Easton Community Center
A 501(c)(3) Charitable Organization

Playtots Participation Waiver

Child's name___________________________ Parent's name____________________________

Policy Handbook Agreement
I have read the Playtots Preschool Handbook and have had a discussion with Playtots staff regarding their Positive Guidance and Discipline Policy and understand and agree to all practices and policies as stated in the Handbook.
Initials_____________

General Field Trip Permission Slip
I give permission for my child to attend both in-school and offsite field trips. In the event of an offsite trip I will receive information about the trip and a permission slip for that particular event.
Initials________

Medical Treatment Permission
When enrolled in an ECC/Playtots Preschool Program, I authorize emergency medical treatment of my child as deemed necessary by the Preschool staff, and I agree to assume costs of such treatment. In consideration of accepting the terms and permitting voluntary participation of the above named participant in this program, I hereby waive, release, discharge, indemnify and agree to hold harmless ECC and Playtots Preschool, its board, employees, volunteers, officials, sponsors and other representatives from any and all claims, demands, costs, expenses and compensation arising out of or in any way related to any injury or other damage that may result to said participant while attending or participating in an ECC/Playtots Preschool sponsored event, including any physical or other injury caused by negligence of any such person while performing his/her duties at any time.
Initials__________

Photography and Information Release
I give the ECC and Playtots Preschool permission to take photographs or videos of my child to use as promotional material for upcoming E CC events, advertisements, newsletter and websites. Further, I give permission for ECC and Playtots Preschool to show my child's home address, phone number and parents' names on our classroom website which is only accessible to parents and teachers in our classroom.
Initials_________

PRINT Parent Name____

Parent Signature____

Date_________________________

Easton Community Center
Emergency Contacts & Authorization for Pick-up

Holland Hill School	North Stratfield School	Stratfield School	Playtots Preschool	ECC Camps
DCCC.70170	DCCC.16645	DCCC.70475	DCCC.16494	YCYC.00647

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

Child's Name: ____ **D.O.B:** __________________

Parents/Guardians Name: ______________________ **Parents/Guardians Name:** ______________________

Cell: _________________**Work:** _________________ **Cell:** _________________**Work:** ________________

E-mail: _____________________________________ **E-mail:** _____________________________________

Employer: __________________________________ **Employer:** __________________________________

Employer Address: ____________________________ **Employer Address:** ____________________________

Password for Unusual Pickup Authorization ________________________________

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

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

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

Name	Relationship	Phone Number

Doctor Information

Name ______________________________ Phone ______________________

Address____Town ____________________Zip__________

Preferred Hospital ____Town ______________________

_______________________________________ _______________________

Signature (Parent or Legal Guardian) Date

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

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

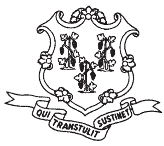
☐ Yes ☐ No (*If yes, please provide the following.)*

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

Allergies to drugs or foods: ____

Please list any special medications or pertinent information: ____

Office Use Only: Date of Enrollment: ___________________Last Day of Enrollment:____________________



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	
Primary Health Care Provider: Name of Dentist:	❑ American Indian/Alaskan Native ❑ Black, not of Hispanic origin ❑ 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
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	*Hearing Screening	*Anemia: at 9 to 12 months and 2 years
❑ 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: ____________	❑ 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: ____________	*Hgb/Hct: *Date *Lead: at 1 and 2 years; if no result screen between 25 – 72 months Lead poisoning (≥ 10ug/dL) ❑ No ❑ Yes
*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	*Result/Level: *Date Other:

***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 **Other Chronic Disease:** ______________________
Seizures ❑ No ❑ Yes: Type: ____________ ______________________

❑ 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. 8/2011

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	
Flu						
Other						

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	2-3 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	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]
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 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.)

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 ____