

GLASTONBURY PARKS & RECREATION DEPARTMENT

Kangaroo Kids Parent/Guardian:

The following forms are mandatory and must be completed and returned to the Parks & Recreation Office no later than Monday, August 22, 2016. Children will not be able to participate until all forms are complete and on file.

CHILD INFORMATION FORM

This form contains important information for parents and additional contacts in case of an emergency. It is imperative it be accurate and legible. All areas must be completed. For the safety of your child, notify Preschool Staff of any change in phone, address, or emergency contacts immediately. Please write neatly!

HEALTH ASSESSMENT/MEDICAL EVALUATION & IMMUNIZATION RECORD

All children are required to have completed a physical and have up to date immunizations. All immunizations will be required according to State of Connecticut Statutes and Regulations for a Child Day Care Center. The physical must be completed by a licensed physician, physician assistant or a certified nurse practitioner. The physical is valid one year from the actual date of the physical and must be kept up to date thereafter. An allowance of 30 days past the physical expiration date will be given to provide Kangaroo Kids with an updated physical before mandatory exclusion from the program.

EMERGENCY MEDICAL CARE

In case of a severe medical emergency, staff will call 911. If necessary, emergency personnel will transport the child to the appropriate medical facility. The family is responsible for the cost of emergency transportation.

MEDICATION AUTHORIZATION FORM

This form must be completed only if your child will need to take any medications during program hours.

RETURN PAPERWORK TO PARKS & RECREATION NO LATER THAN AUGUST 22, 2016

In Person: 2143 Main Street
Glastonbury, CT 06033
Monday-Friday 8:00-4:30 (After Hours Mail Slot available at entrance door)

By Mail Parks & Recreation
Attn: Kelly Devanny, Recreation Supervisor
2155 Main Street
P.O. Box 6523
Glastonbury, CT 06033

By Email: kelly.devanny@glastonbury-ct.gov
Kelly Devanny, Recreation Supervisor

By Fax: 860-652-7691
Attn: Kelly Devanny, Recreation Supervisor

If you have any questions, contact Kelly Devanny, Recreation Supervisor at kelly.devanny@glastonbury-ct.gov or by phone at 860-652-7681.



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)	<input type="checkbox"/> Male <input type="checkbox"/> 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:	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Other	
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	If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have HUSKY insurance?	Y N	

* If applicable

Part I — To be completed by parent/guardian.

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

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

Any health concerns	Y	N	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

ED 191 REV. 3/2015

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

Child's Name _____ Birth Date _____ Date of Exam _____

I have reviewed the health history information provided in Part I of this form (mm/dd/yyyy) (mm/dd/yyyy)

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT _____ in/cm _____ % *Weight _____ lbs. _____ oz / _____ % BMI _____ / _____ % *HC _____ in/cm _____ % *Blood Pressure _____ / _____
(Birth – 24 months) (Annually at 3 – 5 years)

Screenings

<p>*Vision Screening</p> <p><input type="checkbox"/> EPSTD Subjective Screen Completed (Birth to 3 yrs)</p> <p><input type="checkbox"/> EPSTD Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)</p> <table style="width: 100%; border: none;"> <tr> <td style="border: none;">Type:</td> <td style="border: none; text-align: center;"><u>Right</u></td> <td style="border: none; text-align: center;"><u>Left</u></td> </tr> <tr> <td style="border: none;">With glasses</td> <td style="border: none; text-align: center;">20/</td> <td style="border: none; text-align: center;">20/</td> </tr> <tr> <td style="border: none;">Without glasses</td> <td style="border: none; text-align: center;">20/</td> <td style="border: none; text-align: center;">20/</td> </tr> </table> <p><input type="checkbox"/> Unable to assess</p> <p><input type="checkbox"/> Referral made to: _____</p>	Type:	<u>Right</u>	<u>Left</u>	With glasses	20/	20/	Without glasses	20/	20/	<p>*Hearing Screening</p> <p><input type="checkbox"/> EPSTD Subjective Screen Completed (Birth to 4 yrs)</p> <p><input type="checkbox"/> EPSTD Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)</p> <table style="width: 100%; border: none;"> <tr> <td style="border: none;">Type:</td> <td style="border: none; text-align: center;"><u>Right</u></td> <td style="border: none; text-align: center;"><u>Left</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center;"><input type="checkbox"/> Pass <input type="checkbox"/> Pass</td> <td style="border: none; text-align: center;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none; text-align: center;"><input type="checkbox"/> Fail <input type="checkbox"/> Fail</td> <td style="border: none; text-align: center;"></td> </tr> </table> <p><input type="checkbox"/> Unable to assess</p> <p><input type="checkbox"/> Referral made to: _____</p>	Type:	<u>Right</u>	<u>Left</u>		<input type="checkbox"/> Pass <input type="checkbox"/> Pass			<input type="checkbox"/> Fail <input type="checkbox"/> Fail		<p>*Anemia: at 9 to 12 months and 2 years</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">*Hgb/Hct:</td> <td style="width: 30%;">*Date</td> </tr> </table> <p>*Lead: at 1 and 2 years; if no result screen between 25 – 72 months</p> <p>History of Lead level $\geq 5\mu\text{g/dL}$ <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	*Hgb/Hct:	*Date
Type:	<u>Right</u>	<u>Left</u>																				
With glasses	20/	20/																				
Without glasses	20/	20/																				
Type:	<u>Right</u>	<u>Left</u>																				
	<input type="checkbox"/> Pass <input type="checkbox"/> Pass																					
	<input type="checkbox"/> Fail <input type="checkbox"/> Fail																					
*Hgb/Hct:	*Date																					
<p>*TB: High-risk group? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Yes Test done: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____</p> <p>Results: _____</p> <p>Treatment: _____</p>	<p>*Dental Concerns <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Referral made to: _____</p> <p>Has this child received dental care in the last 6 months? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>*Result/Level: _____ *Date _____</p> <p>Other: _____</p>																				

***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
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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				
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 ²	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				
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. 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
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GLASTONBURY PARKS & RECREATION

Kangaroo Kids Preschool

EMERGENCY MEDICAL CARE

Child's name: _____ Birthdate: _____

Mother/Guardian's name: _____ Emergency Phone #: _____

Father/Guardian's name: _____ Emergency Phone #: _____

Address: _____ Town: _____ Zip Code: _____

Allergies: _____ Last Tetanus _____

Medical Facility: _____ Phone #: _____

Insurance Carrier: _____

Insurance ID #: _____

Physician to be called in an Emergency:

Name: _____ Phone #: _____

Address: _____ Town _____ Zip Code _____

I give my consent for the Kangaroo Kids program staff to contact the above named physician if my child has a medical emergency. I understand that if my child's physician is not available, another physician may be contacted on an emergency basis.

I also give my consent for Kangaroo Kids staff to seek medical assistance in an emergency at

_____ I will be responsible for all medical charges.
(hospital or walk-in clinic)

Signature

Printed Name

Date

Glastonbury Parks & Recreation – Kangaroo Kids

Authorization for Administration of Medication by Child Care Personnel

In Connecticut, licensed Child Day Care Centers administering medication to children shall comply with all requirements regarding the Administration of Medications described in State Statutes and Regulations. Parents/Guardians requesting medication administration to their child shall provide the program with the appropriate written authorization(s) and the medication before any medications are administered. **Medications must be in the original container and labeled with the 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, Advance Practice Registered Nurse)

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Address of Child _____ Town _____ State _____ Zip Code _____

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, reactions to/negative interactions with food or drugs _____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number () _____ - _____

Prescriber's Address _____ Town _____ State _____ Zip Code _____

Prescriber's Signature _____ Date: ____/____/____

Parent/Guardian Authorization:

____ I request that medication be administered to my child as described and directed above.

____ I hereby request that the above medication be administered by child care personnel and I give permission for the exchange of information between the prescriber and child care personnel as necessary to ensure the safe administration of this medication.

____ I have administered at least one dose of the medication with the exception of emergency medications to my child without adverse effects.

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.

Prescriber's authorization for self-administration: Yes _____ No _____
Signature _____ Date _____

Parent/Guardian authorization for self-administration: Yes _____ No _____
Signature _____ Date _____

Today's Date ____/____/____	Printed Name of Individual Receiving Written Authorization and Medication _____
Title/Postion _____	Signature _____

Note: This form is in compliance with Section 10-212s, Section 19a-79-9a, 19a-87b-17 and 19-13-B27 a (v).