SUMMER CAMP 2020 Registration Form & Contract

Room Selections: When selecting which room you'd like your child to be in, please note the following: We will have children ages 3-5 years old in the preschool room. We have three school age rooms, in which children will be grouped by age (4-5, 6-7 and 7-9). If your child is just entering kindergarten, the school age room will be suitable for them, but it is entirely your choice if you would prefer to have them in the preschool room!

Child's Name: ____________________________ Age at start of camp: ____ Room (Circle): PRE-K or School Age
Child's Name: ____________________________ Age at start of camp: ____ Room (Circle): PRE-K or School Age
Child's Name: ____________________________ Age at start of camp: ____ Room (Circle): PRE-K or School Age

Program Requirements:
Deposit: $40 Non-Refundable Deposit per child (not applied to tuition)
Registration Minimum: 5 Days Total for duration of camp (not 5 days per week)
Hours: Monday-Thursday 8:00-4:30, Fridays 8:00-12:00
Rates: Monday - Thursday Rate: $60/day, Fridays: $40/day
Sibling Discount: Register each child for 15 days total to receive a 25% discount on each sibling's weekly rate.

Please check each individual day your child(ren) will be attending. Please keep in mind that **only (and all) Fridays are half days**. Monday through Thursdays are **only** full days. There is no half day option M-TH.

Week 1
6/29 ____
6/30 ____
7/1 ____
7/2 ____
7/3 ____

Week 2
7/6 ____
7/7 ____
7/8 ____
7/9 ____
7/10 ____

Week 3
7/13 ____
7/14 ____
7/15 ____
7/16 ____
7/17 ____

Week 4
7/20 ____
7/21 ____
7/22 ____
7/23 ____
7/24 ____

Week 5
7/27 ____
7/28 ____
7/29 ____
7/30 ____
7/31 ____

Week 6
8/3 ____
8/4 ____
8/5 ____
8/6 ____
8/7 ____

Week 7
8/10 ____
8/11 ____
8/12 ____
8/13 ____
8/14 ____

Deposit: Check # ______ Amount: _____ OR Cash Amount ______ Phone #:________________________

Parent's Name: ________________________________ Parent's Email Address: ________________________________

Please visit the reverse side to learn of our enrollment policies. In order to secure your child's spot, we'll need this form, the enrollment contract (reverse side), deposit and Registration Packet all together. We will need an updated health form as well prior to camp. Please make a copy of this schedule and enrollment contract for your records.

Enrollment Contract Summer Camp 2020

I wish to enroll my child(ren) _____________________________________, in Little Farmers Child Care Center (LFCCC) for Summer Camp 2020. I understand and agree to abide by the following school policies.

1. **Enrollment in the Program** – Parents or Guardians agree that the child(ren) shall be enrolled in this Summer Camp Program for the year of 2020. The child will have a set schedule of days that the parent has selected on the Registration Form.

2. **Non-refundable Deposit** -

Registration Fee/Deposit: For new and re-enrolling students, Parents or Guardians agree to pay a $40 non-refundable registration fee per child. Payment of the deposit is due at the time this Enrollment Contract is received by LFCCC and does not guarantee Enrollment at LFCCC. Confirmation of acceptance into the program will be communicated via email within one week of receiving this contract. Should we be unable to accommodate the schedule you've chosen, your deposit will be refunded.

3. Tuition Payments: If your tuition bill is less than $1,000.00, then your payment is due in full by June 1st, 2020. If your tuition payment exceeds $1,000, then you have the option to make payments in three partial installments:

June 1st (covers June 29th – July 10th) **July 13th** (covers July 13th – July 31st) **August 3rd** (covers August 3rd – August 14th) . Parents or Guardians agree to pay for tuition as scheduled. You may pay with a check or cash only. Checks should be made payable to "Little Farmers".

3. CANCELLATION POLICY:

All schedule changes must be made by **June 1st, 2020**. You will not be refunded or have payment waived for any last-minute absences, as we align our teacher's schedules with the attendance. We will accommodate your request to move schedules around last minute only should we have the spot availability to do so. A notice of schedule changes must be emailed to littlefarmers@sharonfamilyfarm.com by June 1st, otherwise, after June 1st you will be responsible for paying for the time you've registered your child for.

5. General Terms and Conditions:

a. **Hours of Operation:** LFCCC is open 8:00-4:30 Monday through Thursday and 8:00-12:00 on Fridays. Please do not arrive earlier than 8:00 and no later than the designated pick up times.

6. Field Trip Consent

During the course of the day, children will walk next door to the Sharon Family Farm (the adjacent property) where they will interact with farm animals. Children will remain supervised by their assigned teacher and we will comply with state ratio regulations while at the farm. Ratios will remain no more than 1 teacher to 10 children. By signing below, you are giving us permission to allow your child to visit the Farm at any time during the day.

I have read and agree to the terms of the above Enrollment Contract as well as the Parent Handbook.
Both parents/guardians shall sign below.

Parent/Guardian Signature ____ Date _______________

Parent/Guardian Signature ____ Date _______________

Director's Signature ____ Date _______________

Little Farmers Child Care Center
Registration Packet

If your child attended summer camp last year, we do not need
a new registration packet unless they have new allergies or medications.
We will need an updated Health Assessment and pick up list.

STAPLE PHOTO OF CHILD HERE

Eye Color _______
Hair Color ______ Height ____
Weight_____

Child's Information

Child's Full Name: ____________________
Date of Birth: ____________________
Address: ____________________
City/Town: ____________________ State: ________
Date of Admission: ____________________

* If you are a working parent, you must provide a phone number for your place of work.

Parent/Guardian 1:

Full Name: ____________________
Home Address: ____________ Town/City: ____________ State: ______ Zip Code: ________
Cell Phone: ____________________
Second Contact Number: ____________________
Email Address: ____________________
Place of Work: ____________ Work's Phone Number: ____________
Marital Status: ____________________
Relationship to Child: ____________________

Parent/Guardian 2:

Full Name: ____________________
Home Address: ____________ Town/City: ____________ State: ______ Zip Code: ________
Cell Phone: ____________________
Second Contact Number: ____________________
Email Address: ____________________
Place of Work: ____________ Work's Phone Number: ____________
Marital Status: ____________________
Relationship to Child: ____________________

Child's Physician: ____________________
Child's Physician's Name: ____________________
Physicians Office Address: ____________________
Physician's Phone Number: ____________________

Pick Up LIST & Security Software

We use a security/check in software called "KidCheck" to track attendance. Please use a computer to complete the following directions.

1. Please go to www.go.kidcheck.com and click on "Create Your Kid Check Account".
2. Under the "Guardians" tab, please list any people who are allowed to pick up your child. Under this tab, you MUST **include yourself and a second guardian** (if applicable). We know it says not to add yourself under the Guardian tab, but I am asking that you do. You should have yourself listed under the "My Profile" tab and the "Guardians" Tab. You should include a picture of everyone, their first and last name and their phone number.
3. Under the "Kids" tab, please fill in their first and last name, birthdate, gender and include a good picture. Please leave the "Medical/Allergy Info" Box completely EMPTY if your child does not require any special needs/health concerns. Do not type anything in the box at all if not applicable, otherwise your child will pop up on our allergy list. **Do not** write "none" or "n/a".
4. Download the KidCheck application on your smartphone. When you arrive for drop off, you will check your child in on our iPAD check in station OR from the "KidCheck" application on your phone (from your car). Your child is then electronically assigned a unique 4-digit code. You must turn "Enable Text Messages" under the settings in your KidCheck account to receive check in notifications. Whoever is checking children should at least be listed as a Guardian on the child's account. All you and they have to do, is type your phone number into the check in iPAD, hit the green arrow, select your child's box, assign them to their room that day, then hit the green arrow. That's it! If you choose to do it from your phone, the steps are laid out for you on the website. On your phone, you can click on "guardian receipts" to get that 4-digit code. All we need is to see your license or the code at pick up time.
5. **Only one person should create an account for a child.** Do not have your pickup personnel or second guardian create an account for the child.

We will also have a hard copy of your alternative pick up list on hand should our Internet service be down. Any person you list below (don't include yourself below, I will already have put your names down on the hard copy), should also be listed on your child's KidCheck profile under the "Guardians" Tab.

PICK UP 1:	**PICK UP 2:**
First & Last Name:	First & Last Name:
Relationship to Child:	Relationship to Child:
Phone Number:	Phone Number:
PICK UP 3:	**PICK UP 4:**
First & Last Name:	First & Last Name:
Relationship to Child:	Relationship to Child:
Phone Number:	Phone Number:

Parent consent: In case of an emergency or change of pick up plans, I give permission to any of the above individuals to be contacted and my child may be released to any of them.

Parent/Guardian signature: ______________________________ Date: ______________

Emergency Medical Consent Form

Little Farmers Child Care Center has my permission to obtain emergency medical treatment for my child when I cannot be reached or if a delay in reaching my child would be dangerous for him/her. Please review our Emergency Policies in your Parent Handbook. Your child's file, which includes this form, will be given to emergency medical staff upon their arrival.

Medical Information

Preferred hospital/treatment center: ______________________________

My child is taking the following medications: ______________________________

My child has been confirmed to be allergic to the following: ______________________________

Please list any existing medical conditions, allergies, or special needs your child may have.

____

____

____

____

Please describe the Severity of Allergies:

____

____

Medication currently being taken and dosage:

1. ______________________________
2. ______________________________
3. ______________________________

If your child has medication that needs to be taken at the center, you must request and complete the following forms prior to attendance:

- Medical Authorization Form for each medication
- Care Plan (completed by parents and staff)
- We will need all medications prior to your child attending.

I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in childcare.

Signature of Parent or Guardian: ______________________________ Date ______________

Financial Management Plan

Summary Camp Rates & Registration Requirements

Please fill out the summer camp form reflecting the dates your child will be registered for. Please note the following daily rates for summer camp.

Full Day Rate: $60 (Monday-Thursday)
Half Day Rate: $40 (Fridays only)
We do not offer a half day option Monday through Thursday – only on Fridays. You may pick up and drop off anytime within the listed timeframes.

Non-refundable Deposit -

Registration Fee/Deposit: For new and re-enrolling students, Parents or Guardians agree to pay a $40 non-refundable registration fee per child. Payment of the deposit is due at the time the Enrollment Contract is received by LFCCC and does not guarantee Enrollment at LFCCC. Confirmation of acceptance into the program will be communicated via email within one week of receiving the contract. Should we be unable to accommodate the schedule you've chosen, your deposit will be refunded.

Tuition Payments: If your tuition payment is less than $1,000.00, then your payment is due in full by June 1st, 2020. If your tuition payment exceeds $1,000, then you have the option to make payments in three partial installments:

June 1st (covers June 29th – July 10th)
July 13th (covers July 13th – July 31st)
August 3rd (covers August 3rd – August 14th)

Parents or Guardians agree to pay for tuition as scheduled. You may pay with a check or cash only. Checks are made out to "Little Farmers".

Cancellation Policy:
All schedule changes must be made by **June 1st, 2020**. You will not be refunded or have payment waived for any last-minute absences, as we align our teacher's schedule with the attendance. Should we have flexibility to move schedules around last minute, we are happy to accommodate you, but please know this is not guaranteed. A notice of schedule changes must be emailed to littlefarmers@sharonfamilyfarm.com by June 1st, otherwise, after June 1st you will be responsible for paying for the time you've registered your child for.

By signing this form, you understand that you are financially responsible for all tuition fees aligned with the schedule you have selected for your child. Please outline below whom is responsible for payment of tuition and fees. Please tell the director if there will be split tuition payments or if the tuition payment is the responsibility of an adult other than the parents/guardians.

Name: __________ Email Address: __________

Name: __________ Email Address: __________

Parent Signature: __________ Date: __________

Photo Release Form

This form is for permission to display photos of your child. With your permission, we will take and use pictures of your child to display throughout the facility, in our newsletters, on our website, and on our Facebook page. This is a great way to show parents and new families what we are doing at the center.

Please indicate below if we may use your child's photograph for the uses mentioned above.

_______ I grant permission for Little Farmers Child Care Center to use my child's photograph for the uses listed above.

_______ **I do not** give my permission to Little Farmers Child Care Center to use my child's photograph for any use.

Child's Name: ____

Parent's Signature: ______________________________ Date: ______________

Parent Consent Form

I have carefully reviewed Little Farmers Child Care Center's Parent Handbook, Registration Information, and any other additional forms provided to me and agree to comply with all of the information I've been given. I also agree that the information that I have provided on this registration form is filled out to the best of my knowledge and includes everything the center should know about my child.

I have reviewed the behavior policies, how misbehavior is handled and the behavior incident report section of the Parent Handbook and expressed any questions I may have regarding these policies with the director. I understand that my child may be released from the program at any time if the director feels the program is not a good fit for my child.

I understand that this program involves live farm animals. I am confident that my child is able to comply with directions given by staff and will be capable of treating all of the animals nicely. I understand that if my child is unable to comply with the rules of the barn or have been found to be mistreating the animals in any way, they may be dismissed from the program upon the incident.

Liability Agreement

By registering your child at Little Farmers Child Care Center (LFCCC), you agree not to hold LFCCC or Sharon Family Farm liable for any injury or illness your child may receive while at the farm. We take all of the precautions that we possibly can to ensure your child's safety and health. You agree that you understand our guidelines for farm sanitation and animal interactions. By signing, you agree to assume any risk, take full responsibility and waive any claims of personal injury or illness while you or your child visit the Sharon Family Farm's barn.

Each parent/guardian need to sign this form as acknowledgment of the above.

Parent Signature (guardian 1): ______________________________ Date: __________

Parent Signature (guardian 2): ______________________________ Date: __________

Director's Signature: ______________________________ Date: __________

Additional information I feel that my child's teachers should know:
____
____
____
____
____
____
____

Quick Notes!

- **What to Bring (Please Label Everything!)**
  - Full Days – 2 snacks & lunch, Half Day -1 snack
  - Water Bottle
  - Overalls & Boots
  - Preschoolers – Change of Clothes
  - Sunscreen

- **Create your KidCheck account!**

- **Drop Off-** There will be two "check in stations". If your child will be in the new classroom (we'll call it the addition), then you'll go in the door closest to the fence in the back of the building. You'll check in on the iPAD mounted on the wall. If your child is in the main building, you'll check your child in on the iPAD located right to the left of you when you walk in (it's mounted to the wall near hand wash station). The attendance sheet is posted on the Pinterest page each week so you'll know ahead of time where your child will be and with which teacher. You may walk your child to their classroom and communicate anything you need to your child's teacher that day (all of their belongings go with them to their designated classroom).

- Please always bring an I.D with you upon pick up!

- Quiet Time – After lunch on full days, we allow some downtime for the kids. We'll offer a movie and other quiet activities from about 12:30-1:30. This helps keep the building quiet for the little ones for some time.

- Overalls – Each child should come with overalls. If you're only attending for a few days, we do have plenty of extra overalls that your child may borrow. If your child is attending more full time, they should bring their own. Each child will need their own boots for the barn. Rainboots work best!

Behavior - I set very high expectations for each child that enters this program. We have sadly experienced quite a few scenarios where our school age children have tried to be too rough or "experimental" with my (Miss Jessica's) animals. I won't allow for it. We go over the barn rules every single time we visit the barn, therefore, everyone will know the rules. Should a child: hit, kick, bite, throw, squeeze or abuse an animal in anyway, they will be sat in the behavior chair immediately and be done with the barn for the day.

- Example: We teach the children that the alpaca will kick if you touch his backside. We had an older boy hit the alpaca on his backend to see the reaction he could get from him – completely not okay.

You must trust our judgment with behavior and discipline and be on board with how we handle these situations. I do not accept excuses for any of the children's poor behaviors. They will have a behavior incident report written up as the situation calls for it. The barn sessions are VERY much supervised.

Outside of the barn, children do not talk back to teachers, bully other children, tease other children, exclude children from activities and any other things listed in the misbehavior section of the handbook. We are constantly trying to encourage kindness and inclusion here. While other programs may be much more lenient, I promise that is not the case here.

If your child ever goes home and tells you that another child was hurting their feelings, you need to communicate with me. You need to give us a chance to correct situations. While our school age groups are broken up into three small groups, and we have low teacher/child ratios, please understand we cannot hear everything being said amongst all of the kids and most kids won't get us for help. We are VERY on top of watching how children treat each other and ensure that they're being respectful to all.

Welcome to Little Farmers, we hope you enjoy your time with us!

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

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

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

* If applicable

Part I — To be completed by parent/guardian.

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

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

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name ______________________ Birth Date ____________ (mm/dd/yyyy) Date of Exam ____________ (mm/dd/yyyy)

❑ 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.

*HT______in/cm______% *Weight______lbs.______oz /______% BMI______/______% *HC______in/cm______% (Birth – 24 months) *Blood Pressure________/______ (Annually at 3 – 5 years)

Screenings

***Vision Screening**
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess
❑ Referral made to: ______________

***Hearing Screening**
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess
❑ Referral made to: ______________

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑ No ❑ Yes

*Result/Level: *Date

Other:

***TB:** High-risk group? ❑ No ❑ Yes Test done: ❑ No ❑ Yes Date: ________
Results: ______________________
Treatment: ______________________

***Dental Concerns** ❑ No ❑ Yes
❑ Referral made to: ______________
Has this child received dental care in the last 6 months? ❑ No ❑ Yes

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*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 an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: ______________________________
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II

Seizures ❑ No ❑ Yes: Type: ______________

Other Chronic Disease: ______________________________

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*______________________________

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

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

❑ No ❑ Yes This child may fully participate in the program.

❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)
____

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

____
Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Child's Name: ____________________ **Birth Date:** ____________ REV. 3/2015

Immunization Record

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

Vaccine (Month/Day/Year) ____________________

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) ____________________
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____

†Recertify Date _________ †Recertify Date _________ †Recertify Date ________

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

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

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.)

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
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

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

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

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

Sample Form

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 or other 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 child care program.

Other relevant information:

Signature(s) of the Parent(s): Date Signed:

____ _____/_____/______

____ _____/_____/______

Note: Section 19a-79-5a(a)(2)(E) 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. Section 19a-79-4a(h)(2)(H)(viii) requires that the health consultant shall assist in the review of individual care plans as needed.

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

Signature of the staff responsible for ____(name of child)

Printed Name	Signature	Date Signed	Printed Name	Signature	Date Signed