



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



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 POLICY

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



Suspension Policy

Policy: Students are only suspended after all other reasonable alternatives have been exhausted. Suspension can only occur pending notification of the parent/guardian and the local education agency (“LEA”).

Summary: The Hubbard Day suspension policy was developed in accordance with IDEA, Title II of the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act. It is also implemented according to the relevant rules and regulations. Students can only be suspended under the provisions of 300.519 through 300.529 of the IDEA regulations.

Hubbard Day students present with significant cognitive and behavioral challenges that prevent them from learning safely and adequately in a general education setting. Even so, Hubbard is committed to implementing IEPs and ensuring that each student receives the services they need, irrespective of their behavioral challenges. That requires designing and implementing individualized behavior intervention plans that target student behaviors and utilize proactive strategies to prevent students from becoming dysregulated and physically unsafe. The behaviors at issue often include aggression, self-harm, property destruction, stimulatings, perseverations, disrobings and others. Behavior plans are therefore required for these students to access their therapy and instruction, maintain safe bodies, and integrate into our scaffolded classrooms. And the plans, along with their diligent implementation by Hubbard Day administrators, teachers, service providers, and support staff, severely limit the need for suspensions or expulsions.

Suspensions only occur if a child is a safety risk to themselves or others (i.e., if the child cannot be supported via 1:1 or 1:2 coverage ratio and the use of PPMT) even after the proper implementation of their behavior plans. Safety risks may arise in instances where a student unremitantly harms him/herself or attacks other students in ways that cannot be preemptively mitigated, sufficiently reduced, or eliminated. In the event students severely harm themselves in ways we cannot mitigate or attack other vulnerable students in ways we cannot prevent, Hubbard will take proper protective actions to ensure everyone’s safety, including the student initiating harm, and initiate a PPT while at the same time considering suspension as a last resort.

Procedures for Suspensions:

- Each student’s caretaker(s), parent(s), or guardian(s) are to be informed of the specific and narrow types of behavior that may result in suspension from our program. These rules will be outlined in our updated parent onboarding packet.
- All reasonable alternatives to suspension are exhausted.
- Unless an emergency exists, no student is suspended without an informal hearing conducted by the Hubbard Day administration at which the student and appropriate caregiver(s) are informed of the reasons for a suspension. The student and the caregiver(s) are given the opportunity to fairly respond and be heard by way of explanation and defense, should they wish.
- A written record of each suspension of a student is maintained.
- A student cannot be suspended for a particular behavior if the student’s IEP mandates an alternative response to the particular behavior.
- In the event a child presents with challenging behaviors and/or significant new ones, the child’s caregiver is contacted immediately—and no later than 24 hours after the incident; the incident is communicated to the parent/guardian through an individually chosen and preferred means of caregiver communication (e.g., phone, email, text—and then via our daily communication book).
- Hubbard notifies the student’s school district, caregiver(s), parent(s), or guardian(s) within 24 hours of the time a student is suspended.

- Hubbard simultaneously contacts the student's local education agency ("LEA"). Hubbard and the LEA determine if a PPT is warranted.
- The rest of the student's "team" convenes to determine if the behavior is a manifestation of the child's disability.
- If the result of a PPT includes a determination that the behavior at issue is a result of the student's disability, Hubbard contacts the student's doctor(s), reviews/updates the child's IEP, collects information from the child's support system, and reviews its own teacher observations. From there, Hubbard will design a plan and programmatic response that addresses the behavior. This process usually unfolds in real time and without any attendant suspension.
- The most extreme action Hubbard would take is asking the child to remain home temporarily and receive his/her services remotely until our program can once again safely and effectively receive the student in person.
- The suspension will not exceed 10 school days.
- In the event a student is suspended repeatedly, Hubbard will make a written request that the student's school district convene a PPT meeting to discuss the student's unique needs. Simultaneously, Hubbard Day will endeavor to create a regular and frequent schedule for the student's school team to meet with the student's treating physicians, psychologists, and other doctors to monitor the students emotional and psychological well-being.



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 physi-

cian 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	<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 1-877-CT-HUSKY
Does your child have dental insurance?	Y N	

* 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

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			*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	History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	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	*HCT/HGB:	
Without glasses 20/ 20/	<input type="checkbox"/> Fail <input type="checkbox"/> Fail	*Speech (school entry only)	
<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 Provider Name and Phone Number
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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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: <input type="checkbox"/> Dentist	Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Risk Assessment <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Describe Risk Factors <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____ </td> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____ </td> <td style="width: 34%; border: none;"></td> </tr> </table>			<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	
<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> 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 <i>Provider</i> 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
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 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 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.