



# 2017-18 Registration

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We are pleased to have your child joining us for the 2017-18 school year!

As a child-care program we are required by Connecticut state law to have specific information on file about your child. You must complete the forms and return them to Nature's Playground prior to your child attending.

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_ M/F: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_  
\_\_\_\_\_

## Parent/Guardian #1:

Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_  
\_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

## Parent/Guardian #2:

Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_  
\_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

## Forms Needed:

- ◆ Early Childhood Health Assessment Record Part 1 **(filled out by parents)**
- ◆ Early Childhood Health Assessment Record Part 2 **(filled out by doctor)**  
NOTE: A copy of your child's health form from school is sufficient
- ◆ Alternate Pick Up/Emergency Contact
- ◆ First Aid / Field Trip Permission
- ◆ Consent Form
- ◆ Medications/Allergies/Dietary Restrictions (if necessary)

Please call or e-mail with any questions.

Aaron Page, Director



# 2017-18 Alternate Pick Up / Emergency Contact

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Child's Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

## IN CASE OF EMERGENCY

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After we have tried to reach parent/guardian #1 & parent/guardian #2, contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

## ALTERNATE PICK-UP PERMISSION

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In addition to the emergency contact, I authorize my child to be released to the following adults:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_



# Medication/Allergies/ Dietary Restrictions

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Child's Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

## MEDICATIONS

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If the staff of Nature's Playground will be administering regularly scheduled medication(s), you must have your doctor complete the attached form. In addition, all medications must be in their original container with your child's name clearly marked on the label.

## ALLERGIES

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Please list your child's allergies below:

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## DIETARY RESTRICTIONS

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Please list your child's allergies below:

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# First Aid / Field Trip Permission

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Child's Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I give Nature's Playground staff permission to administer basic first aid to my child: band aids, minor scrapes, ice packs, etc. I also understand and agree to staff calling 911 in case of emergencies with my child and pay any fees associated with such a call. Please note that we will always call 911 first, then a parent, in case of emergency.

I give my child permission to participate in field trips while at Nature's Playground After School to the following areas:

- a) wigwam/stream; where my child is allowed, with boots or old sneakers on, to play in the stream;
- b) tipi/pond; where my child is allowed, with boots or old sneakers on, to fish, catch frogs, and play in the pond area (no swimming).

Our supervision policy in these field trip areas is as follows:

- 1) We will maintain a 1:6 staff to child ratio in these areas
- 2) A certified lifeguard will be present at all times in these areas
- 3) Non-swimmers will be required, by state law, to be identified to staff and lifeguards by wearing red wristbands.

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Consent Form

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Child's Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Please enroll my child at Nature's Playground after school program for the following days of the week:  
(Circle all that apply)

**MONDAY**

**TUESDAY**

**WEDNESDAY**

**THURSDAY**

**FRIDAY**

By submitting this application, I agree to be bound to the terms, conditions, and regulations of the Incarnation Center. I also give permission for my child to participate in all Nature's Playground activities. Photos or videos in which my child appears, may be used for publicity purposes.

I understand that Incarnation Center will not accommodate children with severe behavior problems. Children with frequent violent or uncontrollable outbursts, an unwillingness to respond to supervision, or behavior that infringes upon the experience of others, will be asked to leave the program.

I understand that tuition is to be paid in full prior to each month's attendance and failure to do so may result in the dismissal of my child from the Nature's Playground after school program.

I understand that I must pickup my child from Nature's Playground by 6:00pm. If I am running late, I will make every effort to call the camp cell phone: 860-395-9794. After one late pickup, any other late pickups will be charged \$3.00 per minute after 6:00pm.

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# 2017-18 Pricing

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After School Rate:  
\$15 per day, prepaid monthly

Drop In Rate:  
\$25 per day

Half Day Rate:  
\$30 enrolled students / \$45 non-enrolled students

Full Day School Vacation Rate:  
\$55 enrolled students / \$65 non-enrolled students

We are open on the following school vacation dates:

September 21st  
October 9th  
November 7th  
January 15th  
February 19th-21st  
March 9th, 30th  
April 16th-20th, 23rd-24th  
May 29th

Hours:  
3pm-6pm school days  
1pm-6pm half days  
7:30am-6pm vacation days



# Nature's Playground

## Credit / Debit Card Authorization

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This agreement may be terminated at any time upon written notice to Incarnation Center.

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

### **Card Information**

Type of Card:    ☐ MasterCard    ☐ Visa    ☐ AMEX    ☐ Discover

Card Number: \_\_\_\_\_

Card Expiration Date: \_\_\_\_\_

Security Code: \_\_\_\_\_

Card Holder's Name: \_\_\_\_\_

Card Holder's Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_



# State of Connecticut Department of Education Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physi-

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 I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y N	Hospitalization or Emergency Room visit	Y N	Concussion	Y N
Allergies to food or bee stings	Y N	Any broken bones or dislocations	Y N	Fainting or blacking out	Y N
Allergies to medication	Y N	Any muscle or joint injuries	Y N	Chest pain	Y N
Any other allergies	Y N	Any neck or back injuries	Y N	Heart problems	Y N
Any daily medications	Y N	Problems running	Y N	High blood pressure	Y N
Any problems with vision	Y N	"Mono" (past 1 year)	Y N	Bleeding more than expected	Y N
Uses contacts or glasses	Y N	Has only 1 kidney or testicle	Y N	Problems breathing or coughing	Y N
Any problems hearing	Y N	Excessive weight gain/loss	Y N	Any smoking	Y N
Any problems with speech	Y N	Dental braces, caps, or bridges	Y N	Asthma treatment (past 3 years)	Y N
<b>Family History</b>				Seizure treatment (past 2 years)	Y N
Any relative ever have a sudden unexplained death (less than 50 years old)		Y N	Diabetes		Y N
Any immediate family members have high cholesterol		Y N	ADHD/ADD		Y N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date



## Part II — Medical Evaluation

HAR-3 REV. 4/2012

**Health Care Provider must complete and sign the medical evaluation and physical examination**

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date of Exam \_\_\_\_\_

☐ I have reviewed the health history information provided in Part I of this form

### Physical Exam

**Note:** \*Mandated Screening/Test to be completed by provider under Connecticut State Law

\*Height \_\_\_\_\_ in. / \_\_\_\_\_% \*Weight \_\_\_\_\_ lbs. / \_\_\_\_\_% BMI \_\_\_\_\_ / \_\_\_\_\_% Pulse \_\_\_\_\_ \*Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			<b>*Postural</b> <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

### Screenings

*Vision Screening	*Auditory Screening	History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	Date
Type: <u>Right</u> <u>Left</u>	Type: <u>Right</u> <u>Left</u>		
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 <b>Provider</b> Name and Phone Number
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# 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 for 7th grade entry	
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	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx \_\_\_\_\_  
of above (Specify) (Date) (Confirmed by)

## Exemption

Religious \_\_\_\_\_ Medical: Permanent \_\_\_\_\_ Temporary \_\_\_\_\_ Date \_\_\_\_\_

Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_

## Immunization Requirements for Newly Enrolled Students at Connecticut Schools

### KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease\*.

### GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 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. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease\*.

### GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease\*.

### GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease\*.

\* **Verification of disease:** Confirmation in writing by a 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 nation-wide shortage of supply for such vaccine.

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

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

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

Name of Child/Student \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address of Child/Student \_\_\_\_\_ Town \_\_\_\_\_

Medication Name/Generic Name of Drug \_\_\_\_\_ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: \_\_\_\_\_

Specific Instructions for Medication Administration \_\_\_\_\_

Dosage \_\_\_\_\_ Method/Route \_\_\_\_\_

Time of Administration \_\_\_\_\_ If PRN, frequency \_\_\_\_\_

Medication shall be administered: Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relevant Side Effects of Medication \_\_\_\_\_ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs \_\_\_\_\_

Plan of Management for Side Effects \_\_\_\_\_

Prescriber's Name/Title \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Prescriber's Address \_\_\_\_\_ Town \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

School Nurse Signature (if applicable) \_\_\_\_\_

### **Parent/Guardian Authorization:**

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

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

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

Parent/Guardian Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent /Guardian's Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### **SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL**

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

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

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

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

\*\*\*\*\*  
Today's Date \_\_\_\_\_ Printed Name of Individual Receiving Written Authorization and Medication \_\_\_\_\_

Title/Position \_\_\_\_\_ Signature (in ink or electronic) \_\_\_\_\_

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