WELCOME TO THE 2017 NEW CANAAN YMCA SUMMER CAMP SEASON

Thank you for choosing New Canaan YMCA Summer Camps!
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 during the camp season.

The 2 forms listed below are to be submitted to the YMCA no later than June 1.
All forms can be emailed to SUMMERCAMP@NEWCANAANYMCA.ORG
Children will not be admitted to camp without the completed forms.
Camp Y-Ki requires that a current school photo be attached to the forms.

1. **HEALTH ASSESSMENT RECORD (Medical Form)–** (Front and back of blue form)
   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, Teen Camp & 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 front page of the Medical form. The back page of the form is for 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 – Front and back**
   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. Please complete front and back of form. Camp Y-Ki is the only camp that requires a current school photo of your child. It must be attached to this paperwork.**

IF YOUR CHILD NEEDS TO HAVE MEDICATION ADMINISTERED DURING THE CAMP SEASON…

THE AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL, CHILD CARE AND YOUTH CAMP 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. This form is available at the Front Desk and on our website. Bring meds to the Camp Director the first day of your child's first session.

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

Enriching all people in spirit, mind, and body
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 – 2 Page form

All forms must be filled out and sent into the YMCA by June 1

A fillable version of this form can be found at newcanaanymca.org. Forms can be emailed to SUMMERCAMP@NEWCANAANYMCA.ORG

Camp Attending (please check all the camps the child is attending)

☐ Mini	☐ Synchro Swimming	☐C.I.T.
☐ Y-Ki	☐ Synchro/Sports Combo	☐ L.I.T.
☐ Sports	☐ Y-Cares Teen Camp	

If your child is participating in the SPECIAL CARES portion of camp, please check here ☐

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

Address _____ **City**_____ **State**___**Zip**_____ **Grade completed**_____

Home Phone _____ **Email** - (Please print clearly)_____

Parent / Guardian_____ **Home Phone** _____
(If Authorized For Pick-Up And Contact)

Cell Phone _____ **Work Phone** _____

Parent / Guardian_____ **Home Phone** _____
(If Authorized For Pick-Up And Contact)

Cell Phone _____ **Work Phone**

T-Shirt Size (select one): Child: ☐ **Small** ☐ **Medium** ☐ **Large** **Adult:** ☐ **Small** ☐ **Medium** ☐ **Large**

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 PARENT/ (GUARDIANS*).***

1. _____ **Home phone:** _____

   Relation to camper:_____ **Work/Cell phone:**_____

2. _____ **Home phone:** _____

   Relation to camper:_____ **Work/Cell phone:**_____

3. _____ **Home phone:**_____

   Relation to camper:_____ **Work/Cell phone:** _____

Parent's Signature: _____ **Date:** _____

New Canaan Community YMCA – Summer Day Camps
Information / Authorization Form – 2 Page Form
All forms must be filled out and sent into the YMCA by June 1

Camp Attending (please check all the camps the child is attending)

☐ Mini	☐ Synchro Swimming	☐C.I.T.
☐ Y-Ki	☐ Synchro/Sports Combo	☐ L.I.T.
☐ Sports	☐ Y-Cares Teen Camp	

If your child is participating in the SPECIAL CARES portion of camp, please check here ☐

Camper's Name _____

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 receive special services at school? If yes, please contact Carolynn Kaufman x 156	☐	☐
3. Does your child have any other specific illness or problems?	☐	☐
4. Does your child have any allergies (food, insects, medication, etc.)?	☐	☐
5. Does your child take any medication (daily, occasionally)?	☐	☐
6. Does your child have physical limitations/restrictions or any problems with vision, hearing, speech (glasses, contacts, eartubes, hearing aids)?	☐	☐
7. Has your child had any hospitalization, operation, or major illness (specify problem and date)?	☐	☐
8. Has your child had any significant injury or accident (Specify problem and date)?	☐	☐
9. Would you like to discuss anything about your child's health with the Camp Director?	☐	☐

Additional Comments

Please attach the camper's picture for all **Y-KI Campers**

Parent 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 9th or 10th grade. Specific grade level will be determined by the local board of education.

Please print

Name of Student (Last, First, Middle)	Birth Date	Sex

Address (Street) (Town and ZIP code)	Race/Ethnicity ❑ American Indian ❑ White, not of Hispanic origin ❑ Asian ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ 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.	❑	❑	Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)?
2.	❑	❑	Has your child been diagnosed with any chronic disease? ❑ asthma ❑ diabetes ❑ seizure disorder ❑ other_____
3.	❑	❑	Does your child have any allergies (food, insects, medication, latex, etc.)?
4.	❑	❑	Does your child take any medications (daily or occasionally)?
5.	❑	❑	Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
6.	❑	❑	Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify.)
7.	❑	❑	In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.)
8.	❑	❑	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.	❑	❑	Does your child have health insurance? (If your child does not have health insurance, call 1-877-CT-HUSKY)
10.	❑	❑	Does your child have dental insurance?
11.	❑	❑	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.

Signature of Parent/Guardian

Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

HAR-3 REV. 4/2008

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

Note: * Mandated Screening/Test under Connecticut State Law

* Height:		BMI:
* Weight:		* Postural:
* Blood Pressure:		❑ Normal
Pulse:		❑ Abnormal
* HCT/HGB:		Min. _____
Urinalysis:		Slight _____
* Gross dental:		Mod. _____
Lead (Date/Result)		Marked _____
		❑ Referral

TB and Other Test Results (Sickle Cell, etc.)

TB: In high-risk group? ❑ Yes ❑ No

Test	Date	Results

* Vision/ Type of Screening			* Auditory/ Type of Screening
With glasses	R 20/	L 20/	Pass/Fail R
Without glasses	R 20/	L 20/	L

*** Chronic Disease Assessment:**

Yes	No		Date of onset
❑	❑	Asthma: ❑ mild ❑ moderate ❑ severe ❑ exercise induced ❑ unclassified	
❑	❑	Diabetes: ❑ Type I ❑ Type II	
❑	❑	Anaphylactic Reaction: ❑ food ❑ insect ❑ latex	
❑	❑	Seizure Disorder	
❑	❑	Other: Please specify _____	

Immunization Record

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	*	*	*	*		
DTP/Hib						
DTaP						
DT/Td						
OPV	*	*	*			
IPV	*	*	*			
MMR						
Measles	*	*		Booster for entry into K and 7th grade		
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep B	*	*	*		Req. for entry into K and 7th grade.	
Varicella	*			Students born 1/1/97 or later. Required for 7th grade entry.		
PCV					Pneumococcal conjugate vaccine	

Other Vaccines (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

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth___/___/___ Today's Date___/___/___

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: ____/____/____ End Date: ____/____/____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date ____/____/____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ___/___/___

Parent /Guardian's Address _____Town_____State____

Home Phone # (____) _____-_____ Work Phone # (____) _____-_____ Cell Phone # (____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature Date

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature Date

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)