



WELCOME TO LEAD ACADEMY 2023/2024

September 11, 2023 – June 12, 2024

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.

****Children must be picked up by 6:00 pm. 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,

Alexis Farrow

Managing Director of Youth Programs

alexis@stamfordymca.org

(203) 357-7000 ext 9991



2023/2024 CALENDAR

VACATION CAMP & HOLIDAY CLOSURES

Sept. 4:	Labor Day	CLOSED
Sept. 25:	Yom Kippur	*VACATION CAMP
Oct. 9:	Columbus Day	*VACATION CAMP
Nov. 7:	Election Day	*VACATION CAMP
Nov. 10:	Veterans Day	CLOSED
Nov. 23-24:	Thanksgiving	CLOSED
Dec. 25:	Christmas Holiday	CLOSED
Jan 1:	New Year's Day	CLOSED
Jan. 15:	MLK Day	CLOSED
Feb. 19:	President's Day	*VACATION CAMP
Mar 29:	Good Friday	CLOSED
Apr. 15-19:	Spring Recess	*VACATION CAMP
May 27:	Memorial Day	CLOSED
June 19:	Juneteenth	CLOSED
July 4:	Independence Day	CLOSED

*VACATION CAMP dates are subject to change



LEAD ACADEMY 2023/2024 ENROLLMENT CHECK LIST

September 11, 2023 – June 12, 2024

CHILD NAME: _____

GRADE 2023/2024: _____

SCHOOL: _____

Welcome Letter – Pg 1. (For your records)

LEAD Academy 2023/2024 Calendar – Pg 2. (For your records)

Enrollment Checklist- Pg 3

_____ **LEAD Academy Payment Form – Pg 5.**

_____ **Stamford Y Credit Card/Bank Draft/EFT Authorization Agreement – Pg 6.**

_____ **Child Enrollment & Emergency Medical Care Form – Pg 7.**

Stamford Y Membership Application Form **Must be completed by all new applicants. – Pg 9.**

_____ **Stamford Y Waiver of Liability – Pg 10 & 11**

_____ **Field Trip Permission – Pg 12.**

_____ **State of CT Health Assessment Record – Pg 13**

_____ **State of CT Part 2 Medical Evaluation – Pg 14**

_____ **State of CT Part 3 — Oral Health Assessment/Screening – Pg 15**

_____ **State of CT Immunization Record – Pg 16**

****WE WILL NOT ACCEPT INCOMPLETE APPLICATIONS UNDER ANY CIRCUMSTANCES. ****

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LEAD AFTER SCHOOL CHILD CARE PAYMENT FORM

SEPTEMBER 11, 2023 - JUNE 12, 2024

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

** 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 are 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 on the 1st of each month. Credit card or bank draft is required.



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 _____ of every month (or next business day). If we cannot process your draft we will resubmit for payment. _____

INITIAL

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

INITIAL

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. _____

INITIAL

✓ Please Check One: ☐ Checking ☐ Savings Withdrawal Date ☐ 1st _____

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 _____

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

Address _____ Zip _____

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

For Office Use Only: Withdrawal Date ☐ 1st _____

New ☐ Change ☐ Staff Initials _____

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:** _____

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THE STAMFORD FAMILY YMCA MEMBERSHIP INFORMATION

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

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:** _____



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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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, aphysi-

cian 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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other
Primary Care Provider		
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 1 — 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)				Diabetes	Y N
Any immediate family members have high cholesterol				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

Part 2 — Medical Evaluation

HAR-3 REV. 1/2022

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 1 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			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: 		

Screenings

*Vision Screening			*Auditory Screening			History of Lead level	Date
Type:	<u>Right</u>	<u>Left</u>	Type:	<u>Right</u>	<u>Left</u>	≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass		*HCT/HGB:	
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail		*Speech (school entry only)	
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made			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

Part 3 — Oral Health Assessment/Screening **Health Care Provider must complete and sign the oral health assessment.**

HAR-3 REV. 1/2022

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: <input type="checkbox"/> Dentist	Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) 	Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No
Risk Assessment <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Describe Risk Factors		
	<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	

Recommendation(s) by health care provider: _____

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 _____

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	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) 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)

Religious Exemption:

Religious exemptions must meet the criteria established in
Public Act 21-6: <https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf>.

Medical Exemption:

Must have signed and completed medical exemption form attached.
https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

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 the 1st 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 the 1st 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.