2020 Summer Day Camp Registration Packet

Registration begins

Registration Checklist

☐ 2019 Federal Income Tax Return *(No W2’s)*
☐ Updated Immunization & Health Exam Records from Physician
☐ Completed 2020 Summer Day Camp Registration Card
☐ Completed Permission Slips for Field Trips
☐ Read Shehan Center Rules and Guidelines
☐ Payment
   
   NO REGISTRATION will be complete without full payment.
   All cash, credit or check payments must be made in full for each Session, Field Trip, etc.
   Deposits/partial payments are not accepted.

☐ Current Authorization for the Administration of Medication Form
   Completed by Physician. All medications are due the first day of camp,
   labeled “Camp” in original packaging with prescription, child’s name, and directions for use.
   OR

☐ Medical Liability Release Form
   If you do not wish to provide medication

All forms are available at the Cardinal Shehan Center lobby!
2020 SUMMER DAY CAMP POLICIES & PROCEDURES

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

You Need the Following to Register Your Child
1. A copy of your 2019 Federal Income Tax Return (Pay stubs and/or W-2 forms are not accepted)
2. Completed registration form
3. Full payment for the camp session you wish to put your child in AND full payment for the field trip that falls in each session. (Field trip fees must be paid at the time you make your payment for each session. Field trip fees can not be paid separately. If the payment is not made at the time of registration, your child will not be allowed to go).
4. An up-to-date physical WITH immunization records for each child attending.
5. Campers Needing Medicine: (inhaler, allergy pens, etc.) must have medical authorization form signed by doctor and handed in at time of registration. Must bring in all medicine on the medical authorization form in ORIGINAL PACKAGING-(with prescription, child’s name, and direction on the package). NO EXCEPTIONS. This is a state requirement. If they do not wish to bring the medicine in, parent/guardian must sign a medical release form. ALL CAMPERS MEDICINE MUST BE HANDED IN ON THE FIRST DAY OF CAMP OR BEFORE. CHILD MAY NOT ATTEND CAMP IF THEY ARE REQUIRED BY A DOCTOR TO HAVE MEDICINE AT CAMP AND DO NOT BRING THAT MEDICINE.

CHILDREN CAN NOT BE REGISTERED WITHOUT ALL OF THE ABOVE LISTED ITEMS!

PLEASE NOTE
No discounts or refunds will be given for partial session attendance, the cancellation of a session, or switching a session. We DO NOT take payment deposits to hold a spot for your child. If you are switching from one session to another, the switch must be completed at the registration desk the Wednesday before that session begins. There will be a $15.00 administration fee for switching from a previously registered session into a new session.

REMINDERS
Breakfast and Lunch are provided daily at the Cardinal Shehan Center Children.
All Campers must be completely potty-trained and able to dress him/herself in the bathroom/locker room.
Late fees will be charge for children dropped off early or picked up late.

THANK YOU FOR CHOOSING THE CARDINAL SHEHAN
Norma F Pfriem 2020
Summer Day Camp

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

Camper’s Name ___________________________  □ Boy  □ Girl  Grade Entering in Fall 2020____________________

Date of Birth ___________________________ Age as of 07-01-2020 ___________________________ T-shirt size: YS YM YL AS AM AL AXL

Race (for funding purposes only):  □ Caucasian  □ African American  □ Hispanic  □ Asian  □ Other ____________

Street ___________________________ City/State/Zip ___________________________

Mother ___________________________ Cell Phone ___________________________ Email ___________________________

Father ___________________________ Cell Phone ___________________________ Email ___________________________

Emergency Contact ___________________________ Home Phone ___________________________ Cell Phone ___________________________

Adults 18+ Authorized to Pick-up Child: No one else will be permitted to pick-up child unless cleared by Director. Must show ID at pick-up. PLEASE PROVIDE FULL NAMES AS STATED ON ID.

Mother ___________________________ Father ___________________________ Other ___________________________

Other ___________________________ Other ___________________________ Other ___________________________

Anyone NOT allowed to pick-up child: ________________________________________________________________

PARENT/GUARDIAN AUTHORIZATION (REQUIRED FOR ALL PERSONS UNDER AGE 18)
The health history presented for the camper named on this registration card is correct, and I give him/her permission to participate in all camp activities and registered field trips, except noted by me or examining physician. I agree to all terms and conditions presented on this registration card and all other Cardinal Shehan Center informational paperwork. The Cardinal Shehan Center and all outside affiliates are granted the right to use any and all pictures taken of camp activities in their publication of promotional materials. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the Director to hospitalize, secure proper treatment for, and order injection and/or anesthesia for surgery for the person.

PARENT/GUARDIAN SIGNATURE: ___________________________ Date: ___________________________

Space is limited and registration is subject to availability!

<table>
<thead>
<tr>
<th>Summer Day Camp Sessions:</th>
<th>Deadline:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: June 22 - June 26</td>
<td>June 19</td>
</tr>
<tr>
<td>Session 2: July 29 - July 2</td>
<td>June 26</td>
</tr>
<tr>
<td>Session 3: July 6 - July 10</td>
<td>July 2</td>
</tr>
<tr>
<td>Session 4: July 13 - July 17</td>
<td>July 10</td>
</tr>
<tr>
<td>Session 5: July 20 - July 24</td>
<td>July 17</td>
</tr>
<tr>
<td>Session 6: July 27 - July 31</td>
<td>July 24</td>
</tr>
<tr>
<td>Session 7: August 3 - August 7</td>
<td>July 31</td>
</tr>
<tr>
<td>Basketball/Swim Camp August 10- August 14</td>
<td>Aug 7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Family Income</th>
<th>1 Child</th>
<th>2 Children</th>
<th>3 Children</th>
<th>4+ Children</th>
</tr>
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<tbody>
<tr>
<td>Less than $10,000</td>
<td>$80</td>
<td>$75</td>
<td>$70</td>
<td>$65</td>
</tr>
<tr>
<td>$10,001-$20,000</td>
<td>$90</td>
<td>$85</td>
<td>$80</td>
<td>$75</td>
</tr>
<tr>
<td>$20,001-$30,000</td>
<td>$100</td>
<td>$95</td>
<td>$90</td>
<td>$85</td>
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<tr>
<td>$30,001-$40,000</td>
<td>$110</td>
<td>$105</td>
<td>$100</td>
<td>$95</td>
</tr>
<tr>
<td>$40,001-$50,000</td>
<td>$120</td>
<td>$115</td>
<td>$110</td>
<td>$105</td>
</tr>
<tr>
<td>$50,001-$60,000</td>
<td>$130</td>
<td>$125</td>
<td>$120</td>
<td>$115</td>
</tr>
<tr>
<td>Over $60,000</td>
<td>$140</td>
<td>$135</td>
<td>$130</td>
<td>$125</td>
</tr>
</tbody>
</table>
Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family 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.)
# Medication Administration Record (MAR)

**Name of Child/Student**

**Date of Birth** __/__/__

**Pharmacy Name**

**Prescription Number**

**Medication Order**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Dosage</th>
<th>Remarks</th>
<th>Was This Medication Self Administered?</th>
<th>Signature of Person Observing or Administering Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Yes</td>
<td>No</td>
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<td>Yes</td>
<td>No</td>
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<td>Yes</td>
<td>No</td>
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<td></td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*Medication authorization form must be used as either a two-sided document or attached first and second page.

- [ ] Authorization form is complete
- [ ] Medication is appropriately labeled
- [ ] Medication is in original container
- [ ] Date on label is current

**Person Accepting Medication (print name)** ___________________________ **Date** __/__/__
State of Connecticut Department of Education  
Health Assessment Record

To Parent or Guardian:

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

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine. An advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

<table>
<thead>
<tr>
<th>Student Name (Last, First, Middle)</th>
<th>Birth Date</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, Town and ZIP code)</td>
<td>Home Phone</td>
<td>Cell Phone</td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian Name (Last, First, Middle)</td>
<td>Race/Ethnicity</td>
<td>Black, not of Hispanic origin</td>
<td></td>
</tr>
<tr>
<td>School/Grade</td>
<td>American Indian/</td>
<td>White, not of Hispanic origin</td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>Alaskan Native</td>
<td>Asian/Pacific Islander</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hispanic/Latino</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Health Insurance Company/Number* or Medicaid/Number*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call 1-877-CT-HUSKY

*If applicable

Part I — To be completed by parent/guardian.

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

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

<table>
<thead>
<tr>
<th>Any health concerns</th>
<th>Y N</th>
<th>Hospitalization or Emergency Room visit</th>
<th>Y N</th>
<th>Concussion</th>
<th>Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies to food or bee stings</td>
<td>Y N</td>
<td>Any broken bones or dislocations</td>
<td>Y N</td>
<td>Fainting or blacking out</td>
<td>Y N</td>
</tr>
<tr>
<td>Allergies to medication</td>
<td>Y N</td>
<td>Any muscle or joint injuries</td>
<td>Y N</td>
<td>Chest pain</td>
<td>Y N</td>
</tr>
<tr>
<td>Any other allergies</td>
<td>Y N</td>
<td>Any neck or back injuries</td>
<td>Y N</td>
<td>Heart problems</td>
<td>Y N</td>
</tr>
<tr>
<td>Any daily medications</td>
<td>Y N</td>
<td>Problems running</td>
<td>Y N</td>
<td>High blood pressure</td>
<td>Y N</td>
</tr>
<tr>
<td>Any problems with vision</td>
<td>Y N</td>
<td>“Mono” (past 1 year)</td>
<td>Y N</td>
<td>Bleeding more than expected</td>
<td>Y N</td>
</tr>
<tr>
<td>Uses contacts or glasses</td>
<td>Y N</td>
<td>Has only 1 kidney or testicle</td>
<td>Y N</td>
<td>Problems breathing or coughing</td>
<td>Y N</td>
</tr>
<tr>
<td>Any problems hearing</td>
<td>Y N</td>
<td>Excessive weight gain/loss</td>
<td>Y N</td>
<td>Any smoking</td>
<td>Y N</td>
</tr>
<tr>
<td>Any problems with speech</td>
<td>Y N</td>
<td>Dental braces, caps, or bridges</td>
<td>Y N</td>
<td>Asthma treatment (past 3 years)</td>
<td>Y N</td>
</tr>
</tbody>
</table>

Family History

Any relative ever have a sudden unexplained death (less than 50 years old) | Y N | Seizure treatment (past 2 years) | Y N |
Any immediate family members have high cholesterol | Y N | Diabetes | 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

HAR-3 REV. 4/2017

To be maintained in the student’s Cumulative School Health Record
Part II — Medical Evaluation
Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name ___________________________ Birth Date __________ Date of Exam __________
☐ I have reviewed the health history information provided in Part I of this form

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

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

<table>
<thead>
<tr>
<th>Normal</th>
<th>Describe Abnormal</th>
<th>Normal</th>
<th>Describe Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurologic</td>
<td></td>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td>Shoulders</td>
<td></td>
</tr>
<tr>
<td>*Gross Dental</td>
<td></td>
<td>Arms/Hands</td>
<td></td>
</tr>
<tr>
<td>Lymphatic</td>
<td></td>
<td>Hips</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td>Knees</td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td>Feet/Ankles</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td>*Postural ☐ No spinal abnormality ☐ Spine abnormality: ☐ Mild ☐ Moderate ☐ Marked ☐ Referral made</td>
<td></td>
</tr>
<tr>
<td>Genitalia/ hernia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Screenings

*Vision Screening
Type: Right Left
With glasses 20/ 20/
Without glasses 20/ 20/
☐ Referall made

*Auditory Screening
Type: Right Left
☐ Pass ☐ Pass ☐ Fail ☐ Fail ☐ Referall made

History of Lead level ≥ 5μg/dL ☐ No ☐ Yes

*HCT/HGB:

*Speech (school entry only)

Other:

TB: High-risk group? ☐ No ☐ Yes
PPD date read: ___________________________
Results: ___________________________
Treatment: ___________________________

*IMMUNIZATIONS
☐ Up to Date or ☐ Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

*Chronic Disease Assessment:

Asthma ☐ No ☐ Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise induced
If yes, please provide a copy of the Asthma Action Plan to School

Anaphylaxis ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Unknown source

Allergies ☐ No ☐ Yes: ☐ History of Anaphylaxis ☐ No ☐ Yes: Epi Pen required ☐ No ☐ Yes
If yes, please provide a copy of the Emergency Allergy Plan to School

Diabetes ☐ No ☐ Yes: ☐ Type I ☐ Type II ☐ Other Chronic Disease:

Seizures ☐ No ☐ Yes, type:

☐ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.

Explain:

Daily Medications (specify): ___________________________

This student may: ☐ participate fully in the school program
☐ participate in the school program with the following restriction/adaptation:

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

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

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

To the Health Care Provider: Please complete and initial below.

<table>
<thead>
<tr>
<th>Vaccine (Month/Day/Year)</th>
<th>Note:</th>
<th>Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dose 1</td>
<td>Dose 2</td>
<td>Dose 3</td>
</tr>
<tr>
<td>DTP/DTaP</td>
<td>*</td>
<td>*</td>
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<tr>
<td>DT/Td</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>IPV/OPV</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>MMR</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>*</td>
<td></td>
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<tr>
<td>Hib</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Hep A</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Hep B</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Varicella</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>PCV</td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>HPV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu</td>
<td>*</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Disease Hx of above</th>
<th>(Specify)</th>
<th>(Date)</th>
<th>(Confirmed by)</th>
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<tbody>
<tr>
<td>Exemption: Religious</td>
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</tr>
<tr>
<td>Medical: Permanent</td>
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<td></td>
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<tr>
<td>Temporary</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Renew Date</td>
<td></td>
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</tbody>
</table>

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

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

**KINDERGARTEN THROUGH GRADE 6**

- DTP: 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 started 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.
Summer Day Camp 2020
Medical Liability Release Form

Child’s Name: ____________________________________________

Parent/Guardian Name: ____________________________________

Today’s Date: ____________________________________________

I, ____________________________________________, have chosen to not provide the Administration of Medication form that was offered and provided to me by the Cardinal Shehan Center in regards to my child: ____________________________________________.

I understand that his or her physical form shows an allergy or medical condition that may require the administration of medication. I am aware of the risks of not having the required medication and I understand that in an emergency, the Cardinal Shehan Center is not liable for the administration of medication. The Camp Directors will contact Emergency Medical Response if the child is having a medical issue related to child’s medical history.

__________________________________________  _____________
Parent/Guardian Signature                          Date
Behavior Policies:

Three strike policy:
1. First offense: warning.
2. Second offense: second strike given and age-appropriate time-out.
3. Conduct referral write up and sent to camp director. Camp director will determine punishment based on behavior.

Immediate conduct referrals:
1. Verbal fighting/inappropriate language
2. Disrespectful to staff
3. Third strike

Immediate conduct referral with suspension:
1. Hitting/fighting: 1-3 day suspension
2. Vandalism or destruction of property: 1-2 day suspension
3. Stealing: 1-2 day suspension
4. Inappropriate touching/behavior: 1-2 day suspension

Conduct referral Consequences:
1. Any camper receiving 2+ conducts in one day = 1 day suspension.
2. 3 or more conduct referrals in a week = 2 day suspension.
3. Conducts may result in the loss of field trip

**If a child is suspended during a scheduled field trip, the child will not be allowed to participate in the field trip. No refunds for field trips are given.

Extra Fees:

1. Campers dropped off before 8:30am who are not registered and paid for EARLY MORNING DROP OFF will be charged a **$15.00 Fee**. Please do not drop off your child early if not registered for Early Morning Drop Off.

2. Regular camp ends at 3:00PM. Campers who are **not** picked up by 3:15pm will be charged a **late fee of $15.00**. Families will be charged an additional dollar per minute for every minute after 3:30pm.

3. Extended day ends at 5:00pm. Campers who are registered for Extended Day must be picked up by 5:00pm. Campers picked up after 5:15pm will be charged a **late fee of $15.00**. Families will be charged an additional dollar per minute for every minute after 5:30pm.

Reimbursement Policies:

Please note that **no refunds or reimbursements** will be given for partial camp session attendance, the cancellation of a session, or the switching of a session.

If you need to cancel a previously registered session, the cancellation must be done by the **Wednesday** before the session begins.

If you wish to switch sessions, the switch must be done at the Registration Desk by the **Wednesday** before the start of the sessions. There will be a $15.00 administration fee for switching from a previously registered session into a new session. Switching of a registration week can only be done if there is availability.

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2020 Summer Camp

Parent Info Brochure

Camp Sessions:

<table>
<thead>
<tr>
<th>Session 1: June 22 - June 26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2: June 29 - July 2</td>
</tr>
<tr>
<td>Session 3: July 6 - July 10</td>
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<tr>
<td>Session 4: July 13 - July 17</td>
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<tr>
<td>Session 5: July 20 - July 24</td>
</tr>
<tr>
<td>Session 6: July 27 - July 31</td>
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<td>Session 7: August 3 - August 7</td>
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</tbody>
</table>

Basketball or Swim Camps

Camp Director: Kathy Giglio

August 10 - August 14

Cardinal Shehan Center
1494 Main Street,
Bridgeport, CT 06604
(203) 336-4468

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**What to bring to Camp:**

PLEASE LABEL EVERYTHING!
1. Cold lunch (if not eating camp lunch)
2. Athletic clothing and closed-toe shoes
3. Swimwear: Towel, bathing suit, googles, shower supplies
4. Camp t-shirt (on field trip days only)

**What NOT to bring to Camp:**
1. Electronics (including game systems, tablets, music devices, cellphones, etc.)
2. Jewelry
3. Hats (unless for outside use)

**The Shehan Center is not liable for lost or stolen belongings. Please do not bring anything valuable to camp. The locker rooms are there for your needs. Please bring your own lock if you wish to lock your children's belongings. Locks must be removed from the lockers at the end of each camp day.**

**Field Trip Policies:**
1. All field trips must be registered, paid for, and permission slips must be signed at the time of camp registration. **NO EXCEPTIONS**
2. Buses will leave at the scheduled time. If campers are not present at the time of departure, they will miss the field trip. **NO REFUNDS** are given for missed trips.
3. **NO REFUNDS ARE GIVEN FOR FIELD TRIPS.** All of the tickets are bought and buses are preordered and paid for.
4. Parents may not pick up their child from a field trip without prior verbal and written consent by the camp director.
5. There are no exceptions to these policies.

**Summer Day Camp**

**Overview:**
- Regular camp hours: 8:30am - 3:00pm
- Extended hours: Early morning begins at 7:30am ($20.00 a week). Extended day is from 3:00pm - 5:00pm ($30.00 a week).
- Breakfast and lunch are served at camp.
- Please bring snacks, as they will not be provided.
- Campers should be in athletic wear, please no sandals.
- Space will **NOT** be held or reserved for any session that is not paid for in full. This means if you have paid for sessions 1 and 2, but not 3-7, your child does not have space in sessions 3-7 until you make the payment.

**Medication Policies:**
1. All medication must be in the original container, with label from the pharmacy. For prescriptions and Epi-pens, parents and Licensed Prescribers (i.e. child's doctor) must fill out a written order form.
2. Children may **NOT** bring non-prescription medications to camp! (lotions, over the counter, etc.).
3. A camper will not be able to start camp until all paper work and medication in the original container is given to the Center and Camp Nurse.
4. Please see the Camp Director if you have questions.

**Camper Drop Off and Pick-Up Policies:**

**Drop Off:**
1. Campers must be dropped off at their registered time. (EARLY MORNING: 7:30am, REGULAR: 8:30am). Campers dropped off before their registered time will be charged an early drop-off fee.
2. Campers must be dropped off by their guardian. No one younger than 16 may drop off or pick up a child.

**Pick Up:**
1. Campers may only leave with the authorized individuals written on the original application form. If changes must be made to the list, they must be done in person.
2. ALL authorized individuals MUST HAVE PROPER PHOTO IDENTIFICATION EACH TIME THEY PICK UP THE CHILD. THERE ARE NO EXEMPTIONS TO THIS POLICY.
3. No campers may walk home.
4. All campers must be picked up at their registered time. (REGULAR: 3:00pm, EXTENDED DAY: 5:00pm). Campers not picked up by their registered time will be charged a late fee.
5. If you, or anyone on your authorized pick up list is not available to pick up your child, we will need a written letter by the guardian stating who will be picking up your child with the guardian's signature. This may be faxed or emailed over. The child will not be allowed to leave the building with anyone not on the pickup list, without the Director being properly notified prior to dismissal. In addition to fax or letter, a phone call must be made to confirm/change.
<table>
<thead>
<tr>
<th>Annual Family Income</th>
<th>1 Child</th>
<th>2 Children</th>
<th>3 Children</th>
<th>4+ Children</th>
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