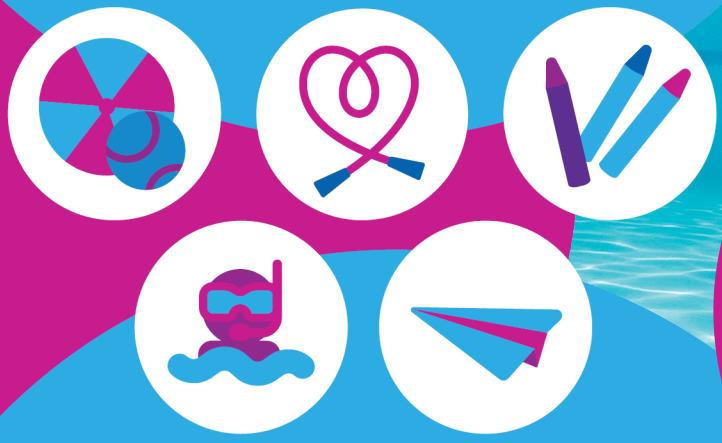
the YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

STAMFORD FAMILY YMCA

CAMP WOW

BEST SUMMER EVER™



Pick up your Application Packet at the Front Desk or online at: www.stamfordymca.org/campapp

June 22–Aug 14, 2020

Members: $450 Per Session
Non-Members: $545 Per Session

Session 1: June 22nd – July 3rd, 2020
Session 2: July 6th – July 17th, 2020
Session 3: July 20th – July 31st, 2020
Session 4: Aug 3rd – Aug 14th, 2020

FOR MORE INFORMATION:
Contact Melody Laing 203-724-9991
or Melody@stamfordymca.org

Stamford Family YMCA | 10 Bell Street, Stamford CT 06901 | www.stamofrdymca.org

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

SUMMER CAMP REGISTRATION CHECKLIST

☐ **Camper Information Form**

☐ **Registration Form**

☐ **Health Information**

☐ **Medication Consent Form**

☐ **General Consent**

☐ **Payment Agreement**

☐ **Field Trip Information**

- **Copy of Child's physical and immunizations from physician**
- **Physical must be dated within one year of the weeks that the camper is attending**
- **Prescription medicines administered during the camp day require a signed note from doctor.**

** Asthma Action Plans and EPI pen emergency plan are helpful, please encourage your child's physical to include these.

Campers will not be registered until all the above paperwork has been received, all pass due payments are paid in full and confirmation by the Camp Director.

For office use only
Group Name:

_____

Today's Date: _____
Please print information on form.

CAMP REGISTRATION FORM

Child's Information:

Last Name: _____ First Name: _____ MI: _____
Nickname: _____ Gender: ☐ Female ☐ Male Birth Date: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone #: _____ Stamford YMCA Member: ☐ Yes ☐ No
List Previous Child Care Center/School: _____ Member #: _____
School Attending: _____ School Phone #: _____ Grade during the 2019-2020 Academic Year: _____

Parent(s)/Guardian(s) Information:

Parent/Guardian: _____ Birth Date: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Place of Employment: _____ Business Address: _____
Primary E-mail:
(To receive program updates)

Parent/Guardian: _____ Birth Date: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Place of Employment: _____ Business Address: _____
Primary E-mail:
(To receive program updates)

Person or agency having legal custody: _____
Address if different from above: _____

EMERGENCY CONTACT INFORMATION: (Must list 2; local and other than Parent(s)/Guardian(s) listed above)

First Emergency Contact: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Company Name: _____
Cell Phone: _____ Alternate Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Second Emergency Contact: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Company Name: _____
Cell Phone: _____ Alternate Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Person(s) authorized to PICK-UP your child: _____ Relationship: _____
Person(s) authorized to PICK-UP your child: _____ Relationship: _____
Person(s) NOT authorized to PICK-UP your child: _____ Relationship: _____
Person(s) NOT authorized to PICK-UP your child: _____ Relationship: _____

Please note: Appropriate paperwork, such as custody papers, must be attached if the custodial parent requests not to release the child to the other parent.

Medical Information:

Allergies or intolerance to food, medication, or any other substance:

_____

If an allergic reaction occurs, please list steps to relieve reaction:

_____

Chronic physical problems, pertinent developmental information, any special accommodations needed:

_____

For special accommodations, or to share important information about your camper, please schedule a meeting with the Camp Director.

Does your child take medications or vitamins on doctor's orders? _____

Please specify: _____

Registrants must submit a physical examination or a Youth Camp Exam Record Form completed by the camper's physician by June 1, 2020.

Physician Name: _____ Physician's Phone: _____

Emergency Medical Authorization:

I give The Stamford Family YMCA permission to provide my child cardiopulmonary resuscitation (CPR) and first aid treatment by a certified staff member. I also give permission to transport my child by ambulance, staff vehicle, or YMCA vehicle to an emergency center for treatment. I authorize the Stamford Family YMCA to obtain immediate medical care and give consent to the hospitalization and performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to my child or ward if an emergency occurs and I cannot be located immediately. It is also understood that this agreement may only cover those situations which are true emergencies. I understand that the provider will make every effort to contact me and/or my designated emergency contacts.

I/we will be responsible for payment of medical expenses. Medical treatment costs are covered by:

Medical Insurance Provider: _____ Policy#: _____

Parental Agreements:

I give permission for my child, _____, to attend The Stamford Family YMCA's summer camp and to participate in all activities and field trips. I authorize the camp program to use photographs and videos of my child (ren) for the purpose of telling the program story and promoting the message of the program. I understand that the program is not responsible for the personal property of the participant (s). In case of an emergency, I understand that every effort will be made to reach the parent (s) or guardian (s) of the participant (s).

Cancellation Policy:

If fees have been paid and cancellation is made two weeks before the start of camp session, the balance camp session, the balance will be returned less the deposit. If fees have been paid out but cancellation is made less than two weeks before the start of the camp session, no refund will be issued.

Swimming Assessment:

- ☐ Non-Swimmer (unable to swim/no swim instruction)
- ☐ Beginner (some limited swim instruction)
- ☐ Intermediate (average swimming ability)
- ☐ Advanced (skilled swimmer)

All information on this form is true and complete to the best of my knowledge. I understand and agree to the Emergency Medical Authorization, Parental Agreements, and Cancellation Policy outlined above.

Parent/Guardian Signature: _____ Date: _____

STOP! If you are completing an online registration, please sign the participant waiver form, submit required additional forms & STOP HERE.

GO! If you are completing an in-person, mailed, e-mailed, or faxed registration, please CONTINUE TO THE NEXT PAGE as well as submit required additional forms.

2020 CAMP SELECTION & FEES

Please fill out one form for each camper

Camper Name: _____ **Date:** _____

STAMFORD FAMILY YMCA SUMMER CAMPS

REGISTRATION FORM Please check all that apply	FULL SEASON June 22 - Aug 14	SESSION 1 June 22 - July 3	SESSION 2 July 6 - July 17	SESSION 3 July 20 - Aug 31	SESSION 4 Aug 3 - Aug 14
CAMP MINI (Kindergarten)					
Member	☐ $1,800	☐ $450	☐ $450	☐ $450	☐ $450
Non-Member	☐ $2,180	☐ $545	☐ $545	☐ $545	☐ $545
CAMP WOW (First Grade - Fifth Grade)					
Member	☐ $1,800	☐ $450	☐ $450	☐ $450	☐ $450
Non-Member	☐ $2,180	☐ $545	☐ $545	☐ $545	☐ $545
TEEN ADVENTURE CAMP (Sixth Grade - Eighth Grade)					
Member	☐ $1,980	☐ $470	☐ $470	☐ $470	☐ $570
Non-Member	☐ $2,356	☐ $564	☐ $564	☐ $564	☐ $664
CIT PROGRAM (Ages 15 - 16)					
Member	☐ $420	☐ $105	☐ $105	☐ $105	☐ $105
Non-Member	☐ $620	☐ $155	☐ $155	☐ $155	☐ $155

EXTENDED CARE HOURS OPTIONS

EXTENDED CARE OPTIONS	FULL SEASON June 22 - Aug 14	SESSION 1 June 22 - July 3	SESSION 2 July 6 - July 17	SESSION 3 July 20 - Aug 31	SESSION 4 Aug 3 - Aug 14
Before Care 7:30 AM - 9:00 AM	☐ $240	☐ $60	☐ $60	☐ $60	☐ $60
After Care 4:00 PM - 6:00 PM	☐ $240	☐ $60	☐ $60	☐ $60	☐ $60
Extended Care Before 7:30-9:00am/4-6pm After	☐ $340	☐ $85	☐ $85	☐ $85	☐ $85

CAMP T-SHIRT INFORMATION
Size:

☐ Youth XS ☐ Youth S ☐ Youth M ☐ Youth L

☐ Adult S ☐ Adult M ☐ Adult L ☐ Adult XL

Camp Shirts are required on every field trip and beach day!

Each camper receives 1 camp shirt with registration

Additional camp shirts are $10 each. Would you like to order camp shirts? ☐ Yes ☐ No

How Many? ☐ 1 ☐ 2 ☐ 3 ☐ 4

TOTAL CAMP FEE:	
EXTENDED HOURS FEE:	
ADDITIONAL CAMP SHIRT(S):	
GRAND TOTAL:	
TOTAL FEES PAID AT THIS TIME:	
REMAINING BALANCE DUE:	

CAMP PAYMENT OPTIONS

YMCA Financial Assistance participants must be authorized BEFORE REGISTERING. For more information call 203-357-7000 x 1170 or email melody@stamfordymca.org **BEFORE** registering.

CAMP FEES: Camp fees must be paid in full prior to Monday June 1, 2020. Participant must be an active member to receive member rates (M) or non-member (NM) rates will apply.

CANCELLATIONS: If fees have been paid and cancellation is made two weeks before the start of camp session, the balance will be returned less the deposit. If fees have been paid out but cancellation is made less than two weeks before the start of the camp session no refund will be issued.

ADDS: Additional camp sessions can be added after initial registration by submitting a new camper registration form. However, we cannot guarantee availability.

PAYMENT OPTIONS: A $250.00 non-refundable deposit fee per camper is due upon registration. Camp fees may be paid in full upon registration or remaining balance will be automatically drafted per fee schedule below. For drafted balances YOU MUST:

1) **Pay the $250.00 non-refundable deposit fee**
2) **List the dates and amounts you want your remaining camp balance drafted**
3) **Provide an approved debit or credit card for scheduled balance payment;**
4) **Recieve signed approval from ONLY the Camp Director or VP of Operations.**

Connecticut Care 4 Kids: If you receive Connecticut Care 4 Kids you MUST pay half of your total camp balance prior to June 5, 2020.

$ _____Total Camp Fees $ _____ Total Fees Paid At This Time $ _____ Balance Due

Payment Method

I have enclosed a check for $ _____ Check# _____ OR Credit/Debit (check one) ☐ VISA ☐ MC ☐ AMEX ☐ DISC

Name on Card: _____ Card# _____

Exp. _____ VCODE _____ Signature _____ Date _____

Fee Schedule: By providing my signature below, I authorize the Stamford Family YMCA to charge my credit card on the following dates:

Payment 1: $_____ on _____

Payment 2: $_____ on _____

Payment 3: $_____ on _____

Payment 4: $_____ on _____

Payment 5: $_____ on _____

Payment 6: $_____ on _____

Payment 7: $_____ on _____

Payment 8: $_____ on _____

Total balance remaining balance of $_____ paid in full on _____

I/We understand and agree to the above payment terms. I/We understand that completion of all required summer camp forms is a required condition of participation in summer camp programs.

PARENT/LEGAL GUARDIAN Print Name: _____ Signature: _____ Date: _____

CAMP DIRECTOR APPROVAL Print Name: _____ Signature: _____ Date: _____

Summer Camp Registration Checklist:

__ Completed and signed camp registration form

__ Signed payment plan form (if applicable)

__ $250 non-refundable deposit made upon registration

__ A physical examination or a Youth Camp Exam Record Form completed by campers physician

__ Administration of Medication Form or Self Administration Form (must be signed by parent and physician) or you will not be able to leave medicine at the YMCA

*** All Summer Camp fees must be paid by Monday, June 1, 2020. If your child receives Connecticut Care 4 Kids, you must pay your total family fees by Friday, June 5, 2020.**

FOR OFFICE USE ONLY:

Accepted By: _____ Date: _____ Processed By: _____ Date: _____

Group Placement: _____

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 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	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
	❑ Hispanic/Latino	❑ Asian/Pacific Islander
		❑ Other
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 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

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

Part II — 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 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					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
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

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 4/2017

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 the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name_____ Date of Birth_____ Phone_____

Guardian_____ Address_____

Emergency Contact_____ Telephone_____

Date of Arrival at Camp: _____ Departure Date: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Date of Exam ____/____/____

May participate in all camp activities ☐ YES ☐ NO

May participate except for: _____

Does the individual have any known medical or emotional illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp? ☐ YES ☐ NO

If yes, please explain _____

_____

Are there any prescription or over the counter medication(s) this individual needs to take while at camp? ☐ YES ☐ NO

If yes, indicate names of medication(s):_____

NOTE: A written authorization and parent permission for the administration of medication at camp are required.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? ☐ YES ☐ NO

If yes, please explain _____

_____

NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If camper/staff is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health pursuant to section 19a-7f of the Connecticut General Statutes? ☐ YES ☐ NO

Additional Comments:

_____

_____

Printed Name of Health Care Provider: _____

Address: _____ Phone: _____

Signature of Physician, PA, APRN or RN _____ Date Form Signed: _____