Emergency Contact and Release Authorization

Child/Parent Contact Information

Child Name: Date:

Parent/Guardian Name: Parent/Guardian Name:

Email: Email:

Cell: Work: Cell: Work:

Home Phone: Home Phone:

Contacts *(other than parent/guardian)*

Emergency Contact Name: Emergency Contact Name:

Relationship to Child: Phone: Relationship to Child: Phone:

Emergency medical contact: Phone: Preferred Hospital:

Authorized to pick-up this child *(including parents)*

1. Name: 2.Name:

Relationship to Child: Phone: Relationship to Child: Phone

3. Name: 4.Name:

Relationship to Child: Phone: Relationship to Child: Phone:

*In the event of any emergency and **someone not listed** must pick up the child, please call the Hubbard Day Program Director. Please do not send anyone to pick up your child who is not authorized without notifying us, and please do not send someone your child will not recognize. I authorize Hubbard Day to make any medical decisions for my child should none of the above emergency contacts be able to be reached.*

Parent/Guardian Signature **Date**

Child Name(s): _____

Date: _____

Liability Release

I am the parent and/or legal guardian for_____ ("Student") and hereby release and hold harmless Hubbard Day, The Foundry Center, Happy Hour 4 Kids Inc., its parent, subsidiaries and affiliates, and their executives, administrators, agents, representatives, employees, investors, board members and owners from all claims, damages and other liability for injury to the Student or for loss of Student property, where such claims, damages or other liability are not the result of willful negligence by Hubbard Day or its affiliates, administrators, agents, representatives, owners or employees.

As the parent or legal guardian, I agree that Hubbard will be released and held harmless for any injury or death to the Student that is not a result of willful negligence, including the transportation of the Student in a Hubbard vehicle and the transportation of the Student in a Hubbard vehicle to and from Hubbard Day when the request for transportation is made by me or the Student's home school district. Transportation is an acknowledged action and activity that I will hold Hubbard Day harmless for of all liabilities, including all claims, damages and other liability for injury to the Student or for loss of the Student's property or life, where such claims, damages or other liability are not the result of willful negligence by Hubbard or its affiliates.

I hereby waive, release, and discharge any and all claims for damage, for personal injury, death or property damage which I may have or which may hereafter accrue to me, as a result of participation in the various events, programs and services, including but not limited to the contractual agreed upon therapy/therapies, special instruction, socialization groups, etc.

In addition, I give the Student permission to attend any and all field trips/community outings, to be walked or be transported in any participating vehicle (NYC MTA or TLC), and to participate in all activities planned for the Student while at Hubbard Day.

This release is intended to discharge in advance, Hubbard Day, the agents and employees, including but not limited to contract workers, fee for service providers, and volunteers from any liability, of any assumed or unforeseen risk that may arise out of participation in the program or any of its features. It is understood that some of the activities may involve an element of risk or danger of accident, and knowing those risks, I hereby assume those risks. It is further understood and agreed that this waiver, release and assumption of risk is to be binding on my heirs and assigns.

I hereby give my consent to have the above-mentioned child treated by a physician or surgeon in case of sudden illness or injury while participating in the above-mentioned activities and attending Hubbard Day. It is understood that if a physician is mentioned below, every effort will be made to contact such physician. However, I also give my permission for Hubbard Day and Happy Hour 4 Kids, Inc., their agents and employees to use emergency medical personnel if they feel it necessary and agree to assume all costs and expenses resulting from any of the above services. I also give Hubbard Day, their agents and employees permission to administer first aid and medications, to the above-mentioned child; to the best of their judgment should they feel it necessary.

(PRINT) Parent or Guardian Name | Parent or Guardian Signature | Date

Preferred Physician's Name Physician | Phone | Address

Confidentiality Agreement

Federal law guarantees privacy and confidentiality for children, families, and their records. As a visitor (parent, care giver, volunteer, etc.) at Hubbard Day and/or Happy Hour 4 Kids Inc. you may under limited circumstances, have access to or observe a child/client or family enrolled in a program/group, receiving treatment, in a session, and or other student/client information while you are on site. Child/client/family information includes enrollment, group membership, related services, and any records, files, documents and other materials that contain personally identifiable information of any child/client/family. As a child/client/family enrolled in a program or receiving treatment from or at Hubbard Day you and your treatment team will have access to the records, treatment plans, progress reports, etc. of your child/children. It is imperative that you not disclose or discuss any child/client/family information and operating procedures that you may observe, participate in/with, meet, and or observe while at Hubbard Day to any unauthorized individuals. An unauthorized individual would be any person that is not currently an employee of Hubbard Day or an individual that does not have written consent from the parent/guardian of the client and Hubbard Day. This includes but is not limited to doctors, other agencies, outside therapists, caregivers (nannies), extended family, members of the press, and lawyers.

In order to maintain the privacy rights of our clients and their families as well as the integrity of our practice and program we ask that as a parent/caregiver/visitor to Hubbard Day you agree to the following:

1. I will not disclose or discuss with unauthorized individuals the identity, treatment, or records of any child/client/family treated by Hubbard Day
2. I will provide written authorization and consent to an individual that I wish to have access my child/children's records/information.
3. I understand that Hubbard Day can refuse to speak an individual even if I provide written authorization, if they feel as though it jeopardizes the privacy and integrity of their clients/families and practice.
4. I understand that only the treatment team (therapists/educators/teachers/fee for service providers) employed or contracted by Hubbard Day and Jonathan Trichter and Joel Maute will have access to my child/children's records and information, unless I provide written consent.
5. I will not discuss or reveal the identity of any other children/clients/families, the operating/treatment procedures, staff, contract employees, volunteers, and or fee for service providers from Hubbard Day with anyone.
6. I understand that questions about Hubbard Day and or previously defined confidential child/client/family information must be directed to Jonathan Trichter.
7. I must report any breach or suspected breach in confidentiality, immediately upon my discovery, to Jonathan Trichter.
8. As the parent/caregiver/visitor, I am at Hubbard Day to receive services in the contracted area of treatment and should only report on my child.

I have read and understand the Hubbard Day policies concerning confidentiality and nondisclosure of any information regarding children/client(s)/families, treatments, programs and or staff. I agree to maintain the confidentiality of all information obtained in the course of my child/children enrollment/treatment, but not limited to, financial, technical, or propriety information of Hubbard Day as well as any personal and sensitive information regarding students/clients, parents, treatment, and employees.

I understand that inappropriate disclosure or release of any information is grounds for immediate termination of treatment/enrollment, without refund, and subject to legal action.

Signature Date

Print Name

Photo Release Waiver

Child's Name_____

I give permission for Hubbard Day to use photographs/videos of my child for the following:

☐ To be posted on the Hubbard Day website.
☐ To be shared on Hubbard Day social media accounts.
☐ To be used for promotional purposes.

☐ I do not give permission for images of my child to be used on the Hubbard Day website, social media, or for promotional purposes.

Parent Signature _____ Date _____

Parent Handbook

NAMES TO REMEMBER
Hubbard Day ("Hubbard", "Hubbard Academy")
Happy Hour 4 Kids (our parent company)

HOURS OF OPERATION
9:00 AM to 3:00 PM

Owners (in the event of an emergency or urgency):
Jonathan Trichter (Cell: 646-573-9928)
Joel Maute, OTR/L (Cell: 917-902-3426)

PARENT ROLES AND RESPONSIBILITIES
The family's involvement and commitment to their child's academics and therapies will be critical. We view parents as our partners in helping a child develop, grow and learn—both behaviorally and academically. For our partnership to be effective, we will work together with clear goals and clear roles.

Our role is to design and give your child the most advanced, physical, behavioral and educational therapies via an individualized program in order to impart the tools needed to reach his/her maximum potential. Your role in our partnership will include helping generalize all that your child learns here at Hubbard Day. We will work in close collaboration with you to ensure that progress extends beyond our doors into your homes and the world around us.

Beyond the application of therapies and academics, there are the practical matters parents at Hubbard should attend to in order for us to best serve your family and child. What follows is a list of the administrative things we ask of you. Please keep the following expectations close at hand as you ready your child for Hubbard Day and be sure to relay the information we need to keep your child safe and moving towards his/her goals:

- Please advise us of any allergies or medical conditions your child may have, and please supply us with any medical devices that may be necessary for his/her well-being. Be sure we are aware of those medical devices so we stand ready to use them when necessary.
- Your child must have all required school vaccinations in order to comply with Connecticut State law. Your physician will know what vaccinations are required for your child based on his/her age and can administer them appropriately. Please obtain a copy of your child's vaccination records and submit them to Hubbard upon enrollment.
- Make sure we have emergency contact information for your family and that it is current and on file here. There is an emergency form included in this parent handbook that you must fill out.
- Make sure we have a copy of your child's annual IEP, any neuropsychological reports, progress reports, and other developmental evaluations.
- To protect the health and well-being of the children at Hubbard, please appropriately handle any illnesses your child may contract that could be contagious. You can refer to our illness policy below.
- Please make sure to read our separate Covid-19 protocols and procedures document.
- Make sure your child is in regular attendance.
- There are no uniforms or dress codes at Hubbard. Simply dress your child to come to Hubbard Day in comfortable and weather appropriate clothing. Please provide us with a labelled change of clothes that we will keep here in case of any accidents.

- Keep personal toys and books at home, unless you make arrangements with your child's therapists, teacher, or provider. Please label all personal belongings you or your child intend to keep here.
- We will develop a number of home programs and behavioral strategies designed for your child and ask that you participate in them as often as you are able to.
- Keep our office notified of changes in important information (e.g., address, phone, child's behavior changes at home, etc.).
- Notify us (Hubbard) or your child's therapist/provider/teacher if someone else will be dropping off or picking up your child. This is important.

POLICY ON ADMINISTERING MEDICATIONS

If we are asked or needed to administer any medications to your child either regularly or acutely, we require documentation from your child's prescribing physician that includes proper dosage and other relevant directions. We have a form here for parents to fill out to help facilitate that. We also require a note from a doctor for any changes in medications or dosages (even allergy medications).

LUNCH/SNACKS

Please be sure to pack a lunch for your child every day. If a child's lunch requires refrigeration, we should be notified ahead of time as we do not automatically put a packed lunch into a refrigerator. It's safest to pack a meal that can keep. We also might recommend considering insulated lunch-bags/boxes with optional ice packs and insulation for hot foods, as we do not have the facilities to cook anything. Hubbard will provide water, of course, but please pack other drinks if needed or desired. You may also wish to pack snacks for your child, although we do provide snacks here for the kids.

Hubbard is a nu-free environment. No nuts or nut products are allowed at Hubbard Day. In addition, if your child has an allergy to nuts (or anything else), please let us know.

PRIVACY AND OBSERVATION

For privacy reasons, we ask all parents to remain in the waiting room on our first floor (rather than come into therapy/treatment/group areas). If you would like to watch part of your child's therapy session/group/class, please talk to your child's therapist/s/provider/teacher/s and he/she will make accommodations. In addition, open communication is essential and we will be implementing regular parent observation opportunities and programs, and we will encourage you to participate in those whenever you are able to. We also encourage communications with staff here during drop-off and dismissal/pickup times. And we will have designated parent conferences in addition to always being available for ad hoc meetings and conferences when required. Finally, you are encouraged to contact us immediately with any problems or concerns.

TEAM MEETINGS

It is important that your child's teachers and therapists at Hubbard (and elsewhere) collaborate on his/her individualized program and progress. As a result, Hubbard will encourage and participate in team meetings for your child each year.

ATTENDANCE POLICY

Please contact your child's teacher/therapist/provider directly if your child is unable to attend class for the day. We request that you contact us as early in the morning as possible, understanding there are exceptions in the case of emergencies and unforeseen illnesses. All requests for changes in your child's schedule will need to be discussed with your child's therapist/provider/teacher.

Note that if your child's attendance rate falls below a certain level, there is a possibility that your child's slot at Hubbard may be at risk. In cases of prolonged illnesses or medical conditions we will surely reach an understanding with the family and work around that.

ILLNESS AND INJURY

If a child is believed to be ill and or contagious, a parent or guardian will be contacted immediately who will be responsible for picking up, or arranging pick up, for the child as soon as possible. We will take care of the child as best we can while you make the appropriate arrangements. Please also read our Covid-19 protocols, which we have provided in a separate document.

For the safety of other children and our staff, please do not send your child to class if your child is ill, and please call to let us know he/she will not be in attendance at the earliest opportunity. Below are guidelines to assist you in deciding whether your child should attend Hubbard if he/she is not feeling well or sick.

Remember: Children should be kept home when sick. Please call to let us know your child will not be attending Hubbard for the day, if your child meets any of the following **exclusion criteria**:

- Temperature of 100 or higher
- Conjunctivitis ("pink eye"), redness of the eye and/or lids, usually with yellow discharge and crusting
- Presence of nits or lice
- Bronchitis, which begins with hoarseness, cough, and a slight elevation in temperature
- A rash you cannot identify which has not been diagnosed
- Impetigo: red bumps/pimples on the skin, which become small vesicles surrounded by a reddened area
- Diarrhea three or more times within 24 hours
- Vomiting within 24 hours (more than usual "spitting up")
- A cold with fever, sneezing, and nose drainage
- A contagious disease, including measles, chicken pox, mumps, roseola, strep throat, etc.

While we regret the inconvenience caused by strict adherence to these guidelines, our concern for all the children dictates a cautious and conservative approach when dealing with health matters.

Parents/guardians or individuals listed as emergency contacts will be notified immediately, if a child becomes seriously ill or injured during the day. Emergency telephone numbers must be available and kept current. In the event of a serious accident or illness where the parent/guardian or other emergency contact individuals cannot be reached, an ambulance will be called, and the student will be transported to the nearest hospital emergency room accompanied by a staff member. Additional staff will continue to attempt to reach the student's parent/guardian.

SCHEDULE
Hubbard Day follows an independent schedule concerning holidays. Please see the calendar we supply to all parents and refer to it when planning for your child's schedule with us here.

INCLEMENT WEATHER POLICY
We will be closed anytime Greenwich Public School closes due to weather.

GRIEVANCE POLICY
If you have an issue or concern, we encourage you to speak directly with the staff/person involved. We believe that is usually the best way to solve a problem. If that does not work, please do not hesitate to speak with the owner, Jonathan Trichter.

USE OF PICTURES
Our clinic may occasionally video tape, audio tape and/or photograph therapy sessions. Please be assured **we will seek your permission first** and have you sign a release form before we use photographs for anything other than part of your child's documentation.

ARRIVAL & DISMISSAL
Drop off is at 9:00am and dismissal/pickup (during all non-holiday weekdays) is at 3:00pm. An adult must accompany students at all times for those children who do not use bussing. Otherwise, no student will be released unless a designated parent or guardian is there to pick him or her up. If someone else is picking up your child, please inform us ahead of time. Please note that punctual arrival is imperative. Please also note that the school day must end on time.

PETS
There are no pets allowed on the premises or directly outside our premises during drop-off and pickup or any other time.

SAFETY DRILLS

We conduct numerous fire and safety drills throughout the course of the year—all in compliance with the Fire Department. Children and teachers will have advanced notice of the first few drills. Later, the teachers will know when to expect a safety drill, although the children may not. Ultimately, no one will be notified in advance. We are very serious about your child's safety and our compliance with safety regulations.

RESTRAINT & SECLUSION POILICY

Hubbard Day does not have nor employ the use of a seclusion room. In addition, Hubbard Day (a) prohibits school personnel from using seclusion, mechanical, and chemical restraints on preschool, elementary and secondary students; (b) prohibits school personnel from using physical restraint on preschool, elementary, and secondary students unless the student's behavior poses an imminent danger of serious physical injury to self or others, and only after all less intrusive, non-physical interventions have been tried and failed or deemed inappropriate to protect the student or others; (c) prohibits, in situations where physical restraint is used because there is an imminent danger of serious physical injury, the use of restraints in a face-down position or any other position that is likely to impair a student's ability to breathe or communicate distress, places pressure on a student's head, neck, or torso, or obstructs a staff member's view of a student's face; and (d) requires professional development and ongoing training in positive behavior interventions and trauma-informed care, including crisis de-escalation, restorative practices, and behavior management practices, for all school personnel.

Acknowledgement (Please fill out & sign)

LIABILITY WAIVER & CONFIDENTIALITY AGREEMENT ACKNOWLEDGEMENT

We value your child's safety and privacy above all as well as the safety and privacy of our clients and their families. Please review and sign your Liability Waiver and Confidentiality Agreement, your child may not attend any programs or receive scheduled services until these documents have been signed and returned.

I acknowledge receipt of and reading of this Hubbard Day Handbook. I understand that parents and caregivers are expected to adhere to the rules outlined here as well as all other Hubbard Day rules, irrespective of whether they are listed here, elsewhere or otherwise.

_____ _____

Parent/Guardian Signature Date

Administration of Medications Policy

I. Policy Statement for Administration of Medications by School Personnel

It is the policy of Hubbard Day School to be in conformity with Section 10-212a-1 to 10-212a7, as revised of the General Statutes of Connecticut. To this end, no principal, teacher, nurse, or trained employee shall administer a medicinal preparation to any child enrolled in school unless (1) a specific written order of a physician, dentist, advanced practiced registered nurse (APRN), or physician assistant (PA), licensed to practice in Connecticut, and (2) the written authorization of a parent or guardian is on file in the student's cumulative health folder or individual School Medication Log. Under no circumstance may school personnel provide or administer nonprescription "over the counter" medications including aspirin, acetaminophen, and ibuprofen, except by following this policy. This policy will be made known to students, parents, and guardians at least once a year. To provide immunity afforded to school personnel who administer medication, these procedures, and regulations for administering medication shall be those as approved by the medical advisor.

Date: _____

Authorization for the Administration of Medication

In Connecticut schools, 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. This authorization and waiver is meant to authorize Happy Hour 4 Kids Inc. doing business as Hubbard Day in Connecticut to have its nurse administer medications upon approval and authorization by the student's doctor and/or licensed medical provider and permissions granted by the student's parent(s). This permission absolves Hubbard Day and all its agents, employees, board members, investors and representatives of any liability in the administering of the medications listed on this waiver.

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: _____

Dosage _____Method /Route_____ Time of Administration _____ Start Date ____/____/____ End Date ____/____/____

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 Hubbard Day and its personnel and I give permission for the exchange of information between the prescriber and the school nurse 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 to my child/student without adverse effects.

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

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, 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

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

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

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

* 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** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

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

❑ Referral made

***Auditory Screening**

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

❑ Referral made

	Date
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 *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 ***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	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ 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 ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 7/2018

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 of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption: Religious _____ **Medical:** Permanent _____ Temporary _____ **Date:** _____

Renew Date: _____ _____ _____ _____

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

- 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 the1st 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 the1st 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