 6/24-6/28	WEEK 3 7/1-7/5	WEEK 4 7/8-7/12	WEEK 5 7/15-7/19	WEEK 6 7/22-7/26	WEEK 7 7/29-8/2	WEEK 8 8/5-8/9	WEEK 9 8/12-8/16	WEEK 10 8/19-8/23	TOTAL WEEKS
GREENHORNS Member \$175 Community \$260	K-1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EXPLORERS Member \$175 Community \$260	2-3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PIONEERS Member \$175 Community \$260	4-6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ARCHERY CAMP Member \$238 Community \$357	4-6				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
CHALLENGE CAMP Member \$238 Community \$357	4-6				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
CREATIVE ARTS CAMP Member \$238 Community \$357	2-6				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
MUSEUM CAMP Member \$238 Community \$357	4-6					<input type="checkbox"/>						
SPORTS CAMP Member \$238 Community \$357	2-6		<input type="checkbox"/>									
STEAM CAMP Member \$238 Community \$357	2-6							<input type="checkbox"/>				
ADVENTURERS Member \$226 Community \$339	7-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CITS (14 & 15 YRS) Member \$122 Community \$183	8-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PRE CARE Member \$34 Community \$51	All	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
POST CARE Member \$48 Community \$72	All	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Challenge Course Statement

I, _____, am aware and understand that participating in activities while at Camp Wepawaug, including high ropes course, climbing wall, and challenge activities involve a potential risk of physical injury.

Parent/Guardian Signature

Date

Registration Fee (Per Child) \$25.00

Total weeks _____ X \$50 Deposit = _____

Total due at registration _____

Staff initials _____



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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 1st 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 the Wednesday 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 Wednesday before each session begins to act as payment for Summer Camp services for the following week. I understand that final payment for each session is due no later than the Wednesday 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 \$20.00 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: _____

2019

SUMMER CAMP ONLY

Attach voided check here for EFT Accounts



FOR YOUTH DEVELOPMENT®
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WOODRUFF FAMILY YMCA CAMP WEPAWAUG
2019 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



FOR YOUTH DEVELOPMENT®
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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.

Your signature below indicates that you have read and understand the above Camp Behavioral Contract.

Signature

Signature

Date

CONCUSSION Information Sheet



This sheet has information to help protect your children or teens from concussion or other serious brain injury. Use this information at your children's or teens' games and practices to learn how to spot a concussion and what to do if a concussion occurs.

What Is a Concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

How Can I Help Keep My Children or Teens Safe?

Sports are a great way for children and teens to stay healthy and can help them do well in school. To help lower your children's or teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
 - › Work with their coach to teach ways to lower the chances of getting a concussion.
 - › Talk with your children or teens about concussion and ask if they have concerns about reporting a concussion. Talk with them about their concerns; emphasize the importance of reporting concussions and taking time to recover from one.
 - › Ensure that they follow their coach's rules for safety and the rules of the sport.
 - › Tell your children or teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your children or teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. However, there is no "concussion-proof" helmet. So, even with a helmet, it is important for children and teens to avoid hits to the head.



Plan ahead. What do you want your child or teen to know about concussion?

How Can I Spot a Possible Concussion?

Children and teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

Signs Observed by Parents or Coaches

- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness (*even briefly*).
- Shows mood, behavior, or personality changes.
- Can't recall events *prior to* or *after* a hit or fall.

Symptoms Reported by Children and Teens

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not "feeling right," or "feeling down."

Talk with your children and teens about concussion. Tell them to report their concussion symptoms to you and their coach right away. Some children and teens think concussions aren't serious or worry that if they report a concussion they will lose their position on the team or look weak. Be sure to remind them that *it's better to miss one game than the whole season.*

To learn more, go to www.cdc.gov/HEADSUP



Centers for Disease
Control and Prevention
National Center for Injury
Prevention and Control

Concussions affect each child and teen differently. While most children and teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your children's or teens' health care provider if their concussion symptoms do not go away or if they get worse after they return to their regular activities.



What Are Some More Serious Danger Signs to Look Out For?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or take your child or teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other.
- Drowsiness or inability to wake up.
- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching).
- Unusual behavior, increased confusion, restlessness, or agitation.
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously.

Children and teens who continue to play while having concussion symptoms or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious and can affect a child or teen for a lifetime. It can even be fatal.

Revised 5/2015

What Should I Do If My Child or Teen Has a Possible Concussion?

As a parent, if you think your child or teen may have a concussion, you should:

1. Remove your child or teen from play.
2. Keep your child or teen out of play the day of the injury. Your child or teen should be seen by a health care provider and only return to play with permission from a health care provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's health care provider for written instructions on helping your child or teen return to school. You can give the instructions to your child's or teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a health care provider should assess a child or teen for a possible concussion. Concussion signs and symptoms often show up soon after the injury. But you may not know how serious the concussion is at first, and some symptoms may not show up for hours or days.

The brain needs time to heal after a concussion. A child's or teen's return to school and sports should be a gradual process that is carefully managed and monitored by a health care provider.



To learn more, go to www.cdc.gov/HEADSUP

You can also download the CDC *HEADS UP* app to get concussion information at your fingertips. Just scan the QR code pictured at left with your smartphone.

Discuss the risks of concussion and other serious brain injury with your child or teen and have each person sign below.

Detach the section below and keep this information sheet to use at your children's or teens' games and practices to help protect them from concussion or other serious brain injury.

I learned about concussion and talked with my parent or coach about what to do if I have a concussion or other serious brain injury.

Athlete Name Printed: _____ Date: _____

Athlete Signature: _____

I have read this fact sheet for parents on concussion with my child or teen and talked about what to do if they have a concussion or other serious brain injury.

Parent or Legal Guardian Name Printed: _____ Date: _____

Parent or Legal Guardian Signature: _____



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 I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

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 1-877-CT-HUSKY
Does your child have dental insurance?	Y N	

* If applicable

Part I — 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

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 I 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>	Type:	<u>Right</u>	<u>Left</u>	*HCT/HGB:	
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass	*Speech (school entry only)		
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail			
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made			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 Provider 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
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) _____

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.