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 Friday, August 23, 2019. 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 EVLUATION & 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 Statues 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 23, 2019

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.

GLASTONBURY PARKS & RECREATION
Kangaroo Kids Preschool - Child Information Form

Child's Name:_____ Nick Name:_____ Date of Birth:_____

Address:_____ Home Phone:_____

Check off the session/days your child is enrolled:

AM 3&4:	AM3&4:	AM 3&4:	PM 4:
Monday 9:00-11:30 ____	Tuesday 9:00-11:30 ____	Monday 9:00-11:30____	Monday 12:30-3:00____
Thursday 9:00-11:30 ____	Friday 9:00-11:30 ____	Tuesday 9:00-11:30____	Tuesday 12:30-3:00____
		Thursday 9:00-11:30____	Thursday 12:30-3:00____
		Friday 9:00-11:30____	Friday 12:30-3:00____

Parent/Guardian Information:

Name of Parent/Guardian(s) and where they may be **reached** by phone during the day in case of a problem/emergency

Mother/Guardian:_____ Father/Guardian:_____

Address:_____ Address:_____

Phone#'s: _____ (home) Phone#'s: _____ (home)

_____ (cell) _____ (cell)

_____ (day/work) _____ (day/work)

Email: _____ Email: _____

Emergency/Other Contacts:

Provide us the names of person(s) you want us to contact in the event the Parent/Guardian cannot be reached. Every effort will be made to contact Parent/Guardian first, but if you cannot be reached the following will be contacted. Please be sure to provide phone numbers where the people may be **reached** during the day.

1. Name:_____ Relationship to Child: _____

Phone #s: _____ (home)
_____ (cell)
_____ (day/work)

I give permission for the Kangaroo Kids staff to allow the above person to pick up my child when requested by the Parent/Guardian(s).
YES ☐ NO ☐

In an emergency, I give permission for the above person to assume temporary care and to provide transportation for my child if we, the Parent/Guardian(s) cannot be notified. YES ☐ NO ☐

2. Name:_____ Relationship to Child: _____

Phone #s: _____ (home)
_____ (cell)
_____ (day/work)

I give permission for the Kangaroo Kids staff to allow the above person to pick up my child when requested by the Parent/Guardian(s).
YES ☐ NO ☐

In an emergency, I give permission for the above person to assume temporary care and to provide transportation for my child if we, the Parent/Guardian(s) cannot be notified. YES ☐ NO ☐

Field Trip Consent

☐ I consent that my child,_____ while a registered participant in the Kangaroo Kids program, be permitted to participate in scheduled off-site activities. The Parent/Guardian will be notified of activities in advance.

Photographs

☐ I give permission for films or photographs of my child,_____ while a registered participant in the Kangaroo Kids program to be used in Glastonbury Parks & Recreation Department public relations programs.

The information outlined on this form has been completed by me and has my approval

Signature of Parent/Guardian:_____ Date_____

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

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

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander	
Primary Health Care Provider: Name of Dentist:	❑ White, not of Hispanic origin ❑ 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			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months	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			6. Interaction with others	Y	N	Eating concerns	Y	N
to another	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

ED 191 REV. 8/2011

Part II — Medical Evaluation

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

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

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

Physical Exam

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

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

Screenings

***Vision Screening**

❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)

❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess

❑ Referral made to: _____

***Hearing Screening**

❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)

❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess

❑ Referral made to: _____

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

***Hgb/Hct:** *Date

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

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

GLASTONBURY PARKS & RECREATION

Kangaroo Kids Preschool

EMERGENCY MEDICAL CARE

EMERGENCY STATEMENT

If in the opinion of the Parks & Recreation program Staff, emergency transportation to a hospital is required, 911 will be called. Should emergency transportation to a hospital be required, it will be coordinated by Emergency Medical Services (EMS). Parent/Guardians will be notified by the numbers provided under the Parent/Guardian Information listed below as soon as possible. If a child is transported by ambulance, a staff member will accompany them until a Parent/Guardian arrives at the hospital.

Child's Name:_____ Birthdate:_____

1. Mother/Guardian:_____ Address:_____ Town/Zip Code:_____

   Phone #s: _____ (home)
   _____ (cell)
   _____ (day/work)

2. Father/Guardian:_____ Address:_____ Town/Zip Code:_____

   Phone #s: _____ (home)
   _____ (cell)
   _____ (day/work)

MEDICAL INFORMATION

Child's Name:_____ Birthdate:_____

Medical History:_____

Known Allergies:_____

All Medications Currently Taking:_____

Insurance Carrier:_____

Insurance ID #:_____

EMERGENCY/OTHER CONTACTS

Provide us the names of person(s) you want us to contact in the event the Parent/Guardian cannot be reached. Every effort will be made to contact Parent/Guardian first, but if you cannot be reached the following will be contacted. Please be sure to provide phone numbers where the people may be **reached** during the day.

1. Name:_____ Relationship to Child: _____

   Phone #s: _____ (home)
   _____ (cell)
   _____ (day/work)

   In an emergency, I give permission for the above person to assume temporary care and to provide transportation for my child if we, the Parent/Guardian(s) cannot be notified. YES ☐ NO ☐

2. Name:_____ Relationship to Child: _____

   Phone #s: _____ (home)
   _____ (cell)
   _____ (day/work)

   In an emergency, I give permission for the above person to assume temporary care and to provide transportation for my child if we, the Parent/Guardian(s) cannot be notified. YES ☐ NO ☐

_____ _____ _____

Parent/Guardian 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 authorizations(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_____/_____/_____ Todays 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).

GLASTONBURY PARKS & RECREATION – KANGAROO KIDS

Parent/Guardian Authorization for Administration of Non-Prescription Topical Medications by Child Care Personnel

To Child Care Personnel:

I hereby request that the following non-prescription topical medication be administered to my child by a child care staff member of the Kangaroo Kids program.

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

This authorization is limited to the following topical medications:

1. Ointments free of antibiotic, antifungal or steroidal medications
2. Medicated powders
3. Gum or lip medications

Name of Child:_____ Date of Birth:____/____/____

Address:_____

Name of Medication:_____

Schedule of Administration:_____

Site of Administration:_____

Reason medication is being administere:_____

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 TO COMPLETE

Parent authorization and medication received by:_____
(Print Name) (Signature)

Medication Started:_____(Date and Time)

Medication Ended:_____(Date and Time)

**File this Form and Medication Administration Record with child's health record when medication has stopped.*