CHILD NAME: ____________________________________________________________

GRADE 2022/2023: _______________________________________________________

SCHOOL: ______________________________________________________________

1. Lead Academy Enrollment Form
2. Field Trip Permission Slip
3. Child Enrollment & Emergency Medical Care Form
4. Membership Application  All new enrollees must complete
5. Payment Authorization Form
6. Waiver
5. Early Childhood Assessment Record
6. Immunization Record

FOR OFFICE USE ONLY:

RECEIVED BY: ___________________________  VERIFY CHECK LIST COMPLETE INITIALS: __________

DATE: ________________________________
Dear Families:

Welcome, and thank you for choosing the Stamford Family YMCA’S LEAD after-school program for your childcare needs. Our LEAD Academy is comprised of students in grades K-8th in the Stamford community. Our program is designed to provide students with 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 for an additional fee.

**(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 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 at the Stamford Family YMCA!

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

Best,

Shawn Patch

Shawn Patch
Stamford Family YMCA
CEO
10 Bell Street
Stamford, CT 06901
shawn@stamfordymca.org
(203) 357–7000 ext 1250
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 5</td>
<td>Labor Day</td>
<td>CLOSED</td>
</tr>
<tr>
<td>Sept. 26–27</td>
<td>Rosh Hashanah</td>
<td>*VACATION CAMP</td>
</tr>
<tr>
<td>Oct. 5</td>
<td>Yom Kippur</td>
<td>*VACATION CAMP</td>
</tr>
<tr>
<td>Oct. 10</td>
<td>Columbus Day</td>
<td>*VACATION CAMP</td>
</tr>
<tr>
<td>Nov. 8</td>
<td>Election Day</td>
<td>*VACATION CAMP</td>
</tr>
<tr>
<td>Nov. 11</td>
<td>Veterans Day</td>
<td>CLOSED</td>
</tr>
<tr>
<td>Nov. 24–25</td>
<td>Thanksgiving</td>
<td>CLOSED</td>
</tr>
<tr>
<td>Dec. 23 – 26</td>
<td>Christmas Holiday</td>
<td>CLOSED</td>
</tr>
<tr>
<td>Dec. 27–30</td>
<td>Winter Recess</td>
<td>*VACATION CAMP</td>
</tr>
<tr>
<td>Jan 2</td>
<td>New Year’s Day</td>
<td>CLOSED</td>
</tr>
<tr>
<td>Jan. 16</td>
<td>MLK Day</td>
<td>CLOSED</td>
</tr>
<tr>
<td>April 3–7</td>
<td>Spring Recess</td>
<td>*VACATION CAMP</td>
</tr>
<tr>
<td>Apr 17</td>
<td>Good Friday</td>
<td>CLOSED</td>
</tr>
<tr>
<td>May 29</td>
<td>Memorial Day</td>
<td>CLOSED</td>
</tr>
<tr>
<td>June 19</td>
<td>Juneteenth</td>
<td>CLOSED</td>
</tr>
<tr>
<td>July 4</td>
<td>Independence Day</td>
<td>CLOSED</td>
</tr>
</tbody>
</table>

*VACATION CAMP dates are subject to change*
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:

<table>
<thead>
<tr>
<th>Type</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Membership</td>
<td>$29 per month (one youth)</td>
</tr>
<tr>
<td>LEAD Academy 2 Student Membership</td>
<td>$41.75 per month (must be in same household)</td>
</tr>
<tr>
<td>Family Membership</td>
<td>$85 per month (two adults &amp; all children in household)</td>
</tr>
</tbody>
</table>

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.
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: _____________
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 #: (_____) ____________________ Relationship _________

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: __________________
THIS PAGE WAS INTENTIONALLY LEFT BLANK
### 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 ___________
I hereby authorize the YMCA to initiate debits to the bank/credit cards listed on this form.

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.

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.

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

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.

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

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

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.

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.

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

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.

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 _________
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 SUED 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 INDEMNITY AGREEMENT, 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
Please let us know if you need this document translated.
Déjenos saber si usted desea que este documento sea traducido.
Tanpri, fè-n konnen si-w bezwen dokiman sa-a an Kreyòl

CONSENT FOR THE CITY OF STAMFORD, STAMFORD PUBLIC SCHOOLS
AND COMMUNITY PARTNER TO SHARE STUDENT INFORMATION

Community organizations are working with the City of Stamford and the Stamford Public Schools (collectively “SPS”) in partnership with Stamford Cradle to Career (“SC2C”) to improve access to student performance data for community partner organizations. SC2C is an organization independent of SPS but contracted by SPS to provide data support in the form of liaising between community partners and the SPS student database system.

In this collaborative arrangement, community partners must ensure guardians of students enrolled in their program sign the following consent form providing access to student data. Accessible data includes all the information that a parent/guardian may access in PowerSchool, Naviance and other school data systems. The purpose of this data access is to help community partners provide improved academic support to SPS students enrolled in their programming.

Type of Data Shared: Student’s personally identifiable information, report cards, age, grade, classroom information, academic progress, homework assignments, assessments, reports, special education status and records, 504 plan status and records.

Purpose: To increase the student’s potential for success, both in school and at the Community Partner(s); to inform instruction; to measure progress; to make determinations about other supports that may be available for your child.

Parties: This information may be shared between SPS, SC2C, and the staff and volunteers of the Community Partner(s).

Duration: This authorization shall remain in place through the current academic year and summer term.

I understand that I may revoke this authorization at any time by providing a written notice of revocation to the SPS with a copy to the Community Partner(s).
YES, I DO want to share my child’s personally identifiable information with the Community Partner(s) I check off below. Further, I authorize this information be shared between SPS, SC2C, and the Community Partner(s) throughout this academic year and summer term. I understand that I may revoke this authorization at any time by providing a written notice of revocation to the SPS with a copy to the Community Partner(s) and SC2C. I also agree that a photocopy of this form or electronically signed PowerSchool version of this form shall be as valid as the original.

Please type or print clearly:

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Click or tap here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>School:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>PowerSchool ID #:</td>
<td>Click or tap here to enter text.</td>
</tr>
</tbody>
</table>

*Note: this is the 7-digit number your student uses as their username to log into google classroom*

<table>
<thead>
<tr>
<th>Parent/Guardian Signature:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name:</th>
<th>Click or tap here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Click or tap to enter a date.</td>
</tr>
<tr>
<td>Address:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>City:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>State:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Zipcode:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>Click or tap here to enter text.</td>
</tr>
<tr>
<td>Email:</td>
<td>Click or tap here to enter text.</td>
</tr>
</tbody>
</table>

Please select all community partners your child is involved with that you wish to grant access to:

- ☐ Beyond Limits
- ☐ Boys & Girls Club
- ☐ Building One Community
- ☐ Creative Learning
- ☐ Domus
- ☐ Future 5
- ☐ Family Centers
- ☐ Grassroots Tennis
- ☐ Horizons
- ☐ INTEMPO
- ☐ Jewish Community Center
- ☐ ROSSCO
- ☐ SPEF
- ☐ Women’s Mentoring Network
- ☐ YMCA

Other (specify all other programs or organizations here): Click or tap here to enter text.
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)

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 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  Very high or low activity level  Y  N  Emergency room visits  Y  N
Any problems with vision  Y  N  Weight concerns  Y  N  Any major illness or injury  Y  N
Uses contacts or glasses  Y  N  Any hearing concerns  Y  N  Any operations/surgeries  Y  N

Developmental — Any concern about your child’s:

1. Physical development  Y  N  5. Ability to communicate needs  Y  N  Sleeping concerns  Y  N
2. Movement from one place to another  Y  N  6. Interaction with others  Y  N  High blood pressure  Y  N
4. Emotional development  Y  N  8. Ability to understand  Y  N  Toileting concerns  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.

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Birth Date</th>
<th>Date of Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(mm/dd/yyyy)</td>
<td>(mm/dd/yyyy)</td>
</tr>
</tbody>
</table>

☐ 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.

*IF_____ in/cm %  *WEIGHT_____ lbs. oz./%  *BMI_____ / %  *HTC_____ in/cm %  *SBDP / %  (Birth – 24 months)  (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: __________________________

*Dental Concerns

☐ No ☐ Yes

☐ Referral made to: __________________________

Has this child received dental care in the last 6 months? ☐ No ☐ Yes

*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 Other Chronic Disease: __________________________

Seizures ☐ No ☐ Yes: Type: __________________________

☐ 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
Immunization Record

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

Vaccine (Month/Day/Year) __________

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Dose 4</th>
<th>Dose 5</th>
<th>Dose 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP/DTaP/DT</td>
<td></td>
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<tr>
<td>IPV/OPV</td>
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<tr>
<td>MMR</td>
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</tr>
<tr>
<td>Measles</td>
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<tr>
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<tr>
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<tr>
<td>Hib</td>
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</tr>
<tr>
<td>Hepatitis A</td>
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<tr>
<td>Hepatitis B</td>
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</tr>
<tr>
<td>Varicella</td>
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</tr>
<tr>
<td>PCV* vaccine</td>
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<tr>
<td>MCV**</td>
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<tr>
<td>Influenza</td>
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<td>Tdap/Td</td>
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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

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Under 2 months of age</th>
<th>By 3 months of age</th>
<th>By 5 months of age</th>
<th>By 7 months of age</th>
<th>By 16 months of age</th>
<th>By 19 months of age</th>
<th>By 2 years of age (24-35 mos.)</th>
<th>3-5 years of age (36-59 mos.)</th>
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</thead>
<tbody>
<tr>
<td>DTP/DTaP/DT</td>
<td>None</td>
<td>1 dose</td>
<td>2 doses</td>
<td>3 doses</td>
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<tr>
<td>Polio</td>
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<td>1 dose</td>
<td>2 doses</td>
<td>2 doses</td>
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<td>3 doses</td>
<td>3 doses</td>
<td>3 doses</td>
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<tr>
<td>MMR</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
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<tr>
<td>Hep B</td>
<td>None</td>
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<td>2 doses</td>
<td>2 doses</td>
<td>2 doses</td>
<td>3 doses</td>
<td>3 doses</td>
<td>3 doses</td>
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<tr>
<td>Hib</td>
<td>None</td>
<td>1 dose</td>
<td>2 doses</td>
<td>2 doses</td>
<td>2 doses</td>
<td>3 doses</td>
<td>3 doses</td>
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</tr>
<tr>
<td>Varicella</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
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</tr>
<tr>
<td>Pneumococcal Conjugate Vaccine (PCV)</td>
<td>None</td>
<td>1 dose</td>
<td>2 doses</td>
<td>3 doses</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
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<tr>
<td>Hepatitis A</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
<td>1 dose after 1st birthday¹</td>
<td>2 doses given 6 months apart</td>
</tr>
<tr>
<td>Influenza</td>
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<td>None</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
<td>1 or 2 doses</td>
</tr>
</tbody>
</table>

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