

ECC HKMS After School Program (ASP) Enrollment

Family (Household) Name:

Parent Name

Parent Name

Address:

Phone # (H)

Phone # (W)

Phone # (C)

Email

Emergency Contact

List all children participating in the After School Program

Child Name:

Gender

Grade

D.O.B

Required

ASP

Child Name:

Gender

Grade

D.O.B

Required

ASP

Child Name:

Gender

Grade

D.O.B

Required

ASP

Alternate Pick up Arrangements

In case I cannot pick up my child/children, please release my child/children to one of the following individuals (note: a drivers license or photo ID will be required at time of pick up). Written authorization will be required for anyone other than those listed to pick up your child/children.

Name

Relation

Home phone

Cell phone

Business phone

Name

Relation

Home phone

Cell phone

Business phone

Consent

When enrolled in an ECC program, I authorize emergency medical treatment of all family members listed under this household, as deemed necessary by the ECC staff, and I agree to assume the costs of any such treatment.

In consideration of accepting the membership and permitting the voluntary participation of the above named family members in ECC programs, rentals or events, I/We hereby waive, release, discharge, indemnify and agree to hold harmless [ECC] its board, employees, volunteers, officials, sponsors and other representatives from any and all claims, demands, costs, expenses, and compensation arising out of or in any way related to any injury or other damage that may result to said participant while attending and/or participating in any [ECC] sponsored event, including any physical or other injury caused by negligence of any such person while performing his/her duties at any time.

I authorize the ECC to have and use photographs and/or slides of the person/s named on this enrolment as may be needed for its records and/or promotional purposes.

Parent/Guardian signature

Date

**ECC HKMS After school Program
Covid-19 Parent Consent Form**

Child's Name _____

_____ I am aware of the following Covid-19 symptoms listed below:
(initial)

- Fever
- Cough
- Shortness of breath or difficulty breathing
- Sore throat
- Chills
- Muscle pain
- New loss of taste or smell

_____ I will perform a daily health screening, including a temperature check, of my children by
(initial) checking for Covid-19 symptoms as outlined by the CDC and addressed in the ECC Covid-19 Guidelines.

_____ I will keep my child home if they, or anyone in our house, has a fever above 99.9, are ill
(initial) and/or show any Covid-19 symptoms.

_____ I will alert the ECC immediately if my child, or someone in our house, is sick and/or has
(initial) been positively diagnosed with Covid-19.

_____ I will discuss Covid-19 preventive measures with my child to better prepare them
(initial) to follow these guidelines while in our care. (Information provided)

_____ I will be prepared with an alternative pick-up plan/person in the event that an
(initial) immediate pick-up is necessary.

_____ I will be prepared with a back-up childcare plan in the event that my child
(initial) has symptoms and is not allowed to attend the program.
(Call 211 if unable to secure a back-up care plan)

_____ I will not pick-up, drop-off, and/or enter the program if myself or someone in my
(initial) household has tested positive or is showing symptoms of Covid-19.

_____ I hereby attest that I have been informed of the following pertaining to the
(initial) coronavirus/Covid-19:

- People who are 65 years and older, and people of any age who have serious underlying medical conditions, or who are at higher risk for severe illness from Covid-19 are recommended to stay at home. A list of medical conditions associated with a higher risk for severe illness from Covid-19 can be found in the CDC's guidance. Individuals and families should consult their healthcare provider to determine whether they have medical conditions that place them at increased medical risk.
- Staff and children living in households with individuals who are 65 years and older OR who have a higher risk for severe illness from Covid-19 are recommended to stay home.

_____ I understand that if my child is absent from the program for any amount of
(initial) time due to circumstances related to Covid-19 that no refunds will be given.

I have reviewed and agree to follow the above guidelines.

Print Name

Signature of parent/guardian

Date



A 501(c)(3) Charitable Organization

GLOBAL WAIVER AGREEMENT

(Please Print All Information Clearly)

Date _____

Name _____

D.O.B _____

Age _____ Gender _____

Address _____

City _____ State _____

Zip Code _____

Home Phone _____

Cell Phone _____

E-mail _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name _____

Relationship _____

Phone Number _____

IN CONSIDERATION OF BEING PERMITTED TO UTILIZE THE FACILITIES, SERVICES AND PROGRAMS OF THE EASTON COMMUNITY CENTER FOR ANY PURPOSE, INCLUDING BUT NOT LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT OR PARTICIPATION IN ANY PROGRAM AFFILIATED WITH THE EASTON COMMUNITY CENTER WITHOUT RESPECT AS TO LOCATION, I HEREBY AGREE TO THE FOLLOWING:

I agree to follow all rules and regulations of the Easton Community Center while in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the Easton Community Center without respect as to location, and understand and agree that I may be expelled at any time, with no refund of any monies paid, for failure to abide by such rules and regulations.

1. ASSUMPTION OF RISK: I understand that activities at the facility or elsewhere, including use of equipment and participation in programs, can involve movement, strain and other elements that create inherent risks. I hereby assume full responsibility for and risk of bodily injury, property damage or loss, regardless of severity, that I or my minor child/ward may sustain from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the Easton Community Center without respect as to location. If I see or feel anything is questionable or dangerous, it is my responsibility to ask or inform ECC employees until corrected or satisfactorily answered.

2. RELEASE: I, for myself, any personal representatives, assigns, heirs and next of kin, hereby fully release, waive, discharge and covenant not to sue the Town of Easton, the Easton Community Center, its operating centers, their respective officers, directors, Board of Managers, Trustees, members, volunteers, employees or agents (the "Releasees") and each of them from any and all claims for injuries, damages or loss that I or my minor child/ward may have or which may accrue to me or my minor child/ward from my and/or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the Easton Community Center without respect as to location. I hereby agree to allow my minor child/ward to observe and/or participate in the following activities:

- All of the Available Options
- Rock Climbing
- Trips
- Archery
- Photos
- BMX/Skateboarding
- Other general sport activities
- Water Fun/ Off Site Swimming

3. INDEMNIFICATION: I hereby agree to indemnify and save and hold harmless the Releasees and each of them from any loss, liability, damage or cost they may incur from my or my minor child/ward's presence in, upon or about the premises or while using or observing the premises or any facilities or equipment, or participating in any program affiliated with the Easton Community Center without respect as to location, except for any loss, liability, damage or cost that is caused solely by the Easton Community Center's gross negligence.

I further expressly agree that the foregoing ASSUMPTION OF RISK, 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 if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

This agreement applies to all past, present and future visits and uses by me to any Easton Community Center activity, facility or property.

I HAVE READ AND VOLUNTARILY SIGNED THIS ASSUMPTION OF RISK, RELEASE, WAIVER AND INDEMNITY AGREEMENT, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE AGREEMENT. THIS AGREEMENT CONTAINS A WAIVER AND RELEASE.

SIGNATURE _____ PRINTED NAME _____ DATE _____
(Participant's signature)

SIGNATURE _____ PRINTED NAME _____ DATE _____
(In the case of a minor only: Parent's or Guardian's signature)



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"/> Black, not of Hispanic origin
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 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
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.

Signature of Parent/Guardian

Date

Part II — Medical Evaluation

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			*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>	*HCT/HGB:	
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass	*Speech (school entry only)		
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail			
<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
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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.

Easton Community Center

Emergency Contacts & Authorization for Pick-up

Holland Hill School
DCCC.70170

North Stratfield School
DCCC.16645

Stratfield School
DCCC.70475

Playtots Preschool
DCCC.16494

ECC Camps
YCYC.00647

The names of at least one or two individuals, in addition to parents, who are authorized to pick up your child, must be on file with the program. If anyone else will be picking up your child, it is imperative that you notify the ECC. The ECC staff shall not release a child to anyone who is not authorized in writing for pick-up.

Child's Name: _____		D.O.B.: _____	
Parents/Guardians Name: _____		Parents/Guardians Name: _____	
Cell: _____	Work: _____	Cell: _____	Work: _____
E-mail: _____		E-mail: _____	
Employer: _____		Employer: _____	
Employer Address: _____		Employer Address: _____	

Password for Unusual Pickup Authorization

This password should be kept confidential. Only the parent and the ECC staff will know it. The password is used as a means of positively identifying a parent if they call the center to authorize an unusual pick-up. This password may also be used for the curbside sign-out. The pick-up person does not need to know the password. They will need to show a photo ID.

Check here if a court order exists limiting who may pick up your child/children from childcare, please bring in a copy of the court order, and a picture if available. Otherwise, we will assume that either parent can pick up your child or children.

Emergency Contacts & Authorized For Pick-Up (Other than parents)

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Doctor Information

Name _____ Phone _____

Address _____ Town _____ Zip _____

Preferred Hospital _____ Town _____

Signature (Parent or Legal Guardian) _____
Date

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

In the event of an emergency requiring a physician's care, do you wish us to call your family physician?

Yes No (If yes, please provide the following.)

I (we), _____ and _____, do hereby state that I am (we are) parent(s) or legal guardian(s) of _____, who resides with me. I (we), _____ authorize for emergency purposes only, a designated employee of the Easton Community Center to transport the above minor by ambulance, and consent to any necessary examination, anesthetic, medical advice, and/or medical treatment from a physician or surgeon licensed to practice medicine in the State of Connecticut.

Allergies to drugs or foods: _____

Please list any special medications or pertinent information: _____

Office Use Only: Date of Enrollment: _____ Last Day of Enrollment: _____