



Greenwich Historical Society

Art & History Camp

Parent Packet



Parent Packet Contents

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Section 1:
Camp Guidelines and
Policies Handbook



Camp Guidelines and Policies Handbook

Please read and review all guidelines and policies pertaining to the Greenwich Historical Society's Art & History Camp. All items on the following pages are set so that all parents have the information they need to ensure their campers can have an enjoyable and safe camp experience.

Drop-Off/Pick-Up Regulations:

In order to ensure all campers are safe at the start and end of each camp day, please note the below regulations for camper drop-off and pick-up.

Camp Hours are Monday-Friday, 9:30am-12:30pm

Drop-off will begin promptly at 9:30am and pickup will begin promptly at 12:30pm.

Any camper dropped off early or picked up late will incur an extension charge of \$20 per 15 minutes. Campers not picked up by 12:40pm will wait in the museum office until a parent or guardian arrives.

Camper drop-off and pick-up is located in the museum building lobby

The museum building is located by the parking lot. Please refer to the map at the end of the handbook. Upon arrival, please pull into the Historical Society parking lot and bring or meet your camper inside the lobby.

Please sign in and sign out your camper

When dropping off your camper at the start of the day, you MUST sign in your camper with the Camp Director. When picking up your camper at the end of the day, you MUST sign out your camper with the Camp Director.

Please DO NOT leave until you have done so. Connecticut camp regulations require a log to be kept of camper check in and check out. This is for your camper's safety.

Alert us regarding late or absent campers

If your camper will be late or absent, please call our main number 203-869-6899 before 10:00am to ensure camp staff is alerted.

Alternate pick-up guardians

If your camper will be going home with someone other than who is on the list you provided on the permission form, please provide a note or call to inform our staff in advance.

This is for your camper's protection. We will NOT release the camper unless their parent or guardian has given permission.

Preparing Your Camper:

We will make every effort to ensure campers are prepared for a fun and enjoyable learning experience during our camp sessions. However, we kindly ask all parents and guardians to ensure they send their camper prepared.

Please send your camper with a bag or backpack complete with:

- Water bottle
- Snack
- Sunscreen (for outdoor activities)
- Umbrella and/or jacket in case of rainy weather
- Required medications

Please ensure your camper's name is labeled on all items brought to camp to prevent them from being misplaced.

Camper's clothing should be appropriate for camp

Campers should wear light, comfortable clothing that can get dirty in the event of outdoor activities or messy crafts. Sneakers or comfortable outdoor shoes are recommended. Please do not wear flip flops. Light jackets are suggested in the event of rainy or cooler weather.

Please ensure camper's snacks are wholesome and nut free

Campers are permitted to bring wholesome snacks and beverages to camp. All snacks and beverages will be refrigerated until snack time.

We are very attentive to counselors and campers who have allergies to tree nuts and peanut products. Touching, smelling or ingesting these items may cause a life-threatening reaction that requires emergency medical treatment.

To reduce the chance of this occurring, **we are a NUT FREE CAMP!** Your camper's snack **MUST BE NUT FREE** – this includes peanuts, peanut and nut butters, pecans, walnuts, pistachios, nut oils (i.e. peanut oil), and nut flavorings (i.e. almond extract).

If your camper has eaten peanuts/nuts before coming to camp, please be sure your camper's hands and face have been thoroughly washed.

If you have questions about what foods are safe alternatives, please do not hesitate to ask the Camp Director.

Please leave the technology at home

We kindly ask that campers leave their gadgets at home. In an effort to make sure every camper has an enjoyable time without distraction from digital possessions, or potentially losing expensive items, please leave phones, tablets, laptops, and portable gaming devices at home.

Health and Wellness Information (REQUIRED READING):

As a youth camp licensed by the State of Connecticut, we must uphold state standards of medical care and concern for your camper. Please take a moment to review these requirements and how they affect your camper's experience during Art & History Camp.

Health forms must be on file before your camper can participate

Every camper and counselor is required to complete a general medical health form. This notifies the camp and the state of your camper's general well-being and status of their vaccinations.

Note: IF YOUR CAMPER DOES NOT HAVE FORMS SUBMITTED AND ON FILE BY THE FIRST DAY OF CAMP, YOUR CAMPER WILL NOT BE ALLOWED TO PARTICIPATE UNTIL THEY ARE SUBMITTED. This is to ensure the safety, health, and wellness of your camper during camp.

First Aid regulations will be adhered to throughout the camp season

As our enrollment is under 250 campers, we are not required to have a Registered Nurse on site. In lieu of a Nurse, the Art & History Camp has a certified and dedicated Director of First Aid/First Aider who is available during camp hours to ensure the best care for your camper's medical needs. In addition to the Director of First Aid, all camp staff, including the Camp Director, have been trained and certified in First Aid and CPR and have passed a certification course on the administration of epi-pens and oral, topical, and inhalant medication.

Note: If your camper becomes ill or is injured during the camp session, the Camp Director will contact you. If your camper has a fever, presents vomiting or excessive diarrhea, or other symptoms of being ill, they will be sent home immediately.

Medication requirements

Definition: A medication is any chemical substance used to treat or prevent physical illness; including, cough syrup, cough drops, asthma inhalers, allergy medication, epi-pens, Advil, Tylenol, etc.

All medications as outlined above that are brought to camp must be given to the Director of First Aid during the day for safekeeping.

For all medications, please note the following:

- **Each medication brought to camp must be unopened and labeled with your camper's name.** Inhalers may be open, but must be in the original box. Over-the-counter medications such as cough syrup and Benadryl must be contained in their original packaging with the safety seals intact.
- **Prescription labels must be placed directly on medication containers, not on the boxes enclosing them.**
- **All medication should be enclosed in a Ziploc bag, along with a completed copy of the Authorization for the Administration of Medication form signed by your camper's physician**

Note: WE LEGALLY CANNOT ACCEPT MEDICATION THAT IS NOT GIVEN TO US IN THIS WAY.

Administering medications will be followed according to regulations

When a camper needs to take their medication, they will report to the Director of First Aid at the appropriate time. By law, the Director of First Aid or other camp staff are not permitted to administer oral or topical medications to your camper.

If your camper will be taking any medication of that form during their time at camp, it must be self-administered. The Director of First Aid will monitor the administration, but your camper must be knowledgeable about the medication and how it is taken.

If your camper is unable to self-administer the medication, a parent or guardian must be present to assist them.

Emergency Procedures:

In case of an emergency, whether medical, fire, natural disaster, or national crisis, every effort will be made to contact you by a member of our staff.

Emergency contact procedure

The following phone order has been set as a policy and will be used when making phone calls. This cycle will be repeated until contact has been made:

1. Parent/guardian #1 phone
2. Parent/guardian #2 phone
3. Home phone
4. Alternate phone number if you provided

If you would like us to follow a different procedure for you and your camper, please contact us before the start of the camp session.

Behavior Policy

We expect all campers to maintain acceptable and appropriate behavior throughout the Art & History Camp week(s).

We expect campers to:

- Take responsibility for their actions
 - Respect themselves, each other, camp equipment, and the environment
 - Be kind towards others
 - Be honest with staff and fellow campers
 - Ask for help when they need it
 - Talk to a counselor/staff member if they are uncomfortable with any experience while at camp
-

Examples of unacceptable behavior:

- Refusing to follow behavior guidelines/camp rules
- Using profanity, vulgarity or obscenity
- Stealing or damaging personal or camp property
- Refusal to participate in activities or cooperate with staff
- Disrupting a program
- Leaving a program without permission
- Endangering the health and safety of other campers or staff
- Teasing, making fun, or bullying of other campers or staff
- Fighting of any kind

Discipline Procedures:

When a camper does not follow the behavior guidelines, camp staff will take the following steps:

1. Staff will redirect the camper to more appropriate behavior.
2. If inappropriate behavior continues, the camper will be reminded of behavior guidelines, then asked on how they will change their behavior as a first warning.
3. If a camper's behavior still does not meet expectations and is affecting the experience of other campers, they will be sent to the Camp Director. The Camp Director will notify parents of their camper's behavior and issue a second warning. If the behavior was severe enough, parents will be asked to come and pick up their camper early.
4. If a camper amasses three warnings, the camper may be dismissed from camp.

Abuse and Neglect Policy

As a facility paid to care for and educate children under the age of eighteen, and licensed by the State of Connecticut, the Greenwich Historical Society has a responsibility to prevent the abuse and/or neglect of children enrolled in the summer Art & History Camp as per The Connecticut Department of Children and Family (DCF) standards.

The camp staff will be trained on the procedure to follow if abuse or neglect is suspected, and are required to complete the half hour DCF Mandated Reporter Training during the pre-camp employee training. Any employee that is unable to attend must complete the training on their own time before the start of camp.

All camp staff is required to follow the below policies regarding abuse and neglect:

Believing

If a camper comes to a staff member in earnest and says they're being abused or neglected, staff should believe them. Staff should listen to what they say, then tell the camper that they are going to contact people who can help. They will not press the camper for details, as they will need to give these later and often saying anything is the biggest hurdle for a child.

Staff need only suspect abuse to make a report. They should not display horror, shock, or disapproval of parents/guardians, campers, or the situation, and they will not place blame or make judgements about the parents/guardians or camper.

Reporting

If an employee witnesses, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, or neglect has occurred, the employee is required to report their suspicion immediately to the Camp Director or Assistant Camp Director. They must also write out a written report of what they have observed. This report is to be given to the Camp Director or Assistant Camp Director to be filed into camp records.

When making the written report, the following information will be provided:

- Name of the camper and their parent(s) or responsible caregiver(s)
- The camper's age and gender
- Name of the reporter
- Nature and extent of injury, maltreatment, or neglect
- Date and time the injury, maltreatment, or neglect was observed
- The circumstances in which the injury, maltreatment, or neglect became known to the reporter
- Any previous injury, maltreatment, or neglect of the camper or siblings known to the reporter
- Name of the person suspected to have caused the injury, maltreatment, or neglect
- Time and date that staff reported their suspicion to the Camp Director or Assistant Camp Director
- Any action taken to treat or help the camper
- Any other information the reporter believes would be helpful

When notified of suspected abuse or neglect, the Camp Director or Assistant Camp Director will investigate the suspicion. If they too suspect abuse, they must also write a dated record of what they observed to be filled into camp records along with the official DCF reporter form. DCF must be called within 12 hours of the first observation of suspected abuse or neglect.

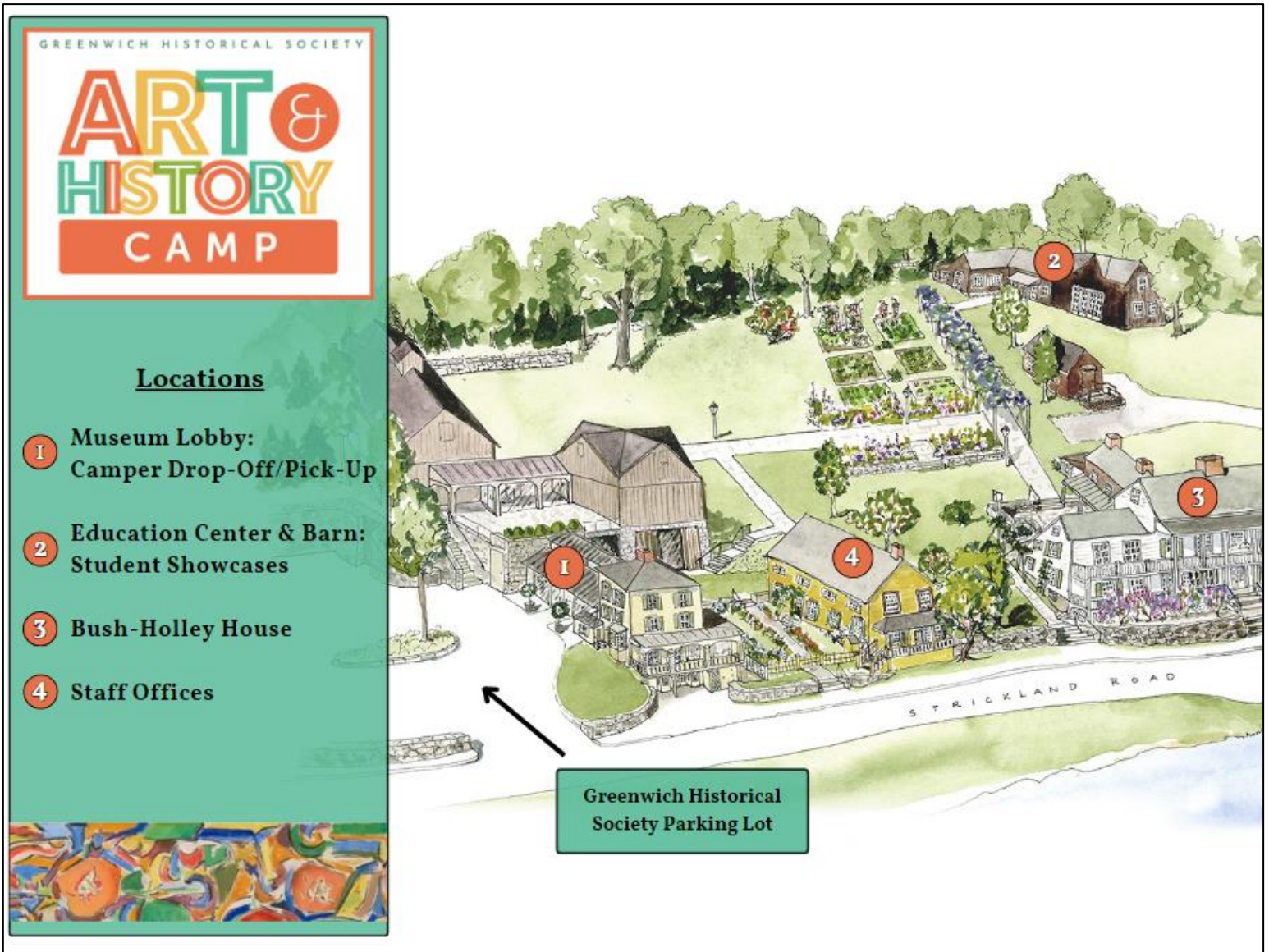
After DCF notifies the Camp Director that an allegation of abuse or neglect has been received, the Camp Director must notify the victim or his/her legal guardian, if applicable, of the allegation within 24 hours.

If the Camp Director is unable to reach the guardian by phone, a letter of notification shall be sent within 24 hours.

Confidentiality of information

Any allegation(s) or investigation(s) of reports of abuse and neglect shall remain confidential. Besides the report made to the Camp Director, any suspected abuse or neglect will not be talked of amongst staff. It is illegal to talk of suspected abuse or neglect outside of those directly involved in the case. Anyone who in good faith makes a report of child abuse and has reasonable grounds for making the report shall have immunity from any civil or criminal lawsuits. If a case of abuse or neglect that you have reported goes to the court of law, staff have the right not to be named and the right to decline participating in the trial.

Greenwich Historical Society Campus Map



For any questions on any of the Art & History Camp guidelines and policies, please reach out to:

Lauren Ackerley
Assistant Director for Education
lackerley@greenwichhistory.org
203-869-6899 x32

Melissa Houston
Director of Education
mhouston@greenwichhistory.org
203-869-6899 x15

Section 2:
Camp Policies
Acknowledgement Letter



Camp Policies Acknowledgement Letter

Dear Parents/Guardians,

Please take a moment to read and sign the following acknowledgement.

By signing below, I agree to indemnify, defend, save and hold harmless the Greenwich Historical Society, Art & History Camp, and their employees and staff from any and all claims, suits, losses, or injury to any person, of whatever kind and nature, whether direct or indirect, arising from or of the operation of this agreement.

In the case of a medical emergency, I understand that every effort will be made to contact parent(s) or guardian(s). In the event that I cannot be reached, I hereby give permission to the Art & History Camp staff and volunteers to call emergency medical personnel to administer aid and transport my camper to a hospital or health care facility where they would receive further medical attention. I am aware that I am giving permission for the emergency personnel and physicians to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my camper.

I understand that all medical forms MUST be submitted to the Camp Director by the start of camp. If these forms are not submitted, my camper will not be allowed to participate in camp activities until the forms have been submitted. This is for the safety of my camper.

I agree to drop off my camper at 9:30am and to pick up my camper at 12:30pm in the museum lobby. I understand that I must sign in and out my camper with the Camp Director for my camper's safety. I understand that unsupervised campers will not be allowed on Historical Society property prior to 9:30am. There is no early drop off. I understand that campers not picked up by 12:40pm will wait in the museum office until a parent or guardian arrives. A late fee of \$20.00 will be charged for every 15 minutes after 2:40pm that a camper is not picked up.

I understand that if my camper will be going home with someone other than who is listed, I must provide this information in the Permission Form or inform our staff in advance.

I acknowledge that my camper should be sent with a water bottle and clothing conducive to camp activities. This includes outdoor activities that require sunscreen.

I understand that camp is a social environment. I understand my camper cannot attend camp if they present signs of being sick. I will keep my camper home so as to not expose other campers and counselors to illness.

I understand that Art & History Camp is a NUT FREE CAMP. I understand that campers should bring a wholesome snack and beverage that is NUT FREE – i.e. free of peanuts, peanut butter, pecans, walnuts, pistachios, pine nuts, nut oils (ie. peanut oil), and nut flavorings (ie. almond extract).

I will ensure that my camper's belongings, including backpacks, water bottles, and lunch bags must be labeled with my camper's name.

I understand that appropriate behavior is expected from all camp participants and that campers who repeatedly fail to show appropriate behavior might be sent home.

Best Regards,
Camp Director

By signing below, I confirm I acknowledge that I have received and read the aforementioned policies.

Parent/Guardian Signature

Date

Section 3:
Camp Permission Form



Camp Permission Form

Please fill out and return this form along with all medical forms, signature for the Guidelines and Policies Handbook, and signature for the Policies Acknowledgement Letter by July 13th. Permissions are required to be shared before camp begins. Thank You!

Camper Information

Child's First Name: _____

Child's Last Name: _____

Age: _____ Grade in the Fall: _____

My child is attending the following camp(s):

- Artful Adventures, July 13th-17th
 - Colonial Connections, July 20th-24th
 - Historical Happenings, July 27th- 31st
-

Parent/Guardian Information

Parent/Guardian #1 (Primary)

First Name: _____

Last Name: _____

Email: _____

Please fill out the below contact information and check off the PRIMARY contact to reach you in case of emergency.

- Cell Phone: _____
- Home Phone: _____
- Alternative Phone (Optional): _____

Parent/Guardian #2

First Name: _____

Last Name: _____

Email: _____

Please fill out the below contact information and check off the PRIMARY contact to reach you in case of emergency.

- Cell Phone: _____
 - Home Phone: _____
 - Alternative Phone (Optional): _____
-

Permissions

Alternative Camper Drop-Off and Pick-Up

Note: This is optional to fill out but MUST be on record for camper drop-off and pick-up if Parent/Guardian #1 and #2 are absent. Campers will NOT be released unless the parent/guardian has advised permission.

The following individuals have permission to pick up my child from the Art & History Camp in my absence:

First Name: _____

Last Name: _____

Primary Phone Number: _____

First Name: _____

Last Name: _____

Primary Phone Number: _____

Medical Permissions

I authorize Dr. _____ at Address and Phone Number: _____

_____, or any licensed physician to provide any proper emergency treatment to my child in the event of an emergency. I understand that this authorization is given prior to any need for medical care and is given to avoid any unnecessary delay for emergency treatment, which the physician may deem advisable in the exercise of their best judgment. I assume a reasonable attempt will be made to contact me.

I also authorize the Greenwich Historical Society to arrange for emergency transportation away from the site to the nearest medical facility.

Please attach all Health Forms.

- Check here if forms have been attached
-

Photography Permissions

Greenwich Historical Society staff may take photographs during camp. I understand these photographs may include my child.

I understand these photographs may be published in newspapers, magazines, newsletters, program brochures, and/or shared on social media such as Facebook and Instagram in order to promote the Historical Society's educational programs. I ...

- GRANT permission to photograph my child for publishing
- DO NOT GRANT permission to photograph my child for publishing

REQUIRED SECTION:

By signing, I understand and consent where noted to the aforementioned permissions.

Parent/Guardian Signature

Date

Section 4:
Required Camp
Medical Forms

**YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF**
Physical Exams Are Valid For 3 Years
From Date of Last Examination

Please Return Completed Form to the Camp

Camper
 Staff

Name _____ Date of Birth _____ Phone _____

Guardian _____ Address _____

Emergency Contact _____ Telephone _____

Date of Arrival at Camp: _____ Departure Date: _____

**TO BE COMPLETED BY THE
HEALTH CARE PROVIDER**

Date of Exam ____/____/____

May participate in all camp activities YES NO

May participate except for:

Does the individual have any known medical or emotional illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp? YES NO

If yes, please explain _____

Are there any prescription or over the counter medication(s) this individual needs to take while at camp? YES NO

If yes, indicate names of medication(s): _____

NOTE: A written authorization and parent permission for the administration of medication at camp are required.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? YES NO

If yes, please explain _____

NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If camper/staff is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health pursuant to section 19a-7f of the Connecticut General Statutes? YES NO

Additional Comments: _____

Printed Name of Health Care Provider: _____

Address: _____ Phone: _____

Signature of Physician, PA, APRN or RN _____ Date Form Signed: _____



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).

Statelawrequirescompleteprimary immunizationsand ahealth assessment by a legally qualified practitioner of medicine, an advanced practice registerednurseorregisterednurse,licensedpursuanttochapter378,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"/> Black, not of Hispanicorigin
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> White, not of Hispanic origin
	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian/Pacific Islander
		<input type="checkbox"/> Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance?	Y N	If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have dental insurance?	Y N	

* 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)				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.	Date
Signature of Parent/Guardian	

To be maintained in the student's Cumulative School Health Record

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: <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		
Without glasses 20/ 20/	<input type="checkbox"/> Fail <input type="checkbox"/> Fail	*HCT/HGB:	
<input type="checkbox"/> Referral made	<input type="checkbox"/> Referral made	*Speech (school entry only)	
		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
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Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

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 <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <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 _____ </td> <td style="width: 33%; border: none; vertical-align: top;"> <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 _____ </td> </tr> </table>			<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 _____
<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
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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 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)

<p>Religious Exemption: _____</p> <p>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.</p>	<p>Medical Exemption: _____</p> <p>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</p>
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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.

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

Medication Administration Record (MAR)

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

Pharmacy Name _____ Prescription Number _____

Medication Order _____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

- | | |
|--|--|
| <input type="checkbox"/> Authorization form is complete | <input type="checkbox"/> Medication is appropriately labeled |
| <input type="checkbox"/> Medication is in original container | <input type="checkbox"/> Date on label is current |

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

Individual Plan of Care for a Child
With Special Health Care Needs or Disabilities

Child's Name: _____ Date of Birth ____/____/____

Special health care need or disability:

Plan for appropriate care of the child in a medical emergency. An individual Plan of Care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the youth camp.

Other relevant information: (e.g. precautions to be taken to prevent a medical or other emergency)

Signature(s) of the Parent(s):

Date Signed:

____/____/____
____/____/____

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child.

