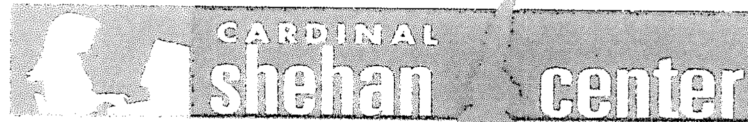


Enriching lives through learning

[illegible] Main Street
Bridgeport, CT 06604

(203) 336-4468
Fax: (203) 368-0901

2018 Summer Day Camp Registration Instructions

Registration begins April 3rd

Registration Checklist:

- ☐ 2017 Federal Income Tax Return (No W2's)
- ☐ Updated Immunization & Health Exam Records from Physician
- ☐ Completed 2018 Summer Day Camp Registration Card
- ☐ Completed Permission Slips for Field Trips
- ☐ Read Shehan Center Rules and Guidelines
- ☐ Payment

  NO REGISTRATION will be complete without full payment.
  All cash, credit or check payments must be made in full for each Session, Field Trip, etc.
  Deposits/partial payments are not accepted.
- ☐ Current Authorization for the Administration of Medication Form

  Completed by Physician. All medications are due the first day of camp.
  Labeled "Camp" in original packaging with prescription, child's name, and directions for use.

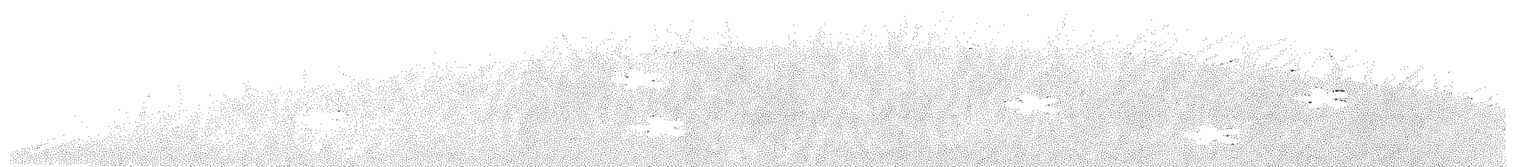
OR

- ☐ Medical Liability Release Form

  If you do not wish to provide medication

All forms are available at the Cardinal Shehan Center lobby.

THANK YOU FOR CHOOSING THE CARDINAL SHEHAN CENTER SUMMER DAY CAMP FOR YOUR CHILD!
WE LOOK FORWARD TO PROVIDING A GREAT SUMMER FOR OUR FAMILIES & CAMPERS!



1494 Main Street
Bridgeport, CT 06604

(203) 336-4468
Fax: (203) 368-0901

Norma F Pfriem
2018 Summer Day Camp
Registration Card

Please fill out the following form completely.
Please read the back of this form for important details about our policies and procedures.

Camper's Name ______________________ ☐ **Boy** ☐ **Girl** **Grade Entering in Fall 2018**__________

Date of Birth__________ **Age as of 07-01-2018**________ **T-shirt size:** YS YM YL AS AM AL AXL

Race (for funding purposes only) : ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other ________

Street ______________________ **City/State/Zip** ______________________

Mother__________________ **Cell Phone**____________ Email______________

Father __________________ **Cell Phone**____________ Email______________

Emergency Contact ______________ **Home Phone**__________ **Cell Phone** __________

How will your child leave camp? ☐ Picked-up from the Cardinal Shehan Center ☐ Other__________

Adults Authorized to Pick-up Child: No one else will be permitted to pick-up child unless cleared by Director. Must show ID at pick-up.
(PLEASE PROVIDE FULL NAMES AS STATED ON ID)

Mother ____________ **Father** ____________ **Other**____________ **Other** ____________

Anyone NOT allowed to pick-up child: ______________________________

PARENT/GUARDIAN AUTHORIZATION (REQUIRED FOR ALL PERSONS UNDER AGE 18)

The health history presented for the camper named on this registration card is correct,
and I give him/her permission to participate in all camp activities and registered field trips, except noted by me or examining physician.
I agree to all terms and conditions presented on this registration card and all other Cardinal Shehan Center informational paperwork.
The Cardinal Shehan Center and all outside affiliates are granted the right
to use any and all pictures taken of camp activities in their publication of promotional materials.
If I cannot be reached in an emergency, I hereby give permission to the physician selected by the Director
to hospitalize, secure proper treatment for, and order injection and/or anesthesia for surgery for the person.

PARENT/GUARDIAN SIGNATURE: ______________________________ **Date:**____________

Summer Day Camp Sessions:	Deadline:
Session 1: June 25-June 29	June 22
Session 2: July 2-July 6	June 29
Session 3: July 9-July 13	July 6
Session 4: July 16-July 20	July 13
Session 5: July 23-July 27	July 20
Session 6: July 30-August 3	July 27
Basketball & Swim Camps: August 6- August 10	August 3

Annual Family Income	1 Child	2 Children	3 Children	4+ Children
Less than $10,000	$80	$75	$70	$65
$10,001-$20,000	$90	$85	$80	$75
$20,001-$30,000	$100	$95	$90	$85
$30,001-$40,000	$110	$105	$100	$95
$40,001-$50,000	$120	$115	$110	$105
$50,001-$60,000	$130	$125	$120	$115
Over $60,000	$140	$135	$130	$125

2018 SUMMER DAY CAMP POLICIES & PROCEDURES

CAMP ACTIVITIES

The Cardinal Shehan Center Summer Day Camp Program offers qualified staff who are committed to
enriching children academically and athletically in a safe, positive, comfortable, and emotionally supportive environment.
Campers have opportunities to use indoor and outdoor enrichment activities to their maximum:
Art/Arts & Crafts, Computer Center, Cooking, Dance, Fields/Courts, Game Room, Literacy,
Math, Movie Room, Photography, Playground, Science, Sports/Fitness, & Swimming

FIELD TRIPS & SPECIAL EVENTS

All Field Trips where camper leaves camp property are optional and have additional fees which must be paid at time of registration.
Some of our greatest experiences over the years have come during our field trips and special events.
Some activities include, but are not limited to:
Basketball Hall of Fame, Beardsley Zoo, Jump Off, Bow Tie Cinema, Dance Off, Dinosaur Place, Hands on Pottery, Lake Quassy,
Luau, Maritime Aquarium, Nutmeg Bowling, Parties, Seaside Beach, Six Flags, Sleepover, Water Day.

CAMP REGISTRATION

The Shehan Center Summer Day Camp will operate 8- one-week camp sessions Monday-Friday from 9:00am to 3:00pm daily.
Camp fee amounts are determined by your annual family income and the number of children you will have attend camp.
Registration automatically closes once a session (age group) is filled.

You Need the Following to Register Your Child:

2016 Federal Income Tax Returns (No W2's or Paystubs)
Completed Youth Camp Health Exam/Record Form from Physician (Updated Immunizations & Physical)
Completed Summer Day Camp Registration Card
Completed Permission Slips for Field Trips

If your child takes medication or has an allergy:

Current Authorization for the Administration of Medication Form completed by Physician, or a Medical Liability Release Form
All medications are due the first day of camp, labeled "Camp" in original packaging with prescription, child's name, and directions of use.

Payment:

No registration will be complete without full payment.
All cash, credit or check payments must be made in full for each Session &/or Field Trip at registration.
Make checks payable to the Cardinal Shehan Center. All returned/bounced checks are subject to an addition fee to the parent/guardian.
Deposits are not accepted to confirm enrollment.
No discounts or refunds are given for partial session attendance, cancellation of a session, or switching a session.
If switching from one session to another, switch must be completed the Wednesday before the session begins.
There will be a $15 administration fee for switching from a previously registered session to a new session.
Field Trip costs vary per trip. Inquire for exact amount.
If a camper is suspended from camp on the day of a field trip, the camper will not be allowed on the field trip. NO FEFUNDS will be given.

CAMPER DROP-OFF

Each camper signs-in with counselor in proper age group.
Standard Drop-Off: Monday - Friday, 8:30am - 9:00am
Early Drop-Off Program: Monday - Friday, 7:30am - 8:30am, $20 per session/per child in addition to camp fee.

CAMPER PICK-UP

All campers must be signed-out with their group counselor.
All parents/guardians/approved adults picking-up campers must be at least 18-years-old and show proper identification.
Standard Pick-Up: Monday - Friday, 2:30pm - 3:00pm
Extended Day Program: Monday - Friday, 3:00pm - 5:00pm, $30 per session/per child in addition to camp fee.
Extended Day Pick-Up: 4:50pm - 5:00pm
If picked-up late, there is a $15 late fee every 15-minutes.
i.e. If a camper is registered for Standard Pick-Up, and is signed-out after 3:15pm = $15 late fee, after 3:30pm = $30 late fee, etc.
or if a camper is registered for Extended Day Program, and is signed-out after 5:15pm = $15 late fee, after 5:30pm = $30 late fee, etc.
We have given a 15-minute grace period with no charge. Thank you for your cooperation with this delicate situation.

REMINDERS

Breakfast and Lunch are provided daily at the Cardinal Shehan Center or on Field Trips, unless otherwise specified on a permission slip.
All Campers receive a Cardinal Shehan Center Summer Day Camp T-Shirt. All campers must wear the Camp T-Shirt on all Field Trips.
Children turning 5 by January 1, 2019 & entering Kindergarten for Fall 2018 school year need proof, i.e. a letter of from school principal.
All Campers must be completely potty-trained and able to dress him/herself in the bathroom/locker room.

THANK YOU FOR CHOOSING THE CARDINAL SHEHAN CENTER SUMMER DAY CAMP FOR YOUR CHILD!
WE LOOK FORWARD TO PROVIDING A GREAT SUMMER FOR OUR FAMILIES & CAMPERS!

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 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	❑ Black, not of Hispanic origin
Primary Care Provider	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
	❑ Hispanic/Latino	❑ Asian/Pacific Islander
		❑ Other

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 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

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

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
Neurologic		
HEENT		
*Gross Dental		
Lymphatic		
Heart		
Lungs		
Abdomen		
Genitalia/ hernia		
Skin		

Ortho	Normal	Describe Abnormal
Neck		
Shoulders		
Arms/Hands		
Hips		
Knees		
Feet/Ankles		

***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 Allergies ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*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

Student Name: ____________ ____________ **Birth Date:** ____________ HAR-3 REV. 4/2017

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)

Exemption: Religious ________ **Medical:** Permanent ________ Temporary ________ **Date:** ________

Renew Date: ________ ________ ________ ________

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

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 through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

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

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: ______________________________

Dosage _____ Method /Route _____ Time of Administration ________ Start Date ___/___/___ End Date ___/___/___

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 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

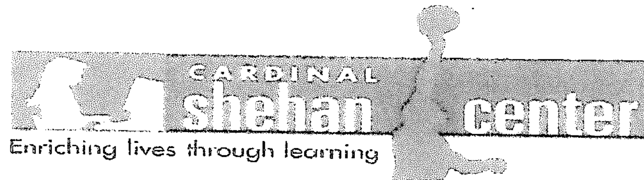
Parent/Guardian authorization for self-administration: ☐ YES ☐ NO ______________________
Signature Date

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) ______________________

Note: This form is a sample form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)



Summer Day Camp 2018
Medical Liability Release Form

Child's Name: ______________________________

Parent/Guardian Name: ______________________________

Today's Date: ______________________________

I, ______________________________, have chosen to not provide the administration of medication form that was offered and provided to me by the Cardinal Shehan Center in regards to my child: ______________________________.
I understand that his or her physical form shows an allergy or medical condition that may require the administration of medication. I am aware of the risks of not having the required medication and I understand that in an emergency, the Cardinal Shehan Center is not liable for the administration of medication. The Camp Directors will contact Emergency Medical Response if the child is having a medical issue related to child's medical history.

______________________________ ______________

Parent/Guardian Signature Date