WELCOME TO LEAD ACADEMY 2022/2023

Dear Families:

Welcome and thank you for choosing the Stamford Family YMCA'S LEAD after-school program for your child care needs. LEAD Academy is comprised of students in grades K-8th in the Stamford community. Our program is designed to provide students' academic and social support by engaging them with counselors and mentors in constructive homework support, enrichment activities and recreational outlets.

We operate based on the Stamford Public Schools calendar, Monday-Friday from the dismissal of school until 6 pm and extended care from 6 pm to 7 pm

****(Children must be picked up by 6:00 pm or 7:00 pm (if enrolled in extended care). A $10.00 late pick-up fee per every 15 minutes will be charged to the child's account, regardless of notification to the staff.**

We look forward to serving you and your family here at the Stamford Family YMCA!

If you have any additional questions or concerns, please feel free to contact me.

Best Regards,

Melody Laing

Melody Laing
School Age Child Care Director
P: (203)357-7000 ext. 9991
E: melody@stamfordymca.org

the YMCA
STAMFORD

CHILD NAME: _____

GRADE 2022/2023: _____

_____**CHILD ENROLLMENT & EMERGENCY MEDICAL FORM**

_____**EARLY CHILDHOOD HEALTH ASSESSMENT RECORD**

_____**IMMUNIZATION RECORD**

_____**AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION (IF NECESSARY)**

_____**STAMFORD FAMILY YMCA MEMBERSHIP INFORMATION**

_____**PAYMENT ELECTION FORM AND YMCA CREDIT CARD/BANK DRAFT AUTHORIZATION**

FOR OFFICE USE ONLY:

RECEIVED BY: _____ VERIFY CHECK LIST COMPLETE INTIALS: _____

DATE: _____

CHILD ENROLLMENT & EMERGENCY MEDICAL CARE FORM

Date of Application: _____ Date of Enrollment: _____ Last Day of Enrollment: _____
Child's Name: _____ Child's Date of Birth: _____
Child's Address: _____ City: _____ Zip Code _____
Mother's Name: _____Address: _____
City: _____ Zip Code: _____e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Mother's Employer: _____ Work #: (_____) _____
Mother's Employer Address: _____ City: _____ Zip Code _____
Father's Name: _____Address: _____
City: _____ Zip Code: _____e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Father's Employer: _____ Work #: (_____) _____
Father's Employer Address: _____ City: _____ Zip Code _____

****

Weekly Care Schedule: (please include the child's hours in care for each day)
Sunday: _____
Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____

Persons permitted to remove the child from the child care program on behalf of parent. (Use back for additional names.)
Name: _____
Phone #: _____Relationship _____

****

In an emergency, adults to be contacted if parent cannot be reached and to whom the child can be released.
(Use back for additional names.)
Name: _____
Phone #: _____Relationship _____

****

Medical Information

Known Allergies: _____ Last Tetanus: _____
Insurance Carrier: _____ Insurance ID: _____

Child's Physician: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____
Child's Dentist: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____

****

Emergency Authorization

I give my consent for the First Aid and CPR certified staff of **(program's name)** _____, to administer first aid and CPR to my child and to contact the above named physician or dentist if my child has a medical emergency. I also give my consent for my child to be transported to the nearest hospital in the event of a medical emergency. I will be responsible for all medical fees.
Preferred Medical Facility: _____

****

Behavior Management and Parent Handbook

I acknowledge that I have read the parent handbook and agree to abide by the policies contained in it and that the techniques used to manage child behaviors in the facility have been discussed with me prior to enrollment.

Signature of Parent or Guardian: _____ **Date**: _____

Signature of Parent or Guardian: _____ **Date**: _____

Field Trip Permission

I give permission for my child, _____, to attend **LEAD Academy** 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).

****

Transportation Permission

LEAD Academy has my permission to transport my child away from the Stamford Family YMCA as part of the child care program.

****

The provisions outlined on this form have been worked out in consultation with me and have my approval.

Signature of Parent or Guardian: _____ **Date**: _____

Signature of Parent or Guardian: _____ **Date**: _____

the YMCA
STAMFORD

LEAD After School Child Care Payment Form

Welcome to the Stamford YMCA After School Child Care Program. All participants are required to purchase a YMCA membership. You may join as a youth member or join as a family.

Please select a membership type:

_____	Youth Membership	$29 per month (one youth)
_____	LEAD Academy 2 Student Membership	$41.75 per month (must be in same household)
_____	Family Membership	$85 per month (two adults & all children in household)

School Age Child Care Program Fees are based on the grade.

Please select your program(s):

_____	Afterschool Child Care Academy (K-5th Grade)	$385 per month
_____	Afterschool Child Care Middle (6-8th Grade)	$295 per month
_____	Extended Care K - Middle School	$150 per month

** A $10.00 late pick-up fee per every 15 minutes will be charged to the child's account, regardless of notification to the staff. See parent handbook section 1.5

$_____ Total monthly fee (membership and program)

Financial Assistance is available upon request. Please request an application at the Membership Desk. This assistance Is available based on the generosity of member and community donations.

Please note, if you receive a third-party subsidy such as Care4Kids, you may not be eligible to receive additional financial assistance. You will be responsible for any portion Care4Kids does not cover.

Please complete the attached payment option form and your account will be charged monthly for your convenience. Credit card or bank draft Is required for this program.

STAMFORD FAMILY YMCA CREDIT CARD/BANK DRAFT/EFT AUTHORIZATION AGREEMENT

Last Name: _____ First Name: _____ Member #: _____

PLEASE CAREFULLY READ ALL INFORMATION BELOW AND INITIAL EACH AS INDICATED.

I hereby authorize the YMCA to initiate debits to the bank/credit cards listed on this form. _____ INITIAL

I agree to notify the Y about any credit cards reported stolen, expiration date changes and address changes. I also agree to notify the Y 10 days prior to the month of the draft to allow for processing time. _____ INITIAL

I understand that I must give 30 days notice to stop my bank/credit card draft. I understand that a membership may be terminated at any time. This must be done in person by signing the cancellation form. _____ INITIAL

NOTE: THE Y WILL NOT ACCEPT A TELEPHONE OR FAX CANCELLATION AT ANY BRANCH. _____ INITIAL

If your EFT or credit card is declined for non-sufficient funds (NSF), the payment may be collected electronically (by a third party) and a NSF fee of up to $35 per incident may be applied. _____ INITIAL

Changes to your checking or savings account will require 30 days to authorize the account to change future withdrawals. _____ INITIAL

I understand that Y memberships are continuous and rates may increase annually on January 1st. _____ INITIAL

I understand that any discount applied to my membership is only good for two years and that I must re-apply to renew the discount at least 30 days prior to loss of eligibility. _____ INITIAL

The Y processes monthly Membership payments on the 1st and/or 15th of every month (or next business day). If we cannot process your draft we will resubmit for payment. _____ NITIAL

The Y reserves the right to cancel/terminate any membership/program if a payment cannot be collected. _____ NITIAL

The Y processes Program Fee payments by varying program dates and can be processed at any regularly scheduled interval. If we are unable to draft your Program Fee payments for any reason, we will automatically redraft on our next scheduled draft date. Please ask for a specific Program schedule when registering for a Program Automatic Draft. _____ NITIAL

✔ Please Check One: ☐ Checking ☐ Savings Withdrawal Date ☐ 1st or ☐15th

Routing Number (9 digits) ☐☐☐☐☐☐☐☐☐

Bank Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank Account Number: _____

_____ Date ____/____/____

Name on Account (Please Print)

_____

Account Holder's Signature

✔ CREDIT CARD OPTION Please Check One: ☐ VISA ☐ M/C ☐ AMEX ☐ DISCOVER Withdrawal Date ☐ 1st or ☐15th

Credit Card Number (Last 4 Digit Only)_____ Expiration Date: ___/___

Address_____ Zip _____

(Name on Card) _____ (Bank Name) _____ Date ___/___/___

For Office Use Only: Withdrawal Date ☐ 1st or ☐15th
New ☐ Change ☐ Staff Initials _____

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

THE STAMFORD FAMILY YMCA

MEMBERSHIP INFORMATION

MEMBERSHIP CATERGORGY			
❑ YOUNG ADULT (18-25) ❑ ADULT (26-61) ❑ SENIOR (62+) ❑ FAMILY ❑ SENIOR FAMILY ❑ COLLEGE ❑ YOUTH (0-18) ❑ PROGRAM			
PRIMARY CUSTOMER (MUST BE 18+ YEARS):			
FIRST NAME	LAST NAME	GENDER	
		MALE ❑ FEMALE ❑	
STREET ADDRESS	CITY/STATE/ZIP	DATE OF BIRTH	
HOME PHONE	CELL PHONE	EMAIL	
EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER	
RACE OPTIONAL			
❑ ASIAN/PACIFIC ISLANDER ❑ AFRICAN AMERICAN/BLACK ❑ ALASKIN NATIVE ❑ HISPANIC/LATION ❑ CAUCASIAN/WHITE ❑ OTHER			
HOUSEHOLD INCOME			
❑ UNDER $12,000 ❑ $12,0001-$19,999 ❑ $20,000-$23,999 ❑ $24,000-$27,999 ❑ $28,000-$31,999 ❑ $32,000-$35,999 ❑ $36,000-$39,999 ❑ $40,000-$58,999 ❑ $59,000-$69,999 ❑ $70,000-79,999 ❑ $80,000-$89,999 ❑ $90,000-$99,000 ❑ $100,000+			
HOW DID YOU HEAR ABOUT OUR YMCA			
❑ WALK BY ❑ WEBSITE ❑ MEMBER REFFERAL ❑ FORMER MEMBER ❑ PLACE OF EMPLOYMENT ❑ OTHER_____			
SECONDARY ADULT			
FIRST	LAST	GENDER	DATE OF BIRTH
		M ❑ F ❑	
EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER	
DEPENDANTS			
1.		M ❑ F ❑	
2.		M ❑ F ❑	
3.		M ❑ F ❑	
4.		M ❑ F ❑	
EMERGENCY CONTACT INFORMATION			
NAME	PHONE NUMBER	RELATIONSHIP	

MEMBERSHIP CODE OF CONDUCT

The Stamford Family YMCA is a non-profit organization and reserves the right to deny membership on a non-discriminatory basis when deemed appropriate. Membership is a privilege which may be suspended or revoked by management for abusive behavior, profanity, noncompliance with rules, failure to comply with staff, or other behavior deemed unacceptable and inappropriate.

Members are required to carry their ID card(s) and scan them each and every time as they come into the building.

Members must have their picture taken and linked to their membership account.

Member Signature_____ Date _____ Staff Verification_____Date _____

THE STAMFORD FAMILY YMCA

RELEASE AND WAIVER OF LIABILITY AND INDEMNITY and PHOTO/TALENT RELEASE AGREEMENT

PLEASE READ CARFULLY. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND IS LEGALLY BINDING. BY SIGNING THIS AGREEMENT, YOU ARE RELEASING the Stamford Family YMCA FROM ALL LIABILITY AND FOREVER GIVING UP ANY CLAIMS THEREFOR

Assumption of Risk

I acknowledge and agree that any use of the Stamford Family YMCA facilities, services, equipment and premises ("Facilities") and any participation in The Stamford Family YMCA programs and activities ("Programs") comes with inherent risks including, but in no way limited to: (1) moderate and severe personal injury, (2) property damage, (3) disability, (4) death, and (5) sickness or disease. I voluntarily accept and assume full responsibility for these risks as well as any and all other risks of the use of Facilities and participation in Programs. I agree that I have full knowledge of the nature and extent of all such risks and am not relying on all such risks being described in this document.

Waiver, Release, Indemnification & Covenant Not to Sue

In consideration of the use of facilities, services and participation in programs I, the undersigned, agree that the Stamford Family YMCA, its officers, directors, agents, employees, volunteers, insurers and representatives ("Releasees") will not be liable for any personal injury, property damage, disability, death, sickness or disease incurred by myself, my family members, dependents, or guests, including minors, however occurring including, but not limited to the negligence of Releasees. I understand that I will be solely responsible for any loss or damage, including personal injury, property damage, disability, death, sickness or disease sustained from the use of Facilities and participation in Programs.

I further agree, on behalf of myself and any and all legal successors and proxies, to release and **HEREBY DO RELEASE, WAIVE AND COVENANT NOT TO SUE** Releasees from any causes of action, claims, suits, liabilities or demands of any nature whatsoever including, but in no way limited to, claims of negligence, which I and any and all legal successors and proxies may have, now or in the future, against Releasees on account of personal injury, property damage, disability, death, sickness, diseases or accident of any kind, arising out of or in any way related to the use of Facilities or participation in Programs, whether that participation is supervised or unsupervised, however the injury or damage occurs, including, but not limited to the negligence of Releasees.

In further consideration of the use of Facilities and participation in Programs, I agree to **INDEMNIFY AND HOLD HARMLESS** Releasees from any and all causes of action, claims, demands, losses, suits, liabilities or costs of any nature whatsoever, including claims of negligence, arising out of or in any way related to the use of Facilities and participation in Programs by myself, my family members, dependents or guests, including any minors.

The YMCA conducts regular sex offender screenings on all members, participants, and guests. If a sex offender match occurs, the YMCA reserves the right to cancel membership, end program participation, and remove visitation access.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE YMCA FOR ANY PURPOSE, INCLUDING BUT NOT LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY PROGRAM AFFILIATED WITH THE YMCA, WITHOUT RESPECT TO LOCATION, THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING ON HIS OR HER BEHALF AND/OR BEHALF OF HIS/HER CHILDREN OR GUESTS (herein referred to as "the undersigned"):

1. MEMBER CONDUCT The undersigned agrees to abide by all rules and regulations of the Stamford Family YMCA (hereafter "YMCA"), and I understand that failure to act in accordance with the rules may result in expulsion from the YMCA and cancellation of membership.
2. PROPERTY LOSS The undersigned understands that the YMCA is not responsible for personal property lost, damaged or stolen while using YMCA facilities or participating in YMCA programs.
3. PHOTO/TALENT RELEASE The undersigned irrevocably releases, consent and allow the YMCA and its agents to use my photograph, likeness, voice, as it pertains to my participation with the YMCA, in any manner for promotional efforts without expectation of any reimbursement for its use. (My initials here revoke photo/talent release_____).
4. INSURANCE The undersigned understands that the YMCA does not provide any accident or health insurance for its members or participants and it is my responsibility to provide such coverage.
5. MEDICAL RELEASE The undersigned authorizes the YMCA, as my agent, to give consent to medical treatment by a licensed physician or hospital when such treatment is deemed necessary by the physician, and I am unable to give such consent. I authorize a qualified YMCA staff member to administer CPR or first aid if necessary. I understand that it may be necessary for me to provide a release form from my physician regarding my current health status.

THE UNDERSIGNED further expressly agrees that the forgoing RELEASE, WAIVER AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of Connecticut and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITYAGREEMENT, and further agrees that no oral representations, statements, or inducement apart from the foregoing written agreement have been made.

I HAVE READ THIS RELEASE		**I HAVE READ THIS RELEASE**	
__/__/__	_____	__/__/__	_____
date	participant's signature	date	parent's or guardian's signature (if participant is legally a minor)
	_____ participant's name printed clearly		

Rev. 06/09/2020

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N Does your child have dental insurance? Y N Does your child have HUSKY 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	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑ 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.

*HT_____in/cm_____% *Weight_____lbs._____oz /_____% BMI____/____% *HC_____in/cm_____% (Birth – 24 months) *Blood Pressure_____/____ (Annually at 3 – 5 years)

Screenings

*Vision Screening
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess
❑ Referral made to: _____

*Hearing Screening
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess
❑ Referral made to: _____

*Anemia: at 9 to 12 months and 2 years

*Hgb/Hct: | *Date

*Lead: at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑ No ❑ Yes

*TB: High-risk group? ❑ No ❑
Yes Test done: ❑ No ❑ Yes Date: _____
Results: _____
Treatment: _____

*Dental Concerns ❑ No ❑ Yes
❑ Referral made to: _____
Has this child received dental care in the last 6 months? ❑ No ❑ Yes

*Result/Level: *Date

Other:

*Developmental Assessment: (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*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 an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: _____
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II
Seizures ❑ No ❑ Yes: Type: _____

Other Chronic Disease: _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑ No ❑ Yes This child may fully participate in the program.
❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

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

Child's Name: _____ **Birth Date:** _____ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

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