Easton Community Center Summer Camp Checklist

Please review this checklist to ensure you have submitted all necessary paperwork, including medical forms, fully completed before Monday June 19th. We will NOT accept forms at drop off. If there is any pertinent information concerning your child to their counselor for the week or pass on any medication to the camp medical staff, that should be communicated prior to your first day please contact Info@EastonCC.com

- [ ] I read through the ECC Summer Camp Vital Information Packet
- [ ] Completed Health Form w/ Immunization Records (Within 2 years) (School Forms No Accepted)
- [ ] Completed the Authorization for Administration of Medication
  (If Med Administration is Required During Camp Hours)
- [ ] Completed Care Plan (If Applicable)
- [ ] Curbside Pick Up Form (Full Day Campers Only)
- [ ] All Forms Submitted Prior to Monday June 3rd
- [ ] Please re-submit all forms as PDF or Scanned image to Info@EastonCC.com, in the following format
  Last Name, First Name, Camp, Weeks Attending.
  (Smith, John, Little Leaders, Weeks 1,3,5,7,9)
  (Forms sent as pictures will not be accepted.


Easton Community Center Vital Camp Information:

This information is vital to your summer camp experience. Please read it carefully. Many of the questions that you may have regarding camp are answered right here.

Please have all necessary paperwork, including medical forms, fully completed and submitted ***before Monday June 3rd*** we will ***NOT*** accept forms at drop off. If there is any pertinent information concerning your child that should be communicated to their counselor for the week or to pass on any medication to the camp medical staff, please contact Info@EastonCC.com

1. **Campers' Time and Place of Arrival –** Campers should arrive on the first day of camp at approximately 8:45 am and 9 am on all other days. We offer a curbside drop-off from 8:45 am-9 am Monday-Friday and curbside pick-up Monday-Thursday from 4:00–4:15 pm (**No curbside pick-up on Friday Afternoons**). Still, need some direction on the first day?

2. **Camper Pick-Up –** The departure time for half-day is noon; come to our lobby for pick-up, and all full-day campers is at 4 pm. Campers depart from our central pick-up point in the ECC gym. If you're picking up between 4 pm and 4:20 pm we encourage you to utilize for our "Curbside Service" for seamless pick up. You will have to complete the Curbside Pick Up ID Tag, and submit it to us. This plaque must be in your windshield at pick up, once our staff sees the plaque, they will radio for your child to be safely escorted to your car.

3. **Medical Staff –** According to State of CT guidelines, the ECC camp medical staff must hold any medications presently prescribed to your son or daughter. Please send such a prescription with an Authorization for Administration of Medication form to be dispensed correctly; as well as a care plan. The medical staff monitors every injury, however minor. See our Medical Policy below.

ECC Medication Policies
Routine medications are not administered in the Easton Community Center program. Medication such as inhalants, oral, topical, and injectables medications may be administered in the case of a specific student with a medically diagnosed condition that may require prompt treatment to protect the student against serious harm or death. A physician's order is required. The student must have a medication administration form signed by their physician and parent or legal guardian that includes the condition for which the medication is necessary, indications for giving medication, strength, dose, and side effects. A parent or guardian must supply medication. Medicine must be in the original container with a label and have valid expiration dates. Medication will only be administered by trained staff. Staff is trained in the administration of medication by our nurse consultant. This training is renewed every three years for inhalants and oral & topical medications. Training for injectables is repeated once per year. At no time is an untrained staff allowed to administer medications.

4. **Medical Form –** It is a State Health requirement that you submit to the camp a copy of a confidential medical form WITH IMMUNIZATION DATES before the camper enters the camp. If you have not submitted a medical form on or before your child's first day of camp, your child will ***NOT*** be admitted to camp (No Exceptions). **Please note**: **School forms are no longer accepted per state licensing, and physical health forms must be within the past two years.**

5. **Camper Packing List –** What you pack depends on your chosen camp. It is suggested that Day Campers bring the following items every day: Extra Set of Sport Clothing, Towels, Bathing Suits, Snacks (**NUT FREE**) or a filled-out Snack Shop Card, Sunscreen (**MUST** be applied at home), and Cold Drinks.

6. **Camper Equipment –** Campers will need a small bag to carry their equipment, such as sweatshirts, towels, or sports equipment, as lockers are unavailable. Please have campers wear sneakers or closed-toed shoes, no sandals or flip-flops.

7. **Cell Phones and Calls –** Electronic devices, such as iPhones and iPads, are only used during free time. This privilege may be revoked if abused. Campers may not have their cell phone out during camp activities. If you wish to contact your child in an emergency, please call the ECC office, and we will be able to locate them very quickly. The ECC is not responsible for lost or broken devices.

8. **Theme Days –** Don't forget about our special day theme days! These days will change, so pick up a new schedule every Monday.

9. **Lunch –** Lunch will be served to all full-day campers. This usually consists of a sandwich, pizza, other kid-friendly meals, a dessert, and a drink. Every effort is made to provide a balanced menu, and cold sandwiches are always available if the chosen meal does not suit your child. However, if your child is a particularly picky eater or has specific dietary needs, you may wish to pack a lunch for them. Please note our camp and facility is a nut-free environment.

10. **Birthdays –** If a camper's birthday falls during their week at camp, please let us know on the first day so that we may honor the occasion in the traditional ECC style.

11. **Homesickness –** Our Wanderers and Little Leader campers can be understandably anxious about their first camp. However, because of the caring and friendly atmosphere we create, we experience very few problems. However, we ask for your support. Please prepare your child for their camp experience. Our experience shows that a parent, who can be understanding yet firm when faced with homesickness, will help their child blossom and mature from the whole experience. Unfortunately, there will be no refunds for early departures due to homesickness.

12. **Payments –** The final payment for your camp is due before our first day of the camp season. Refunds are made under the guidelines set out on the ECC website, or full refund details may be obtained from the ECC office.

13. **Tipping –** We are often asked if we allow tipping. Tipping is, of course, at your discretion.

14. **ECC Directions –** From the Merritt Parkway (exit 46), head north on Rt. 59 (Sport Hill Road), approx. 2 miles to the entrance of Helen Keller Middle School. Take a right into this entrance and bear left following the signs to the ECC.

15. **Parents are Welcome –** We feel that parents should be involved in their child's camp experience.

    Each Friday afternoon, we would like to invite the whole family to our "ECC Show Afternoon," which starts at 3:30 pm. This show will let you see some of the fun everyone has had over the camp week. You will receive a letter on the first day of your camp giving you all the details of the "ECC Show Afternoon."

16. **Thanks –** For choosing the ECC! We fully appreciate the concerns that a parent has in deciding who should be involved in the development and education of their children. If you have a problem with any aspect of our programs or staff, we want to know about it. Please call the ECC office at 203.459.9700.

    Thank you again for choosing the ECC for your child's camp experience! We very much look forward to seeing you this summer. If you have any questions or problems concerning the camp, please do not hesitate to contact our office at (203) 459-9700 or Info@EastonCC.com

GLOBAL WAVIER AGREEMENT

Participant's Name: _____ ***Today's Date:*** _____

D.O.B: _____ ***Age:*** _____ ***Gender:*** _____

Address: _____ ***City:*** _____ ***State:*** _____ ***Zip Code:*** _____

Primary Phone Number: _____ ***Secondary Phone Number:*** _____

Primary Email Address: _____

In case of an 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 Below

☐ Rock Climbing ☐ Archery ☐ Photos/Videos ☐ Inflatables ☐ Other general sport activities

3. **INDEMNIFICATION:** I hereby agree to indemnify and save and hold harmless the Releases 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.**

Participant's Signature: _____ ***Printed Name:*** _____ ***Date:*** _____

Parent / Guardian's Signature: _____ ***Printed Name:*** _____ ***Date:*** _____

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician 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	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

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

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

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

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

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

Part 2 — 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 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					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***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

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	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

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

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Religious Exemption: _____

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

Medical Exemption: _____

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

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st 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 the1st 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 through11th 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

Easton Community Center

Emergency Contacts & Authorization for Pick-Up

Holland Hill School	North Stratfield School	Stratfield School	Playtots Preschool	Osborn Hill School	ECC Camps
DCCC.70170	DCCC.16645	DCCC.70475	DCCC.16494	DCCC. 70622	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: _____ Date of Birth: _____	
Parent/Guardian Name: _____	Parent/Guardian Name: _____
Cell: _____ Work: _____	Cell: _____ Work: _____
E-mail:_____	E-mail:_____
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____

Password for Unusual Pickup Authorization _____ (optional)

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.

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

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

☐ 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.

Doctor Information

Name: _____ Phone: _____

Address: _____Town:_____Zip: _____

Preferred Hospital: _____ Town: _____

In the event of an emergency requiring a physician's care, do you wish us to call your family physician? ☐Yes ☐No

---

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

I, _____ give my consent for the First Aid and CPR certified staff of the Easton Community Center to administer first aid and CPR to my child, _____. In the event of a medical emergency I, _____ give my consent to have my child, _____ transported to the nearest hospital. I will be responsible for all medical fees.

Preferred Hospital: _____

Allergies to drugs or foods: _____

Please list any special medications or pertinent information: _____

_____

_____

Signature (Parent or Legal Guardian) Date

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

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

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day 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.)

Please complete if your health care provider does not provide an Action Plan for Allergies.

Easton Community Center

Action Plan for Allergies if Anaphylactic

Child's Name_____ Grade_____
Allergic to _____
Symptoms of Anaphylaxis:

- **Mouth-itching, swelling of lips and/or tongue**
- **Throat-itching, tightness/closure, hoarseness***
- **Skin-itching, hives, redness, swelling**
- **Gut-vomiting, diarrhea, cramps**
- **Lung-shortness of breath, cough, wheeze***
- **Heart-weak pulse, dizziness, passing out***

ONLY A FEW SYMPTOMS MAY BE PRESENT. SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY.
*SOME SYMPTOMS MAY BE LIFE-THREATENING. ACT FAST!!!

If child ingests or thinks he/she ingested the above-named food but carries a disclaimer or stung by an insect (may contain, processed in, packaged in, etc) OBSERVE for onset of symptoms BEFORE initialing protocol sequence.

1-Administer Benadryl/Diphenhydramine
2-Observe child for symptoms of anaphylaxis
3-Administer epinephrine if symptoms occur
4-Call 911
5-Notify parent
**********If you notice symptoms of anaphylaxis first, skip step #1 and act on step #3.**

Date_____
Parent Signature_____
ECC Staff Member Signature Certified to Administer_____

Care Plan Form

Please complete if your health care provider did not provide an Action Plan for Asthma or mild allergies.

Date_____
Child's Name_____ Grade_____

Chronic Disease Assessment: Results taken from medical form submitted.
Circle One: Asthma: Mild Moderate Severe Exercise Induced Unclassified

Please explain reaction:
_____
_____

Diabetes: Type 1 Type 2
Anaphylactic Reaction: Insect Latex

Please list and explain reaction
_____
_____

Other_____
ECC Plan of Action
_____
_____

Parent Signature _____
ECC Representative Signature _____

Summer Camp Curbside Pickup ID Tag

Child Name:

EASTON COMMUNITY CENTER

EST 2003

CLC Summer Camp Trip Schedule

GIVEBACK THURSDAYS

***All Trips are Subject to Change**

June 24th 1ST DAY OF CAMP!  DAY @ ECC	**June 25th** ADVENTURE PARK @ DISCOVERY 	**June 26th** BEACH DAY W/ EXPLORERS 	**June 27th** COMMUNITY GIVE BACK 	**June 28th** SHELTON SPORTS CENTER 
July 1st DAY @ ECC 	**July 2nd** BEACH DAY 	**July 3rd** DAVE & BUSTERS 	**July 4th** NO CAMP 	**July 5th** NO CAMP 
July 8th DAY @ ECC 	**July 9th** LAKE COMPOUNCE 	**July 10th** BEACH DAY 	**July 11th** COMMUNITY GIVE BACK 	**July 12th** MALL & MOVIE DAY W EXPLORERS 
July 15th DAY @ ECC 	**July 16th** SPLASHDOWN 	**July 17th** BEACH DAY 	**July 18th** STUFF-A-BEAR 	**July 19th** QUASSY W/ EXPLORERS 
July 22nd DAY @ ECC 	**July 23rd** 6 FLAGS 	**July 24th** BEACH DAY W/ EXPLORERS 	**July 25th** COMMUNITY GIVE BACK 	**July 26th** DAVE & BUSTERS 
July 29th DAY @ ECC 	**July 30th** LAKE COMPOUNCE 	**July 31st** BEACH DAY 	**August 1st** COMMUNITY GIVE BACK 	**August 2nd** URBAN AIR W EXPLORERS 
August 5th DAY @ ECC 	**August 6th** SPLASHDOWN 	**August 7th** BEACH DAY W/ EXPLORERS 	**August 8th** COMMUNITY GIVE BACK 	**August 9th** SKYZONE 
August 12th DAY @ ECC 	**August 13th** SHELTON SPORTS CENTER W EXPLORERS 	**August 14th**  FIELD DAY TIME CAPSULE AWARD CEREMONY	**August 15th** BROWNSTONE 	**August 16th** BEACH BBQ