



Dear Parents,

Camp Mahackeno is this county's premier summer day camp. It's got everything to make your child's summer one to remember:

Swimming \* Canoeing \* Sports \* Rock Wall \* Arts & Crafts \* Nature/Science \* Archery \* much more

Plus, you know that this will be positive experience, as the Y is for:

- Youth Development
- Healthy Living
- Social Responsibility

Also, I am pleased to announce:

**2012 rates are lower than 2011!**

Simply complete and return the attached forms (you may want to hold on to the physical assessment form for your camper's next doctor appointment). This is going to be an amazing summer at Camp Mahackeno! Contact me at any time with questions. Also, check out more about the camp at [www.westporty.org](http://www.westporty.org)

Thanks for being a part of the Westport Weston Family Y!

David Cohen

VP, Operations

[dcohen@westporty.org](mailto:dcohen@westporty.org)

(203) 226-8981 x109



WESTPORT WESTON FAMILY Y

# CAMP MAHACKENO SUMMER 2012 REGISTRATION FORM

Use separate form for each camper. Print information clearly.  
Incomplete applications will not be accepted or processed.

Camper's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade completed: \_\_\_\_\_ School as of Sept. 2012: \_\_\_\_\_

T-Shirt: Youth  Small  Medium  Large Adult  Small  Medium  Large

Buddy Request: \_\_\_\_\_

We will do our best but cannot guarantee that requests will be met. One request per camper. Each camper must request each other. **Camper's need to be in the same grade.**

### PLEASE CHECK:

Is your child a returning camper from last year?  Yes  No

Is your child a member of the Westport Weston Family Y?  Yes  No

How did you hear about Camp Mahackeno? \_\_\_\_\_

### PARENTS' (GUARDIAN) INFORMATION: (All Information MUST be filled out)

Parent/Guardian Name (A): \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Email:\* \_\_\_\_\_

Employer name: \_\_\_\_\_

Parent/Guardian Name (B): \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Email:\* \_\_\_\_\_

Employer name: \_\_\_\_\_

\*Critical for communication

### EMERGENCY CONTACTS:

In case of emergency, and the Camp staff is unable to reach the parents/guardians listed above, the following individuals have permission to make decisions regarding the care of my child. The emergency contacts listed below are also authorized for pick up at the end of the day. PHOTO ID will be required in order for camper to be released.

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

MEMBERSHIP USE ONLY

RCVD: \_\_\_\_\_

TIME: \_\_\_\_\_

DATE: \_\_\_\_\_

OFFICE USE ONLY

Date \_\_\_\_\_

CB \_\_\_\_\_

DAX \_\_\_\_\_

Nurse \_\_\_\_\_

Acct \_\_\_\_\_



WESTPORT WESTON FAMILY Y

# CAMP MAHACKENO REGISTRATION FORM

Choose your two-week sessions

**LESS THAN LAST YEAR'S RATES!**

Your \$200 deposit secures your spot!

**CAMPER'S NAME:** \_\_\_\_\_

Use a separate form for each camper. Print information clearly.

<b>ALL CAMPERS</b>	<b>CAMP MAHACKENO SCHEDULE &amp; FEES</b>					
	PLEASE CIRCLE SESSION(S) FOR WHICH YOU WOULD LIKE TO REGISTER					
Group – grade camper will enter in Fall 2012	Session 1 June 25-July 6	Session 2 July 9-20	Session 3 July 23-Aug 3	Session 4 Aug 6-17	SEW Aug 20-24	TOTAL
Shawnee (1st grade)	\$648	\$720	\$720	\$720	\$410	
Mohegan (2nd grade)	\$648	\$720	\$720	\$720	\$410	
Lakota (3rd grade)	\$630	\$700	\$700	\$700	\$410	
Cayuga (4th grade)	\$630	\$700	\$700	\$700	\$410	
Apache (5th grade)	\$630	\$700	\$700	\$700	\$410	
Rangers (6th & 7th grade)	\$693	\$770	\$770	\$770	\$410	
Leaders in Training (grades 8 & 9; ages 13 & 14)	\$513	\$570	\$570	\$570	\$410	
Counselors in Training (grade 10; age 15)	\$513	\$570	\$570	\$570	\$410	
Special Cares	\$828	\$920	\$920	\$920	\$410	
SUBTOTAL FOR REGISTRATION \$						_____

<b>OPTION #1</b>	<b>EXTENDED HOURS &amp; FEES</b>					
	PLEASE CIRCLE SESSION(S) FOR WHICH YOU WOULD LIKE TO REGISTER					
	Session 1 June 25-July 6	Session 2 July 9-20	Session 3 July 23-Aug 3	Session 4 Aug 6-17	SEW Aug 20-24	TOTAL
Sunrise (8:00-9:00am)	\$90	\$100	\$100	\$100	\$100	
Sunset (4:00-6:00pm)	\$135	\$150	\$150	\$150	\$135 (M-Th only)	
SUBTOTAL FOR EXTENDED HOURS \$						_____

<b>OPTION #2</b>	<b>BUS SERVICE &amp; FEES</b>					
	PLEASE CIRCLE SESSION(S) FOR WHICH YOU WOULD LIKE TO REGISTER					
	Session 1 June 25-July 6	Session 2 July 9-20	Session 3 July 23-Aug 3	Session 4 Aug 6-17	SEW Aug 20-24	TOTAL
Bus Service, AM	\$90	\$100	\$100	\$100	(no bus service)	
Bus Service, PM	\$90	\$100	\$100	\$100	(no bus service)	
SUBTOTAL FOR BUS SERVICE \$						_____



WESTPORT WESTON FAMILY Y

# PARENT OR GUARDIAN AGREEMENT

**CAMPER'S NAME:** \_\_\_\_\_  
Use a separate form for each camper. Print information clearly.

I understand that the Westport Weston Family Y (Y) is a non-profit organization which makes its facilities, programs and activities available to persons only on the condition that they agree to assume complete responsibility for any injury or damage. I acknowledge that the Y's programs and activities may involve risk, and assume those risks for my child. Further, in consideration, of acceptance of my child into the Y's camp and/or its sponsored program and activities, I release and hold harmless the Y, its officers, directors, employees and staff, from any claim for damage or loss (including but not limited to physical injury and property damage) that may occur as a result of my child's participation in any Y sponsored program or activity. I hereby give the forgoing release on behalf of myself, my child, and all family members, and confirm that I am authorized to do so. I understand that the Y does not carry medical/accident insurance, and that I am responsible for any and all charges for medical treatment, property damage, or acquiring my own insurance. I acknowledge that participation in Y sponsored activities is conditional upon compliance with all applicable rules and policies established by the Westport Weston Family Y.

I approve this application and certify that I have reviewed the Camper Code of Conduct with my child and propose that my camper is capable of such an experience. I agree to have a health form signed by a physician that includes current medication and physical exam. This exam must have been given within 24 months of the camper's arrival date. Any camper who does not have said form into the Camp Mahackeno office by June 1 will incur the \$25 late fee. I also agree to the payment terms as outlined. \*Final payment is due by June 1, 2012. Refunds requested in writing before April 20, 2012: 100% less \$200 for each session enrolled. Refund or credit requests will not be accepted after April 20, 2012. 100% non-refundable per session deposit required at registration.

I hereby grant permission for the applicant to participate in all planned camp activities and programs, including our camp trips using the Westport Weston Family Y buses, understanding that competent leadership will be provided, and to receive medical attention (if parent/guardian is unavailable). I authorize Camp Mahackeno to have and use the name, photographs, slides, and video of the person named on this application in camp promotional materials.

I understand that it is my responsibility to obtain and read the Parent Handbook prior to my child's start of camp.

I have read and agree to all terms of the Westport Weston Family Y Camp Mahackeno policies and procedures.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MAIL TO: CAMP MAHACKENO, P.O. BOX 190, WESTPORT, CT 06881**

### CAMP FEE TOTALS:

TOTAL FEES:  
(Totals of 1. 2. 3. from other side): ...\$ \_\_\_\_\_

TOTAL DUE: .....\$ \_\_\_\_\_

TOTAL DEPOSIT: .....\$ \_\_\_\_\_

(\$200 NON-REFUNDABLE DEPOSIT  
PER SESSION DUE AT REGISTRATION)

BALANCE DUE: .....\$ \_\_\_\_\_

### PAYMENT METHOD:

I am enclosing the full payment:  Check (payable to Westport Weston Family Y)  Visa  MC  Discover

I authorize my credit card to be charged in monthly installments; paid in full by June 1, 2012.

Credit Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



WESTPORT WESTON FAMILY Y

# CAMPER HEALTH HISTORY RECORD 2012

**Important! Please read!**

**Use a separate form for each camper; print information clearly.  
Incomplete forms will not be accepted.**

**Mail to: Camp Mahackeno, P.O. Box 190, Westport, CT 06881-0190**

This Health History Record must be completed and returned to the camp by 06/01/12. Children are NOT allowed to attend camp until all required health information has been submitted. If this camper has had a physical exam within 2 years from the start of camp, a new exam is not required. If your child has NOT had a physical exam within 2 years of the start of camp, please make an appointment with your child's physician to conduct an examination. Reminder: Without required forms, your camper may not attend camp.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  M  F

Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name (A): \_\_\_\_\_ Relationship: \_\_\_\_\_

Bus. Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Parent/Guardian Name (B): \_\_\_\_\_ Relationship: \_\_\_\_\_

Bus. Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

**EMERGENCY CONTACTS – OTHER THAN A PARENT OR GUARDIAN** (form will not be accepted if parent is listed)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Bus. Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Bus. Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Is your child taking prescription medication?  Yes  No

Is your child taking medication at home?  Yes  No

Prescription(s): \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Will your child be taking medication during camp hours?  Yes  No If yes, please indicate which medication (prescription or over-the-counter – doctor's medication authorization form is needed):

\_\_\_\_\_

**\*Please note:** Your child's physician must provide information about medications in the Recommendations and Restrictions section on the State of Connecticut Department of Education Health Assessment Record in order for the camp to administer medication to your child.

**Camper's Name:** \_\_\_\_\_

**MEDICAL PROBLEMS AND DISEASES:** Please check all areas that apply. The Westport Weston Family Y's Mahackeno Outdoor Center requires background information on your child in order to provide licensed medical staff with pertinent information in case of emergency. General Questions (Please explain any "yes" answers below). Has or does the camper...

- |  |  |
|--|--|
| 1. Had any recent injury, illness or infectious disease? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No | 13. Ever had chest pain during or after exercise? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No        |
| 2. Have any chronic or reoccurring illness? . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                | 14. Ever had high blood pressure? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                        |
| 3. Ever been hospitalized? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                               | 15. Ever been diagnosed with a heart murmur? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No             |
| 4. Have frequent headaches? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                              | 16. Ever had back problems? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                              |
| 5. Ever had surgery? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                                     | 17. Ever had problems with joints? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                       |
| 6. Ever had a head injury? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                               | 18. Have an orthodontic appliance being brought to camp? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No |
| 7. Ever been knocked unconscious? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                        | 19. Have any skin problems? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                              |
| 8. Wear glasses, contacts or protective eye wear? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No        | 20. Have diabetes? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                                       |
| 9. Ever had frequent ear infections? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                     | 21. Have asthma? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No   |
| 10. Ever passed out during or after exercise? . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                  | 22. Had mononucleosis within the past 12 months? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No         |
| 11. Ever been dizzy during or after exercise? . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                  |  |
| 12. Ever had seizures? . . . . . <input type="checkbox"/> Yes .. <input type="checkbox"/> No                                   |  |

Please explain any "yes" answers to above questions (attach additional pages if necessary):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES AND ALLERGIC REACTIONS:** Does your son/daughter react negatively to any medication or foods? If so, please list them.  
 Hay Fever     Poison Ivy     Insect Sting     Penicillin     Other allergies: \_\_\_\_\_

Please provide any additional information: \_\_\_\_\_  
\_\_\_\_\_

**\*INSURANCE INFORMATION:** You are responsible for any incurred medical expenses. If you need pre-approval for out-of-plan services, it is your responsibility to notify your insurance provider (information mandatory).

Insurance provider: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address: \_\_\_\_\_ Pre-approval necessary:  Yes     No  
Name of insured: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_  
ID number or social security number of policy holder: \_\_\_\_\_

**PERMISSION TO PROVIDE TREATMENT OR EMERGENCY CARE:** The health history herein is correct as far as I know. I accept full responsibility for the health and physical condition of the person herein described, and give my permission for him/her to engage in all Mahackeno Outdoor Center sponsored activities, except as noted by me. I give the Westport Weston Family Y's Camp Mahackeno permission to apply sunscreen/lotion to my camper on an as needed basis during the day at camp. In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the Westport Weston Family Y to hospitalize, secure proper treatment or to order injections, anesthesia, or surgery for my child as named above. This completed form may be photocopied for trips out of camp.

Parent or Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

**By state regulation your child may not attend camp until this form is fully completed on both sides and returned to: Westport Weston Family Y, Attn: Camp Mahackeno, P.O. Box 190, Westport, CT 06881-0190**



# 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, a physician assistant or the school medical advisor 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 <b>1-877-CT-HUSKY</b>
Does your child have dental insurance?	Y N	

\* If applicable

### Part I — To be completed by parent/guardian.

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

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

Any health concerns	Y	N	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
<b>Family History</b>						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

**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 \_\_\_\_\_ / \_\_\_\_\_

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

**Screenings**

*Vision Screening			*Auditory Screening			Lead:	Date
Type:	<u>Right</u>	<u>Left</u>	Type:	<u>Right</u>	<u>Left</u>		
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass			
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail	*HCT/HGB:		
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made			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** If yes, please provide a copy of the **Emergency Allergy Plan** to School

History of Anaphylaxis  No  Yes Epi Pen required  No  Yes

**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 <b>Provider</b> 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
<b>DTP/DTaP</b>	*	*	*	*		
<b>DT/Td</b>						
<b>Tdap</b>						
<b>IPV/OPV</b>	*	*	*			
<b>MMR</b>						
<b>Measles</b>	*	*				
<b>Mumps</b>	*					
<b>Rubella</b>	*					
<b>HIB</b>	*				Students under age 5	
<b>Hep A</b>						
<b>Hep B</b>	*	*	*			
<b>Varicella</b>	*					
<b>PCV</b>					Pneumococcal conjugate vaccine	
<b>Meningococcal</b>						
<b>HPV</b>						
<b>Flu</b>						
<b>Other</b>						

**Disease Hx** \_\_\_\_\_  
**of above** (Specify) (Date) (Confirmed by)

### Exemption

**Religious** \_\_\_\_\_ **Medical: Permanent** \_\_\_\_\_ **Temporary** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_ Recertify Date \_\_\_\_\_

### Immunization Requirements for Newly Enrolled Students at Connecticut Schools

**KINDERGARTEN** DTaP: At least 4 doses. The last dose must be given on or after 4th birthday  
 Polio: At least 3 doses. The last dose must be given on or after 4th birthday  
 MMR: 1 dose on or after the 1st birthday  
**Measles:** Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose  
 Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination  
 Hep B: 3 doses  
 Varicella: 1 dose on or after the 1st birthday or verification of disease

**GRADES 1-6** DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday  
 Students who start the series at age 7 or older only need a total of 3 doses  
 Polio: At least 3 doses. The last dose must be given on or after 4th birthday  
 MMR: 1 dose on or after the 1st birthday  
**Measles:** Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose  
 Hep B: 3 doses  
 Varicella: 1 dose on or after the 1st birthday or verification of disease

**GRADES 7-12** Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses  
 Polio: At least 3 doses. The last dose must be given on or after 4th birthday  
 MMR: 1 dose on or after the 1st birthday  
**Measles:** Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose  
 Hep B: 3 doses  
 Varicella: 1 dose on or after first birthday or verification of disease:  
**VARICELLA VACCINE:** For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart  
**VERIFICATION OF DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

_____ Initial/Signature of health care provider MD / DO / APRN / PA	_____ Date Signed	_____ Printed/Stamped <b>Provider</b> Name and Phone Number
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