



Connecticut Early Childhood Health Assessment Record

To Parent or Guardian:

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

Please print

Name of Child (Last, First, Middle)	Social Security No.	Birth Date	Sex
Address (Street)	Home Telephone Number		
(Town and Zip Code)	Early Childhood Program	Program Number	
Parent/Guardian (Last, First, Middle)	Home Telephone Number	Work Telephone Number	
Medicaid Number*	Health Insurance Company/Number*		

* If applicable

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

Part I - To be completed by parent

***Important:* Complete Part I before your child is examined.
 Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.
 (Explain all "yes" answers in the space provided below.)

- | | | | |
|-----|--------------------------|--------------------------|---|
| | Yes | No | |
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health (eating and sleeping habits, weight, teeth, etc.)? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's development or behavior? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, etc.)? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medication (daily or occasionally)? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, or major illness (specify problem)? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any significant injury or accident (specify problem)? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Is your child receiving any special services? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any other specific illness or problem? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Would you like to discuss anything about your child's health with the child care provider or health consultant? |

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

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

 Signature of Parent/Guardian
 To be maintained in Child's Health Record

 Date

Part II - Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

_____ has had a complete history and physical exam on _____
 Child's Name Birth Date Month/Day/Year

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CARE, SPECIAL DIET, AND EMERGENCIES: NONE
 NONE

ALLERGIES TO FOOD, MEDICINE, OR INSECTS:

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE ¹	BLOOD PRESSURE ²
IN/CM %ILE	LB/KG %ILE	IN/CM %ILE	/

PHYSICAL EXAMINATION	NORMAL	ABNORMAL/COMMENTS
HEAD / EARS / EYES / NOSE / THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN / GI		
GENITALIA / BREASTS		
EXTREMITIES / JOINTS / BACK / CHEST		
SKIN / LYMPH NODES		
NEUROLOGIC / TONE		
DEVELOPMENT		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTP/DtaP						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

Disease Hx of above or contagious disease _____
(specify) (date) (Confirmed by)

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

SCREENING TESTS	RESULTS	DATE	ABNORMAL/COMMENTS
VISION (Type of Screening _____) ²			
HEARING (Type of Screening _____) ³			
LEAD ⁴			
ANEMIA (HGB/HCT) ⁴			
URINALYSIS (UA) ⁵			
TB (Risk? Yes / No) ⁵			
DEVELOPMENTAL ASSESSMENT ⁶			
DATE OF LAST DENTIST'S EXAMINATION ⁷			

Minimum requirements: ¹ Up to 2 years; ² annual at 3 years; ³ annual at 4 years; ⁴ 9 – 12 months, 2 years ⁵ as needed; ⁶ each visit through 5 yrs; ⁷ annual at 2 – 3 years
Prior to public school entry: Same as above and Hgb/hct

This child has the following conditions which may affect the educational experience:

- Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior

Re: Licensing: Does this child have a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program? yes no

- This child has a health condition which may require emergency action at school, e.g., seizures, allergies, asthma. *Specify below.*
 The child is on long-term or emergency medication. *Specify below.*

Comments and recommendations (attach additional sheet if necessary): _____

- This child may participate fully in the early childhood program.
 This child may participate in the early childhood program with the following restriction/adaptation: *(Specify reason and restriction)*

- Yes No Based on this comprehensive health history and physical examination, this child has maintained his/her level of wellness.
 I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of Health Care Provider MD/DO Name (please type or print) Phone number
 NP
 PA

Address: Next Appointment: (Mo/Yr):
 Next Appointment for Immunization (Mo/Yr):

2008 Infant/Toddler Program Enrollment Form

Please use a separate form for each child, complete all information, and print clearly. A non-refundable registration fee of \$125 is due upon submission of this form. **No application will be accepted without it.** Please make checks payable to: **Westport Weston Family Y.**

Child Information:

Date of application: ____ / ____ / ____

Child First: _____ Child Last: _____

Gender: M / F Date of Birth: ____ / ____ / ____ Age: _____

Parent/Guardian Information:

Parent/Guardian A – **Child's Residence**

Parent/Guardian B:

First Name: _____ First Name: _____

Last Name: _____ Last Name: _____

Street: _____ Street: _____

Town: _____ Town: _____

State: _____ Zip: _____ State: _____ Zip: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Street: _____ Street: _____

Town: _____ Town: _____

Work Phone: _____ Work Phone: _____

E-Mail: _____ E-Mail: _____

Emergency Information:

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Please list one responsible person, other than parents, who can remove the child from the program in an emergency.

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

Pick-Up Authorization: The following people, in addition to the above, are authorized to pick up my child.

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

2008 INFANT/TODDLER PROGRAM ENROLLMENT FORM

Office use only: Health form complete (/ /)
 In-take meeting (/ /)
 Contract sent (/ /)
 Contract/fee received (/ /)

Start Date: ____/____/____

Monthly Tuition and Schedule:

Member Rates:

- Monday – Friday 7:00-6:00 \$ 1,820.00
- Monday – Friday 8:30 – 5:30 \$ 1,655.00

Non-member Rates:

- Monday – Friday 7:00-6:00 \$ 1,830.00
- Monday – Friday 8:30 – 5:30 \$ 1,665.00

If a current member, member #: _____ Exp. Date: ____/____/____

Payment Information:

- Credit card monthly draft
- Debit card monthly draft
- Bank account monthly draft

Financial Assistance:

Please mark box if you would like us to send you a financial assistance application.

Permission Agreement:

I grant permission for my child to use all play equipment and participate in all activities of the program. I grant permission for my child to be included in pictures connected with the Y's programs. If warranted, I grant permission to the staff to take whatever steps necessary to obtain emergency medical care according to Connecticut State agencies' regulations. These steps may include, but are not limited to, the following: administering first aid, attempting to contact a parent, guardian or child's physician/dentist, directly or through any of the persons listed under the emergency information on the reverse; calling another physician, ambulance, or taking the child to an emergency hospital in the company of a staff member, in a program vehicle, in the event that a parent, guardian, or child's physician cannot be contacted. Any expenses incurred under the above will be borne by the child's family. I understand the program will not be responsible for anything that may happen as a result of false information given at the time of enrollment. The Westport Weston Family Y Child Care staff have permission to transport my child in the YMCA buses to our programs, playground, and/or field trips. I understand that my child will be in the appropriate child safety restraint system and/or wear a seat belt at all times and that the driver will follow State of Connecticut Motor Vehicle Laws. I have read the Child Care Parent Handbook and agree to all of the policies.

_____/_____/_____
PARENT / GUARDIAN SIGNATURE DATE

FORMS THAT ARE NOT SIGNED WILL NOT BE ACCEPTED

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2008 Toddler Program Enrollment Form

Please use a separate form for each child, complete all information, and print clearly. A non-refundable registration fee of \$125 is due upon submission of this form. **No application will be accepted without it.** Please make checks payable to: **Westport Weston Family Y.**

Child Information:

Date of application: ____ / ____ / ____

Child First: _____ Child Last: _____

Gender: M / F Date of Birth: ____ / ____ / ____ Age: _____

Parent/Guardian Information:

Parent/Guardian A – **Child's Residence**

Parent/Guardian B:

First Name: _____ First Name: _____

Last Name: _____ Last Name: _____

Street: _____ Street: _____

Town: _____ Town: _____

State: _____ Zip: _____ State: _____ Zip: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Street: _____ Street: _____

Town: _____ Town: _____

Work Phone: _____ Work Phone: _____

E-Mail: _____ E-Mail: _____

Emergency Information:

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Please list one responsible person, other than parents, who can remove the child from the program in an emergency.

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

Pick-Up Authorization: The following people, in addition to the above, are authorized to pick up my child.

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

2008 TODDLER PROGRAM ENROLLMENT FORM

Office use only: Health form complete (/ /)
 In-take meeting (/ /)
 Contract sent (/ /)
 Contract/fee received (/ /)

Schedule Options and Monthly Tuition:

Circle the tuition of the schedule that you desire.

Start Date: ____/____/____

Member Rates:

	TU/TH	M/W/F	M-F
9:00 AM - 1:00 PM	\$525	\$720	\$1,000
9:00 AM - 3:00 PM	\$720	\$940	\$1,325
8:30 AM - 5:30 PM	\$885	\$1,215	\$1,655
7:00 AM - 6:00 PM	\$965	\$1,325	\$1,820

Non-Member Rates:

	TU/TH	M/W/F	M-F
9:00 AM - 1:00 PM	\$535	\$730	\$1,010
9:00 AM - 3:00 PM	\$730	\$950	\$1,335
8:30 AM - 5:30 PM	\$895	\$1,225	\$1,665
7:00 AM - 6:00 PM	\$975	\$1,335	\$1,830

If a current member, member #: _____ Exp. Date: ____/____/____

Payment Information:

Credit card monthly draft Debit card monthly draft Bank account monthly draft

Financial Assistance:

Please mark box if you would like us to send you a financial assistance application.

Permission Agreement:

I grant permission for my child to use all play equipment and participate in all activities of the program. I grant permission for my child to be included in pictures connected with the Y's programs. If warranted, I grant permission to the staff to take whatever steps necessary to obtain emergency medical care according to Connecticut State agencies' regulations. These steps may include, but are not limited to, the following: administering first aid, attempting to contact a parent, guardian or child's physician/dentist, directly or through any of the persons listed under the emergency information on the reverse; calling another physician, ambulance, or taking the child to an emergency hospital in the company of a staff member, in a program vehicle, in the event that a parent, guardian, or child's physician cannot be contacted. Any expenses incurred under the above will be borne by the child's family. I understand the program will not be responsible for anything that may happen as a result of false information given at the time of enrollment. The Westport Weston Family Y Child Care staff have permission to transport my child in the YMCA buses to our programs, playground, and/or field trips. I understand that my child will be in the appropriate child safety restraint system and/or wear a seat belt at all times and that the driver will follow State of Connecticut Motor Vehicle Laws. I have read the Child Care Parent Handbook and agree to all of the policies.

_____/_____/_____
PARENT / GUARDIAN SIGNATURE DATE

FORMS THAT ARE NOT SIGNED WILL NOT BE ACCEPTED

2008 Preschool Enrollment Form

Please use a separate form for each child, complete all information, and print clearly. A non-refundable registration fee of \$125 is due upon submission of this form. **No application will be accepted without it.** Please make checks payable to: **Westport Weston Family Y.**

Child Information:

Date of application: ____ / ____ / ____

Child First: _____ Child Last: _____

Gender: M / F Date of Birth: ____ / ____ / ____ Age: _____

Parent/Guardian Information:

Parent/Guardian A – **Child's Residence**

Parent/Guardian B:

First Name: _____ First Name: _____

Last Name: _____ Last Name: _____

Street: _____ Street: _____

Town: _____ Town: _____

State: _____ Zip: _____ State: _____ Zip: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Street: _____ Street: _____

Town: _____ Town: _____

Work Phone: _____ Work Phone: _____

E-Mail: _____ E-Mail: _____

Emergency Information:

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Please list one responsible person, other than parents, who can remove the child from the program in an emergency.

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

Pick-Up Authorization: The following people, in addition to the above, are authorized to pick up my child.

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

2008 PRESCHOOL ENROLLMENT FORM

Office use only: Health form complete (/ /)
 In-take meeting (/ /)
 Contract sent (/ /)
 Contract/fee received (/ /)

Schedule Options and Monthly Tuition:

Circle the tuition of the schedule that you desire.

Start Date: ____/____/____

Member Rates:

	TU/TH	M/W/F	M-F
9:00 AM - 1:00 PM	\$365	\$500	\$750
8:30 AM - 5:30 PM	\$635	\$885	\$1,325
7:00 AM - 6:00 PM	\$720	\$995	\$1,495

Non-Member Rates:

	TU/TH	M/W/F	M-F
9:00 AM - 1:00 PM	\$375	\$510	\$760
8:30 AM - 5:30 PM	\$645	\$895	\$1,335
7:00 AM - 6:00 PM	\$730	\$1,005	\$1,505

If a current member, member #: _____ Exp. Date: ____/____/____

Payment Information:

Credit card monthly draft Debit card monthly draft Bank account monthly draft

Financial Assistance:

Please mark box if you would like us to send you a financial assistance application.

Permission Agreement:

I grant permission for my child to use all play equipment and participate in all activities of the program. I grant permission for my child to be included in pictures connected with the Y's programs. If warranted, I grant permission to the staff to take whatever steps necessary to obtain emergency medical care according to Connecticut State agencies' regulations. These steps may include, but are not limited to, the following: administering first aid, attempting to contact a parent, guardian or child's physician/dentist, directly or through any of the persons listed under the emergency information on the reverse; calling another physician, ambulance, or taking the child to an emergency hospital in the company of a staff member, in a program vehicle, in the event that a parent, guardian, or child's physician cannot be contacted. Any expenses incurred under the above will be borne by the child's family. I understand the program will not be responsible for anything that may happen as a result of false information given at the time of enrollment. The Westport Weston Family Y Child Care staff have permission to transport my child in the YMCA buses to our programs, playground, and/or field trips. I understand that my child will be in the appropriate child safety restraint system and/or wear a seat belt at all times and that the driver will follow State of Connecticut Motor Vehicle Laws. I have read the Child Care Parent Handbook and agree to all of the policies.

_____/_____/_____
PARENT / GUARDIAN SIGNATURE DATE

FORMS THAT ARE NOT SIGNED WILL NOT BE ACCEPTED



2008 Kinderkids Program Enrollment Form

Please use a separate form for each child, complete all information, and print clearly. A non-refundable registration fee of \$125 is due upon submission of this form. **No application will be accepted without it.** Please make checks payable to: **Westport Weston Family Y.**

Child Information:

Date of application: ____ / ____ / ____

Child First: _____ Child Last: _____

Gender: M / F Date of Birth: ____ / ____ / ____ Age: _____ Public School Attending: _____

Parent/Guardian Information:

Parent/Guardian A – **Child’s Residence**

Parent/Guardian B:

First Name: _____

First Name: _____

Last Name: _____

Last Name: _____

Street: _____

Street: _____

Town: _____

Town: _____

State: _____ Zip: _____

State: _____ Zip: _____

Home Phone: _____

Home Phone: _____

Employer: _____

Employer: _____

Street: _____

Street: _____

Town: _____

Town: _____

Work Phone: _____

Work Phone: _____

E-Mail: _____

E-Mail: _____

Emergency Information:

Child’s Physician: _____ Phone: _____

Child’s Dentist: _____ Phone: _____

Please list one responsible person, other than parents, who can remove the child from the program in an emergency.

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

Pick-Up Authorization: The following people, in addition to the above, are authorized to pick up my child.

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

First Name: _____ Last Name: _____

Street: _____ Town: _____

Home Phone: _____ Work Phone: _____

