



**2025 SUMMER
PROGRAM
REGISTRATION
www.SONCCA.org**

Automated Payment Processing



Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

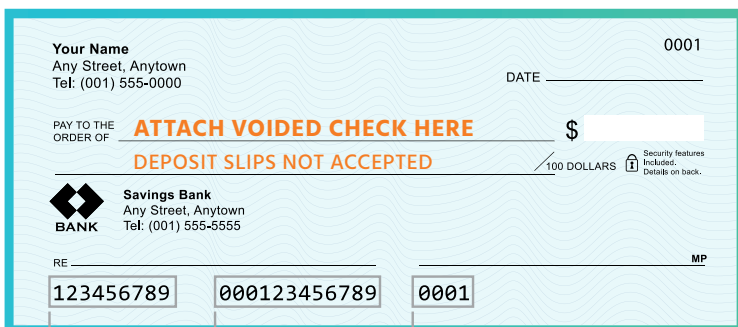
COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name	Phone #		
Cardholder Address	City	State	Zip
Account Number	Expiration Date	*CVV	
Cardholder Signature	Date		

SECTION B (Bank Account)

Your Name	Phone #			
Address	City	State	Zip	
Bank or Credit Union Name	Bank or Credit Union Address	City	State	Zip
Routing Transit Number (see sample below)	Account Number (see sample below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings	
Authorized Signature	Date			



ROUTING NUMBER

ACCOUNT NUMBER

CHECK NUMBER

FOR OFFICIAL USE ONLY

Date Received

Employee Signature

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SUMMER 2025 TUITION EXPRESS

SONCCA Tuition Express Clients

Summer Tuition Bills are due on the 12th of June for weeks 1-4 and the 10th of July for weeks 5-8. Please indicate below how you would like your payment processed:

All Enrolled Weeks Processed on the 12th of June. (Your \$100 deposit will be applied)

Weeks 1-4 Processed on the 12th of June/Weeks 5-8 Processed on the 10th of July.
(Your \$100 deposit will be applied on the July 10th payment)

The summer deposit of \$100 and the registration fee of \$35 per child must be paid by check or money order even if you're paying your tuition thru Tuition Express.

Signature _____ Date _____



2025 SONCCA Summer Program Fee Schedule

Fees Are Weekly & All-Inclusive in Full Time, Full Day Schedules

Two-Week Minimum Registration Is Required
Operates June 23 - August 13, 2025

Full Time (4-5 days) Per Week

7:30 a.m. - 5:30 p.m. \$283

Full Time Additional Child Discount Per Week

7:30 a.m. - 5:30 p.m. \$250

Part Time (1-3 Days) Per Week

7:30 a.m. - 5:30 p.m. \$228

Registration Fee: \$35 per child

If your child is attending summer school, please call the office for adjusted fee.

Check/Money Order payments only will receive a \$7.00 discount for full time and a \$3.00 discount for part time care services weekly Per Family.

Late Child Pick-Up Fee - \$20.00/15 minutes

Late Tuition Payment Fee: \$25.00

If your is enrolled part time and you would like to add a day the cost is \$70.00

Registration forms and payment must be submitted by June 16th in order to start the first week. When submitting Registration forms and payment after the start of our program, all forms and payment must be in our office the Monday prior to the week you would like to start.

SONCCA E.I.N. # (Tax I.D. Number): 06-1155484

2025 SONCCA SUMMER PROGRAM

REGISTRATION PACKET

Check List

Registration Forms

Parent Agreement
Registration Form
Notification and Child Release Form
Photograph Permission Form
Trip Permission Forms
Lunch Form
Important Summer Policy Sunscreen
Sunscreen Permission Form
Grant Information Form
Health Assessment Record
Medication Form (If Needed)
Action Plan (If Needed)

PLEASE READ

***Please provide us with a current copy of your child's (ren) physical. All children must have a copy of their physical to start Summer Camp. (Registration can still be turned in without medicals; we just need them prior to the first day.) *Please note if we do not have them on the first day, your child will not be able to continue to attend.**

***Any needed medications must be given on your child(ren) 's first day, with the correct paperwork, or they will not be able to attend. We are a licensed program and the state mandates that we have the appropriate forms and medication for your child to attend. If you have any questions, please feel free to contact the office.**

***SONCCA Summer hours have changed to 7:30 A.M. till 5:30 P.M.**

***Registration forms and payment must be submitted by June 16th in order to start the first week. When submitting Registration forms and payment after the start of our program, all forms and payment must be in our office the Monday prior to the week you would like to start.**

2025 SONCCA SUMMER PROGRAM PARENT AGREEMENT

Registration for _____

As parent/guardian of the above child, I hereby request SONCCA (Seymour-Oxford Nursery & Child Care Association, Inc.) to provide care for my child at the SONCCA-Seymour Middle School Location. **Please check all the appropriate schedules, times and days needed.**

Week 1: June 23, 2025 - June 27, 2025

Full Time (4-5 days)

Part Time (1-3 days)

Monday

Tuesday

Wednesday

Thursday

Friday

Week 2: June 30, 2025 - July 03, 2025 (Due to the holiday we are closed Friday)

Full Time (4-5 days)

Part Time (1-3 days)

Monday

Tuesday

Wednesday

Thursday

Week 3: July 07, 2025 - July 11, 2025

Full Time (4-5 days)

Part Time (1-3 days)

Monday

Tuesday

Wednesday

Thursday

Friday

Week 4: July 14, 2025 - July 18, 2025

Full Time (4-5 days)

Part Time (1-3 days)

Monday

Tuesday

Wednesday

Thursday

Friday

Week 5: July 21, 2025 - July 25, 2025

Full Time (4-5 days)

Part Time (1-3 days)

Monday

Tuesday

Wednesday

Thursday

Friday

Week 6: July 28, 2025 - August 01, 2025

Full Time (4-5 days)

Part Time (1-3 days)

Monday

Tuesday

Wednesday

Thursday

Friday

Week 7: August 04, 2025 - August 08, 2025

Full Time (4-5 days)

Part Time (1-3 days)

Monday

Tuesday

Wednesday

Thursday

Friday

Week 8: August 11, 2025 - August 13, 2025 (This is a Part Time Week)

Part Time (1-3 days)

Monday

Tuesday

Wednesday

Please be sure to check all that apply.*

Please note*Summer SONCCA is open from 7:30 A.M. till 5:30 P.M.*

*

(Continued on next page)

PAYMENT AGREEMENT:

Enclosed is the \$35.00 non-refundable registration fee and the \$100 deposit payable by check, money order.

Please place a check-mark next to your choice.

A non-refundable deposit of \$100.00 is required at the time of registration by check or money order. The first four weeks balance of \$_____ to be paid by June 12th and a balance of \$_____ for the last four weeks less the deposit by July 10th.

Full tuition of \$_____ for weeks (circle weeks) 1-2-3-4-5-6-7-8 at the time of registration.

The first 4 weeks to be paid in full by June 12th and the last four weeks less your deposit by July 10th.

Tuition to be paid by Tuition Express. (Please sign both Tuition Express forms in regards to payment.)

Tuition fees are payable by Tuition Express, check or money order made out to:

SONCCA, Inc., 256 Bank Street, Seymour, CT 06483

I understand that these fees are payable regardless of the number of days my child attends. I understand that I will be liable for any and all collection fees, legal fees and court fees incurred by SONCCA in its attempt to collect all tuition and fees as agreed upon in this registration contract.

I have received a copy of the PARENT HANDBOOK or read the one on line, including the Discipline Policy, and agree to abide by the policies contained therein. I also grant permission to the following:

1. For the Site Supervisor or any other qualified staff member to take whatever steps may be necessary to obtain emergency medical care, if warranted. These steps may include, but are not limited to, the following:
 - A) Administering emergency first aid (by State-approved first aid certified SONCCA personnel);
 - B) Contacting the parent or guardian, either by calling them at their place of employment, or by attempting to contact them through any of the persons listed on the emergency information form. **(This form MUST be kept updated!);**
 - C) Contacting the child's physician or dentist;
 - D) Contacting another physician or calling an ambulance, if neither parent nor child's physician can be reached;
 - E) Accompanying your child in the ambulance to the hospital emergency room you have selected, if possible, otherwise, taking your child to Griffin Hospital;
 - F) Any expenses incurred will be borne by the parents.
2. For my child to use all of the playground equipment and to participate in all of the SONCCA program activities, unless exceptions are noted here:_____.
3. For my child to leave the school premises under the supervision of a staff member for neighborhood walks or for field trips provided that I signed the specific permission slip for the planned activity. Means of transportation, if any, will be noted.
4. For my child to be included in photographs and evaluations associated with the program.
5. I understand that SONCCA will not be responsible for anything that may happen as a result of false information given at the time of enrollment or during program period.
6. I understand that parents are responsible for the daily signing in and signing out of their children and that SONCCA will not assume responsibility for any child not signed in by a responsible adult upon arrival in the morning.
7. Parents are expected to carry insurance for their children. SONCCA does not carry "medical payments for children" insurance or pay medical reimbursement.
8. I give permission for financial information to be shared with _____, who is responsible for partially or totally paying for my child's tuition fee.

9. IF BOTH PARENTS DO NOT SIGN THIS PAGE AND BOTH PARENTS WANT TO BE ALLOWED TO PICK UP THEIR CHILD, THE OTHER PARENT'S NAME MUST BE INCLUDED ON THE AUTHORIZED PICK-UP PAGE.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

2025 SONCCA SUMMER PROGRAM REGISTRATION FORM

Child's Name: _____

Address: _____ Phone: _____

Age: _____ Date of Birth: _____ Gender: _____

Grade **Entering** in 9/25: _____ School: _____

T-Shirt Size: Youth Small (6-8) Youth Medium (10-12) Youth Large (14-16)

Adult Small (34-36) Adult Medium (38-40) Adult Large (42-44)

Mother's (Legal Guardian's) Name: _____

Date of Birth: _____ Address if different from above: _____
verification purpose

Place of Employment: _____

Business Address: _____

Cell Phone: _____ Business Phone: _____

Father's (Legal Guardian's) Name: _____

Date of Birth: _____ Address if different from above: _____
verification purpose

Place of Employment: _____

Business Address: _____

Cell Phone: _____ Business Phone: _____

Child's Physician: _____ Phone: _____

Address: _____

Child's Dentist: _____ Phone: _____

Address: _____

Hospital Preferred: _____

Health Insurance Company: _____ Policy #: _____

Please provide an e-mail address where you would like to receive correspondence.

E-mail: _____

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

ADMINISTRATIVE OFFICE USE ONLY:

Date Starting Program: _____
() Tuition Deposit Amount Received \$ _____ () Check # _____
() Registration Fee Enclosed () Check # _____
() Tuition Express Forms

Pro Care _____

Billing _____

2025 SONCCA SUMMER PROGRAM NOTIFICATION & CHILD RELEASE AUTHORIZATION

Child's Name: _____

If SONCCA cannot reach me, I authorize the following person(s) to be notified. I also authorize SONCCA to release my child to any of the following person(s). This (these) individual(s) have my permission to sign him/her in or out in the event that I am unable to do so. State regulations require that at least one person other than parents be listed (at least one of the persons listed must be local, within a 10-minute drive, and available for an emergency pickup). **Please cross out and initial any black areas, changes can only be made in person.**

Name: _____

Relationship: _____ Cell Phone: _____

Address: _____

Business Phone: _____ Home Phone: _____

Name: _____

Relationship: _____ Cell Phone: _____

Address: _____

Business Phone: _____ Home Phone: _____

Name: _____

Relationship: _____ Cell Phone: _____

Address: _____

Business Phone: _____ Home Phone: _____

Name: _____

Relationship: _____ Cell Phone: _____

Address: _____

Business Phone: _____ Home Phone: _____

Name: _____

Relationship: _____ Cell Phone: _____

Address: _____

Business Phone: _____ Home Phone: _____

I understand that my child will be permitted to leave SONCCA ONLY with those individuals listed above, all of whom are at least sixteen years of age.

I also understand that if both parents have not signed the forms and are not listed on this page, they will not be allowed to pick-up their child.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

**SONCCA SUMMER 2025
PROGRAM PHOTOGRAPH PERMISSION FORM**

Child's Name: _____

I give permission to SONCCA (Seymour-Oxford Nursery & Child Care Association, Inc.) to take and use photographs of my child participating in the SONCCA program for publicity and fund development purposes, some of which may be included on the SONCCA website.

I do not give permission to SONCCA (Seymour-Oxford Nursery & Child Care Association, Inc.) to take and use photographs of my child participating in the SONCCA program for publicity and fund development purposes, or to be shown on the SONCCA website

I also understand that SONCCA does take pictures and/or video for internal purposes only, even if I do not give permission for SONCCA to use them for publicity and fund development purposes, or to be used on the website. They are only for administrative purposes and are deleted.

Parent/Guardian's Signature: _____

Date: _____

**2025 SONCCA SUMMER PROGRAM
FIELD TRIP & TRANSPORTATION PERMISSION FORM**

Child's Name: _____

As parent/guardian of the above child, I/we give permission for my child to participate in and be transported to and from the following field trip:

Date: Wednesday, June 25, 2025

Departure Location: Seymour Middle School

Destination: **Woodlawn Duckpin Bowling** - 240 Platt Ave. West Haven CT 06516

Departure Time: 9:15 a.m.

Return Time: Between 1:30 p.m. & 2:00 p.m.

Return Location: Seymour Middle School

***CHILDREN NEED TO ARRIVE 45 MINUTES PRIOR TO DEPARTURE TIME IN ORDER TO BE READY AND IN THEIR GROUPS. THE BUS LEAVES PROMPTLY.**

I/We waive and release any and all rights and claims of any nature that I/we may have against SONCCA and any organizations connected with this event, their representatives, successors and assigns, for any and all injuries or damages which my child may suffer while taking part in any activities associated with this event.

PARENT/GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

**2025 SONCCA SUMMER PROGRAM
FIELD TRIP & TRANSPORTATION PERMISSION FORM**

Child's Name: _____

As parent/guardian of the above child, I/we give permission for my child to participate in and be transported to and from the following field trip:

Date: Wednesday, July 16, 2025

Departure Location: Seymour Middle School

Destination: **Quassy Amusement Park** - 2132 Middlebury Road, Middlebury, CT

Departure Time: 10:00 a.m.

Return Time: Between 5:00 p.m. & 6:00 p.m.

Return Location: Seymour Middle School

***CHILDREN NEED TO ARRIVE 45 MINUTES PRIOR TO DEPARTURE TIME IN ORDER TO BE READY AND IN THEIR GROUPS. THE BUS LEAVES PROMPTLY.**

I/We waive and release any and all rights and claims of any nature that I/we may have against SONCCA and any organizations connected with this event, their representatives, successors and assigns, for any and all injuries or damages which my child may suffer while taking part in any activities associated with this event.

PARENT/GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

**2025 SONCCA SUMMER PROGRAM
FIELD TRIP & TRANSPORTATION PERMISSION FORM**

Child's Name: _____

As parent/guardian of the above child, I/we give permission for my child to participate in and be transported to and from the following field trip:

Date: Wednesday, July 23rd, 2025

Departure Location: Seymour Middle School

Destination: **Urban Air** - 425 Bank Street, Waterbury, CT

Departure Time: 9:30 a.m.

Return Time: Between 1:30 p.m. & 2:00 p.m.

Return Location: Seymour Middle School

***CHILDREN NEED TO ARRIVE 45 MINUTES PRIOR TO DEPARTURE TIME IN ORDER TO BE READY AND IN THEIR GROUPS. THE BUS LEAVES PROMPTLY.**

I/We waive and release any and all rights and claims of any nature that I/we may have against SONCCA and any organizations connected with this event, their representatives, successors and assigns, for any and all injuries or damages which my child may suffer while taking part in any activities associated with this event.

***Parents must also sign the the Urban Air waiver form.**

PARENT/GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

2025 SONCCA SUMMER PROGRAM - MONDAY/FRIDAY LUNCH FORMS

Please indicate below if your child would prefer to bring their own lunch or will not be in attendance that day.

Child Name: _____

MONDAY

FRIDAY

June 23, 2025 No choice is needed; Ziti & Meatballs will be served. Pack Own Lunch Not in Attendance	June 27, 2025 No choice is needed; Pizza will be served. Pack Own Lunch Not in Attendance
June 30, 2025 No choice is needed; Chicken Tenders will be served. Pack Own Lunch Not in Attendance	July 4, 2025 <p style="text-align: center;">CLOSED Happy 4th</p>
July 7, 2025 No choice is needed; Mac & Cheese will be served. Pack Own Lunch Not in Attendance	July 11, 2025 No choice is needed; Pizza will be served. Pack Own Lunch Not in Attendance
July 14, 2025 No choice is needed; Ziti & Meatballs will be served. Pack Own Lunch Not in Attendance	July 18, 2025 No choice is needed; Pizza will be served. Pack Own Lunch Not in Attendance
July 21, 2025 No choice is needed; Chicken Tenders will be served. Pack Own Lunch Not in Attendance	July 25, 2025 No choice is needed; Pizza will be served. Pack Own Lunch Not in Attendance
July 28, 2025 No choice is needed; Mac & Cheese will be served. Pack Own Lunch Not in Attendance	August 1, 2025 No choice is needed; Pizza will be served. Pack Own Lunch Not in Attendance
August 4, 2025 No choice is needed; Ziti & Meatballs will be served. Pack Own Lunch Not in Attendance	August 8, 2025 No choice is needed; Pizza will be served. Pack Own Lunch Not in Attendance
August 11, 2025 <p style="text-align: center;">Fun Fair: Taco Bar</p> Pack Own Lunch Not in Attendance	

NOTE: All pizza lunches will have a side salad, Chicken Tenders with mashed potatoes, and mac and cheese with cut hot dogs. For all lunches, we will also offer Milk or 100% Juice.

Lunch

- A Field Trip Lunch Selection Form is provided and must be completed for children registered for the program during scheduled trip days. If your child requires a special diet, please provide lunch for him/her on those days.
- Parents must supply a brown bag lunch two days per week as indicated by the Activity Calendar. Lunches should include a beverage and ice pack for perishable foods. Please note that beverages should be stored in a thermos. Glass containers are not allowed. Cooler bags and lunch boxes are encouraged. Please do not pack lunches which require heating; unfortunately, the program does not have the facilities to accommodate that. If a child arrives on a brown bag day without a lunch, a \$6 charge will be added to the parent's account for the lunch supplied by the program.

Field Trips

- On scheduled field trip days, children must arrive to the site no later than 8:15 a.m.; buses leave promptly.
- A signed Field Trip Permission Form must be completed and on file for your child(ren) to attend field trips.
- Children must wear their Summer SONCCA T-shirt.
- If a scheduled field trip falls on a day a child is not registered to attend, the child may attend the trip for an additional charge of \$70.

Sign In/Sign Out

- All authorized pick-up people and Parents/Guardian should always have their ID with them at the door.
- Please be sure to include as many people needed on your pick up list last minute add-ons can not be accommodated via phone or email. If you need to add a person you must do it in person at the site or through the office several days in advance. This is for safety reasons.
- A staff member will be available at the door starting at 5PM, prior to 5PM upon arrival you will need to call the number posted on our white board.
Please be aware that cell phones often do not work in many sections of the school.
Thank You for your patience and understanding.

Time Change:

Please note our summer hours have changed, we will open for 7:30 A.M. and closing for 5:30 P.M.

Lunch, Field Trips, Sign In/Sign Out & Time Change- Parent Initial: _____

SNACK:

- Snack will only be provided by SONCCA on field trip days.
- Parents will need to provide two snacks per day for their child. You should send your child(ren) with a container that has their name on it. If the snack you provide is a cold snack, please be aware we do not have enough refrigerator space to store your child's snack, it should be sent in a appropriate container with an ice pack to keep items from perishing throughout the day. Please also keep in mind that we are a peanut free camp.

SNACK Parent Initial: _____
(I have read the above statement)

Wet `N' Wild Days

- **Parents are expected to ensure that their child(ren) arrive prepared for Wet "N" Wild Days. Children should have an appropriate bathing suit, water shoes, a towel and a plastic bag to store wet clothing items.**

Wet "N" Wild Days - Parent Initial: _____
(I have read the above statement)

Discipline Guidelines /Parent Handbook Acknowledgement

- SONCCA's Summer Program's discipline policy guidelines and behavior management techniques were discussed with me.
- I have received a copy of SONCCA's Summer Program handbook. I understand it is my responsibility to know the policies and procedures of the handbook.
- Parent Signature: _____ Date: _____

How did you hear about us?

- My child attends SONCCA during the school year.
- I got a flyer from my child's school.
- A friend told me about the program.
- Other: Please explain: _____

Thank You

**Parent/Guardian Authorization for the Administration of
Non-Prescription Topical Medications by Program Staff**

To Staff:

I hereby request that the following non-prescription topical medications be administered to my child by a staff member of the SONCCA Program.

I understand that I must supply SONCCA with the non-prescription topical medication in the original container labeled with the child's name, name of medication, and the directions of the medication administration.

Name of Child: _____ **Date of Birth:** _____

Address: _____

Name of Medication: _____

Schedule of Administration: _____

Site of Administration: _____

Reason medication is being administered: _____

Medication shall be administered from: _____ **to:** _____

Name of Parent/Guardian _____ **Date:** _____

I have administered at least one dose of the above medication to my child without adverse side effects.

Signature: _____ **Relationship to Child:** _____

Address: _____ **Telephone:** _____

STAFF:

Parents authorization form and medication received by: _____
Signature of Staff Person

Medication Started: _____ **Medication Ended:** _____
Date and Time **Date and Time**

**SONCCA 2025
SUMMER GRANT INFORMATION QUESTIONNAIRE**

It is through the receipt of grants that SONCCA is able to provide quality care for your child at reasonable tuition rates. The following information is requested from local, state, federal, and other funding sources as a grant submission and reporting requirement. Please note names are not required. This form will be removed from your child's file and placed in our Grant Statistics file to be used when grant applications are made. If you wish, you may remove it from the rest of the packet and send it to the office separately.

Please place a checkmark or fill in all blanks, as appropriate:

Town: Seymour Oxford

Child's age: _____ Gender: _____ Grade as of September 2025: _____

Child's heritage:

Asian African-American Caucasian Hispanic Native American

Other, Please write in: _____

Family Size: _____ Number of Adults: _____ Number of Children: _____

Number of parents/guardians in the household: _____

Number of parents/guardians working: _____ in training: _____

Income: A: \$23,850 - \$32,913
 B: \$32,913 - \$47,700
 C: \$47,700 - \$71,500
 D: \$71,500 - \$110,000
 E: More than \$110,00

Child is cared for by: Parent(s)
 A "supervising adult" (grandparents, foster parents, etc.)



State of Connecticut Department of Education

Health Assessment Record



To Parent or Guardian:

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

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

Does your child have health insurance?	Y	N	If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have dental insurance?	Y	N	

* If applicable

Part 1 — To be completed by parent/guardian.

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

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

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

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

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

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height _____ in. / _____ % *Weight _____ lbs. / _____ % BMI _____ / _____ % Pulse _____ *Blood Pressure _____ / _____

Table with columns for Normal and Describe Abnormal for Neurologic, HEENT, *Gross Dental, Lymphatic, Heart, Lungs, Abdomen, Genitalia/ hernia, and Skin. Includes Ortho section for Neck, Shoulders, Arms/Hands, Hips, Knees, Feet/Ankles, and *Postural assessment.

Screenings * According to Bright Future's Periodicity Schedule

Table for Screenings including *Vision Screening, *Auditory Screening, *History of Lead Level, *Speech, and *HCT/HGB.

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, Anaphylaxis, Allergies, Diabetes, Seizures assessment items with checkboxes and instructions.

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 or participate with restriction/adaptation:

This student may: participate fully in athletic activities and competitive sports or participate with restriction/adaptation:

Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness. Is this the student's medical home? Yes No I would like to discuss information in this report with the school nurse.

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

Part 3 — Oral Health Assessment/Screening
Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

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

Recommendation(s) by health care provider: _____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian _____ Date _____

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	Date Signed	Printed/Stamped <i>Provider</i> Name and Phone Number
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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 _____

<p>of above _____ (Specify)</p> <p>Religious Exemption: _____</p> <p>Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.</p>	<p>(Date) _____ (Confirmed by) _____</p> <p>Medical Exemption: _____</p> <p>Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf</p>
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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 the 1st 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 the 1st 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 _____
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