

WELCOME TO THE 2010
NEW CANAAN YMCA - SUMMER CAMP SEASON

Thank you for choosing New Canaan YMCA Summer camps!

Important New Information
Please Read:

**Medical, Information/Authorization And Medication Forms
Will Not Be Mailed To You.
Forms Are Available On Our Website:
www.newcanaanymca.org**

We will be using your email address to communicate with you during camp; therefore, it is imperative that you keep us informed of any email address changes by calling the YMCA front desk. *The forms required for admittance to camp are found on our website at www.newcanaanymca.org under Forms / Summer Camp Forms / Required Forms, .* The forms must be downloaded off of the website, filled out, and sent to the YMCA. *If you do not have access to the website, the forms will also be available at the YMCA front desk.*

All Paperwork Must Be Submitted To The YMCA By May 15, 2010.
Children will not be admitted to camp without the completed forms.
Only Camp Y-Ki requires a current school photo to be attached to their camp forms.

THE FOLLOWING 3 FORMS ARE TO BE SUBMITTED BY MAY 15, 2010:

1. **Health Assessment Record (Medical Form)– 2 pages**

All campers must have a Medical Form on file at the YMCA valid* THROUGHOUT ALL registered camp session(s).

* **Camp Mini:** Medical Form is valid for one (1) year from exam date.

Camp Y-Ki & Sports Camp, Diving/Gymnastics & Synchro Camp: Medical Form is valid for three (3) years from exam date.

NOTE: **Please be sure to fill out the child's information on the top of the Medical form and Part I on the first page. The back of the form is for the child's physician to complete.**

An alphabetical list of all campers' Medical Forms from prior summers is on file and available at the YMCA Front Desk. It includes the date, per our records, of when the child had their last physical exam. It is the parent's responsibility to check this list to determine if their child's Medical Form is valid through the end of all camp sessions they will attend. If they need a new Medical Form, we suggest that you make a physician appointment early as, historically, the physicians are booked up very quickly.

2. **Information Authorization Form– 1 page**

A new form must be completed in its entirety each camp season. **Names of parents and other persons permitted to pick-up child must be included on this form.** New this year, a current school photo of your child must be attached to this paperwork for all camps except Camp Mini. **(PLEASE DO NOT STAPLE)**

3. **Annual Medical Update – 1 page**

A new form must be completed and signed each camp season.

If Your Child Needs To Have Medication Administered During The Camp Season,

The Authorization For The Administration Of Medications (Over-The-Counter Or Prescription) By YMCA Personnel form needs to be completed by the child's physician and parent/guardian. **No medication (over-the-counter or prescription) will be administered without this form on file.** This form is due a **minimum** of one week prior to the first day of your child's first camp session. Please be sure and attach a picture of your child to the form.

We look forward to meeting you all this summer. We hope the following information will help to prepare you and your child for an exciting camp season.

Sincerely,
New Canaan YMCA Summer Camp Directors



We build strong kids, strong families, strong communities.
564 South Avenue, New Canaan, Connecticut 06840
Tel. (203) 966-4528; Fax (203) 972-7738
www.newcanaanymca.org

New Canaan Community YMCA – Summer Day Camps
Information / Authorization Form 2010

Camp Attending (Please Check):

Mini Y-Ki Sports Camp Diving/Gymnastics Synchro

Camper's Name _____ Sex _____ Age _____ Date Of Birth _____
(First) (Last)

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Grade Completed June 2010 _____

Email - (Please print clearly) _____

T-Shirt Size (Circle One) **Child- Small Med Large** **Adult- Small Med Large**

Mother / Guardian _____ Home Phone () _____
(If Authorized For Pick-Up And Contact)

Cell Phone () _____ Work Phone () _____

Father / Guardian _____ Home Phone () _____
(If Authorized For Pick-Up And Contact)

Cell Phone () _____ Work Phone () _____

PERMISSION AUTHORIZATION:

- The child named above has my permission, in case of inclement weather, to be transported by bus, van or YMCA staff vehicle from Kiwanis Park (Camp Y-Ki) to the New Canaan YMCA designated rainy day site.
- In the event the YMCA is unable to reach me or the emergency contact person(s) given, I give permission to YMCA staff or hospital physician to order whatever emergency measures as judged necessary for the care and protection of my child.

INSURANCE CO. _____ **INSURANCE POLICY #** _____

- I understand that any expenses incurred, due to the above, will be borne by the child's family.
- The child named above has my permission to apply self-supplied sun screen and bug repellent as necessary.
- I also give permission for any photographs of my child to be used for promotional material by the YMCA.
- I understand **NO REFUNDS** will be made unless the space is filled. (Except for verified medical reasons as stated in camp brochure.)

PICK-UP AUTHORIZATION

- I give permission for the parents/guardians listed above and the following people to pick up my child and respond to emergencies at any time during the camp season.
- **I understand that my child will only be released to the above listed parents/guardians or the people listed below.** Changes and additions must be given in writing to the appropriate Camp Director.
- Due to our Drop-Off and Pick-Up procedure, we do not contact parents if a child is absent from camp.

Additional Contacts (To be contacted only if parents/guardians listed above cannot be reached.)

NOTE: We cannot accept this form unless #'s 1-3 are completed. CANNOT BE MOTHER OR FATHER (GUARDIANS).

1. _____ Home phone: () _____

Relation to child: _____ Work/Cell phone: () _____

2. _____ Home phone: () _____

Relation to child: _____ Work/Cell phone: () _____

3. _____ Home phone: () _____

Relation to child: _____ Work/Cell phone: () _____

Parent's 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 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, a physician assistant or the school medical advisor 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 10th or 11th grade. Specific grade level will be determined by the local board of education.

Please print

Name of Student (Last, First, Middle)		Social Security Number	Birth Date	Sex
Address (Street)		Race/Ethnicity		
(Town and ZIP code)		<input type="checkbox"/> American Indian	<input type="checkbox"/> White, not of Hispanic origin	
		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	
		<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Other	
Home Telephone Number	School			Grade
Name of Parent/Guardian (Last, First, Middle)				
Health Care Provider		Health Insurance Company/Number* or Medicaid/Number*		

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

***Important:* Complete Part I before your child is examined.**

Take this form with you to the health care provider's office.

Please check answers to the following questions in columns on the left.

(Explain all "yes" answers in the space provided below.)

- | | Yes | No | |
|----|--------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.) |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.) |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.) |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the school nurse? |

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

<hr style="border: none; border-top: 1px solid black;"/> Signature of Parent/Guardian	<hr style="border: none; border-top: 1px solid black;"/> Date
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Part II — Medical Evaluation

HAR-3 REV. 1/2008

To the Health Care Provider: Please complete and sign.

_____ has had a complete history and physical exam on _____
 Student's Name Birth Date Month/Day/Year

Findings for this student are as follows:

Screening/Test Results	Immunization Record																																																																																																											
Note: * Mandated Screening/Test under Connecticut State Law																																																																																																												
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TB and Other Test Results (Sickle Cell, etc.) TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																												
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* Chronic Disease Assessment: Yes No Date of onset <input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified _____ <input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II _____ <input type="checkbox"/> <input type="checkbox"/> Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex _____ <input type="checkbox"/> <input type="checkbox"/> Seizure Disorder _____ <input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____	Disease Hx of above _____ (Specify) (Date) (Confirmed by) Exemption Religious _____ Medical: Permanent _____ Temporary _____ Date _____ Recertify Date _____ Recertify Date _____ Recertify Date _____																																																																																																											

This student has the following problems which may adversely affect his or her educational experience:

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior

The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. *Specify below.*

The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

This student may participate fully in the school program, including physical education activities.

This student may participate in the school program and physical education with the following restriction/adaptation.
(Specify reason and restriction.) _____

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

I would like to discuss information in this report with the school nurse.

Signature of health care provider	Name/Group Practice (Please type or print.)	Phone Number
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Annual Medical Update

Camp Attending (please check):

Mini

Y-Ki

Sports Camp

Diving/Gymnastics

Synchro

NAME _____
(First) (Last)

Please Check Correct Answers To The Following Questions:

(Please specify symptoms and remedies/medications.)

YES

NO

1. Do you have any concerns about your child's general health (eating & sleeping habits, weight, teeth, behavioral and emotional, etc)? _____

2. Does your child have any other specific illness or problems? _____

3. Does your child have any allergies (food, insects, medication, etc.)?

4. _____

4. Does your child take any medication (daily or occasionally)? _____

5. Does your child have physical limitations/restrictions or any problems with vision, hearing, speech (glasses, contacts, ear tubes, hearing aids)? _____

6. Has your child had any hospitalization, operation, or major illness (specify problem/ date)? _____

7. Has your child had any significant injury or accident (specify problem/date)? _____

8. Would you like to discuss anything about your child's health with the Camp Director(s)? _____

Additional Comments: _____

Parent's Signature: _____ Date : _____

New Canaan YMCA – Summer Day Camp Programs

Authorization For The Administration Of Medicines Return Only If Medicine Is To Be Administered During Camp

Camp Attending (Please Check):

Mini

Y-Ki

Sports Camp

Gymnastics/Diving

Synchro

If a Youth Camp chooses to administer medications, the Connecticut State Law and Regulations require a physician's or dentist's written order and parent or guardian's authorization for a nurse, first aid provider, the director, alternate director or youth camp counselor to administer medications. Medications must be in pharmacy prepared containers and labeled with the name of the drug, strength, dosage, frequency, physician's or dentist's name and date of the original prescription. Over the counter medication must be in the original container and labeled with the child's name.

Physician Or Dentist's Order: _____ **Date** ____ / ____ / ____

Name of Child: _____ Date of Birth ____ / ____ / ____
(First) (Last)

Street Address: _____ City/Town _____ State _____

Condition for which drug is being administered during camp hours: _____

DRUG: Name of Drug, Dose and Method of Administration

Times of Administration: _____ Medication shall be administered from ____ / ____ - ____ / ____

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____

Allergies to food or drug? If YES, list _____

Physician's / Dentist's Name _____ Phone () _____
(Type or Print)

Street Address _____ City/Town _____ State _____

Physician's or Dentist's Signature _____

Authorization By Parent/Guardian For The Administration Of The Above Medication:

Date: ____ / ____ / ____

To nurse, first aid provider, director, alternate director or youth camp counselor:

_____ I hereby request that the above medication, ordered by the physician/dentist for my child _____, be administered by the nurse, first aid provider, director, alternate director or youth camp counselor.

_____ I understand that I must supply the Youth Camp with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name.

_____ I understand that this medication will be destroyed if it is not picked up within one (1) week following termination of the order.

Name of Parent or Guardian _____ Signature _____
(Print Name)

Relationship to child: _____

Street Address: _____ City/Town _____ State _____

Phone () _____

Camp Y-Ki requires that a picture be attached to this form. Other camps do not.