FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Norwalk YMCA

CAMP SUNRISE 2014

Camper Name:_____

Last Grade Completed_____

Group (please circle)

Explorer (K and 1st)

Pioneers (2nd and 3rd)

Adventurers (4th and 5th)

Trailblazers (6th,7th, and 8th)

CIT (ages 13 to 15)

Ymca Office Use Only

___Completed Registration
___Completed Informational Profile
___Completed Bank ACH/Credit Card Draft Form
___Completed Medication Administration
___Completed General Permission Agreement
___Completed Tuition Profile
___Completed Health Forms
___$50.00 Registration Fee & $50.00 Per Week Deposit (Non-refundable and due at registration)

Camp Sunrise 2014

Tuition Rate Sheet for Explorers, Pioneers, Adventurers, Trailblazers

Early Bird Rate On or Before April 30,2014

Please check all weeks your child will be attending

Week	Regular Day 8:30-3:30pm	Extended Day 7:30-6:00pm
June 30-July 3	_____$158.00	_____$182.00
July 7-11	_____$195.00	_____$225.00
July 14-18	_____$195.00	_____$225.00
July 21-25	_____$195.00	_____$225.00
July 28- Aug 1	_____$195.00	_____$225.00
Aug 4-8	_____$195.00	_____$225.00
Aug 11-15	_____$195.00	_____$225.00
Aug 18-22	_____$195.00	_____$225.00

After April 30, 2014

Week	Regular Day 8:30-3:30pm	Extended Day 7:30-6:00pm
June 30-July 3	_____$182.00	_____$206.00
July 7-11	_____$225.00	_____$255.00
July 14-18	_____$225.00	_____$255.00
July 21-25	_____$225.00	_____$255.00
July 28- Aug 1	_____$225.00	_____$255.00
Aug 4-8	_____$225.00	_____$255.00
Aug 11-15	_____$225.00	_____$255.00
Aug 18-22	_____$225.00	_____$255.00

Camp Sunrise 2014

Tuition Rate Sheet for CIT's

Early Bird Rate On or Before April 30,2014

Please check all weeks your child will be attending

Week	Regular Day 8:30-3:30pm	Extended Day 7:30-6:00pm
June 30-July 3	_____$102.00	_____$126.00
July 7-11	_____$125.00	_____$155.00
July 14-18	_____$125.00	_____$155.00
July 21-25	_____$125.00	_____$155.00
July 28- Aug 1	_____$125.00	_____$155.00
Aug 4-8	_____$125.00	_____$155.00
Aug 11-15	_____$125.00	_____$155.00
Aug 18-22	_____$125.00	_____$155.00

After April 30, 2014

Week	Regular Day 8:30-3:30pm	Extended Day 7:30-6:00pm
June 30-July 3	_____$126.00	_____$150.00
July 7-11	_____$155.00	_____$185.00
July 14-18	_____$155.00	_____$185.00
July 21-25	_____$155.00	_____$185.00
July 28- Aug 1	_____$155.00	_____$185.00
Aug 4-8	_____$155.00	_____$185.00
Aug 11-15	_____$155.00	_____$185.00
Aug 18-22	_____$155.00	_____$185.00

Camp Sunrise **REGISTRATION FORM**

START DATE: _____

Program: _____ Grade Entering: _____

Child's Name _____ Date of Birth_____ Sex _____
Home Address _____ ZIP_____

Mother's Name _____
Mother's Employer _____
Employer's Address _____
City _____
Work Phone _____
Home Phone _____
Cell Phone _____
Email Address _____
Child's Physician _____

Father's Name _____
Father's Employer _____
Employer's Address _____
City _____
Work Phone _____
Home Phone _____
Cell Phone _____
Email Address _____
Physician Phone _____

Do not list a parent who does not have permission to pick up the above child named.
Please list the name and telephone number of three (3) persons, other than the parents, who have permission to pick up your child and may be called in the parents' absences or in an emergency situation. THIS SECTION MUST BE COMPLETED TO ENSURE YOUR CHILD'S SAFETY. Only those names mentioned below will be permitted to pick up and transport your child. If other arrangements have been made for pick-up a note must be sent in with your child and submitted to either the Director or your child's teacher.

Name _____ Relationship _____
Day Phone_____ Home Phone _____ Cell Phone _____

Name _____ Relationship _____
Day Phone_____ Home Phone _____ Cell Phone _____

Name _____ Relationship _____
Day Phone_____ Home Phone _____ Cell Phone _____

Child lives with (check one):

___Mother ___Father ___Both ___Other _____

If one parent retains sole legal custody, for the protection of the child, copy of a court order must accompany this form.

_____ Date _____
Parent Signature

_____
Parent Name Printed

Camp Sunrise - Bank ACH /Credit Card Draft Form

Child's Name: _____

Parent Name: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Bank Draft ***Please attach a voided check.***

Name of Bank: _____ Address of Bank: _____

Bank Account No: _____ Bank Route No: _____

Credit Card Draft ***Please attach a photo copy of the card***

Type of Card (circle): Visa Mastercard Amex Discover

Card Number: _____ Expiration Date: _____

Payment Schedule

Weeks 1,2,3,4	Amount to be charged on 6/1	$ _____
Weeks 5,6,7,8	Amount to be charged on 6/30	$ _____

The undersigned hereby agrees and authorize the YMCA of Norwalk, Inc. to process charges to the above bank or cradit card account on a recurring monthly basis (in accordance with the posted camp draft dates) in the amount noted above. Said monthly charges shall continue until the above mentioned notifies the YMCA, in writing, to cancel/change such charges. The YMCA requires a minimun of 30 days of intention to cancel/change status in the Childcare Camp program.

The above agrees to provide updated information upon request. The YMCA needs updated information to continue to process monthly payments. The above mentioned understands that failure to provide valid information to the YMCA will result in immediae suspension from the Childcare Porgram.

Printed Name: _____

Signature: _____ Date: _____

GENERAL PERMISSION AGREEMENT

In signing this agreement you are giving permission and agreeing to the following:

1. By enrolling my child in the Norwalk YMCA program, I grant permission for him/her to participate in all of the activities of the program, except where medical restrictions apply.

2. The Norwalk YMCA will not assume responsibility of a child until the staff member has acquired supervision of your child at the Norwalk YMCA program facility.

3. I grant permission for my child to leave the Norwalk YMCA facility with adequate supervision of a staff member for a field trip either walking or in a YMCA authorized vehicle.

4. I grant permission for any photographs of my child, connected with the Norwalk YMCA programs, to be used for program publicity.

5. I hereby grant permission for the staff to take whatever steps necessary to obtain immediate medical care for my child if warranted. These steps may include the following: (1) To administer First Aid; (2) To contact parent/guardian or person listed as emergency contact. If the parent or emergency contact can not be contacted, we will contact the child's physician. If the child's physician is not available, we will contact our consulting physician. If necessary, we will call the police or ambulance for emergency transport and have a staff member accompany your child to the hospital.

Child's name_____

Signature (Parent or Legal Guardian) _____ Date_____

CHILD INFORMATIONAL PROFILE

The following questions are designed to aid us in providing the best care for your child. All information is confidential.

Any known allergies? _____

Has your child had any chronic illness or hospitalization? Yes___ No___

If yes, please describe. _____

Has your child ever had surgery? Yes___ No___

If yes, please describe. _____

Has your child had the chicken pox? Yes___ No___

Is your child on a special diet? Yes___ No___

If yes, please describe. _____

Is your child taking daily or frequent medications? Yes___ No___

If yes, please describe. _____

Is your child receiving any on-going treatment that we should be aware of? Yes___ No___

If yes, please describe. _____

Have there been any changes in the family status such as a recent move, a new sibling, a divorce, a separation, or a death of a loved one? _____

What is your child's swimming ability? _____ | **Non-Swimmer?** YES NO |

Please add any other information that would help us to better serve your child.

_____

Name of siblings: _____, _____

_____ _____

Child's Name (Please Print) Last Grade COMPLETED

_____ _____

Parent/Guardian Signature (Please Print) Date

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes 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 by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ___/___/___ Today's Date ___/___/___

Medication Name _____ Controlled Drug? ☐ YES ☐ NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration Start Date ___/___/___ Stop Date ___/___/___

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug Allergies? ☐ YES ☐ NO Reactions to? ☐ YES ☐ NO Interactions with? ☐ YES ☐ NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (___) _____

Prescriber's Address _____ Town _____

Signature _____

Parent/Guardian Authorization:
I request that medication be administered to my child as described and directed above and attest that I have **administered at least one dose of the medication to my child without adverse effects.**

Name of Day Care Program _____ Today's Date ___/___/___

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: ☐ Mother ☐ Father ☐ Guardian/Other explain: _____

Address _____ Town _____ Phone Number (___) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Childcare Personnel Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

Medication Administration Record (MAR)

Name of Child _____ Date of Birth ____/____/____

Pharmacy Name _____ Prescription Number _____

Medication Order _____

Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing / Administering Medication
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ Authorization form is complete ☐ Medication is appropriately labeled

☐ Medication is in original container ☐ Date on label is current

Person Accepting Medication (print name)_____ Date ____/____/____

S:\Division\Licensure\Grp&CC\Field Forms\G_C_AdminMeds.doc 3/31/09 (Website)

State of Connecticut

Early Childhood Health Assessment Record

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 also be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunization and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse, a physician assistant or the school medical advisor prior to entering an early childhood program in Connecticut.

Please print

Name of Child (Last, First, Middle)	Social Security Number	Birth Date	Sex

Address (Street)	Race/Ethnicity	
	❑ American Indian	❑ White, not of Hispanic origin
(Town and ZIP code)	❑ Asian	❑ Hispanic/Latino
	❑ Black, not of Hispanic origin	❑ Other

Parent/Guardian (Last, First, Middle)	Home Phone Number	Work/Cell Phone Number

Early Childhood Program	Program Phone Number

Primary Health Care Provider	Preferred Hospital	Health Insurance Company/Number* or Medicaid/Number*

* if applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

***Important*: Complete Part I before your child is examined.**

Take this form with you to the health care provider's office.

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

	Yes	No	
1.	❑	❑	Do you have any concerns about your child's general health, development or behavior?
2.	❑	❑	Has your child been diagnosed with any chronic disease ❑ asthma ❑ diabetes ❑ seizure disorder ❑ other _____
3.	❑	❑	Does your child have any allergies (food, insects, medication, latex, etc.)? Please specify: _____
4.	❑	❑	Does your child take any medications (daily or occasionally)?
5.	❑	❑	Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
6.	❑	❑	Has your child had any hospitalization, operation, major illness or injury, or significant accident?
7.	❑	❑	In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?
8.	❑	❑	In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?
9.	❑	❑	Has your child had a dental examination in the last 12 months?
10.	❑	❑	Would you like to discuss anything about your child's health with the child care provider or health consultant/coordinator?

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

I give permission for release of 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

CT-191 REV. 8/2004 C.G.S. Section 10-16q, 10-206, 19a-7f(a), 19a-87(b)(c)
P.A. Code Section 19a-7g-1a(a)(2), 19a-87b-1(b)(2)

To be maintained in the child's Health Record

Part II — Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

Child's Name: _____ Birth Date (mm/dd/yy): _____ Date of History/Physical Exam (mm/dd/yy): _____

LENGTH/HEIGHT	WEIGHT	WT FOR HT/BMI	HEAD CIRCUMFERENCE	BLOOD PRESSURE
INCM %ILE	LB/KG %ILE	%ILE	INCM %ILE	/

Screening/Test Results

Screening Test	Result	Date	Abnormal/Comments
Vision[1] Test type:			
Hearing[1] Test type:			
Lead[2] Risk: Yes/No			
TB[3] Risk: Yes/No			
Urinalysis (UA)[4]			
Anemia[5] (Hgb/Hct) Risk: Yes/No			
Developmental Assessment[6] Test type			

Has this child received dental care in the last 12 months? ❑ Yes ❑ No ❑ N/A

* Chronic Disease Assessment:

Yes	No		Date of onset
❑	❑	Asthma: ❑ mild ❑ moderate ❑ severe ❑ exercise induced ❑ unclassified	
❑	❑	Diabetes: ❑ Type I ❑ Type II	
❑	❑	Anaphylaxis: ❑ med. ❑ food ❑ insect ❑ latex	
❑	❑	Seizures. Type _____	
❑	❑	Other: Please specify _____	

Minimum requirements: [1]Up to 2 years; [2]annual at 3 years; [3]annual at 4 years; [4]as needed; [5]9–12 months; [6]each visit through 5 years; [7]annual at 2–3 years. Federal requirements (eg, Head Start, WIC) may vary.
[8]Prior to Public School Entry: Same as above and Hgb/Hct.

Immunization Record

Vaccine (Month/Day/Year)	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP						
DTP/Hib						
DTaP						
DT/Td						
OPV						
IPV						
MMR						
Measles						
Mumps						
Rubella						
HIB						
Hep B						
Varicella						
PCV					Please see list of approved vaccines	

Other Vaccines (Specify)

Disease IDs of above _____ (Specify) _____ (Date mm/yy) _____ (Confirmed by)

Exemption

Religious ____ Medical: Permanent ____ Temporary ____ Date ____

Recertify Date _____ Recertify Date _____ Recertify Date _____

This child has the following problems which may adversely affect his or her educational experience:

❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical Dysfunction ❑ Emotional/Social ❑ Behavior

❑ The child has a health condition which may require intervention in the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medications. *Specify*: _____

❑ Yes ❑ No This child has a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program.

❑ Yes ❑ No Based on this comprehensive history and physical examination, this child has maximized his/her level of wellness.

❑ The child may fully participate in the program.

❑ The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑ I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider MD/DO NP PA	Name (Please type or print.)	Phone number

Address: _____

❑ Yes ❑ No Is this the child's Medical Home?	Next Appointment (mm/yy):	Next Immunization Appointment (mm/yy):