



**R.I.S.E.  
After School Program  
330 Windsor Ave.**



**Windsor Recreation Registration Form (please print)**

<b><u>Participant Name:</u></b>	<b><u>Age</u></b>
<b><u>Address:</u></b>	
<b><u>Date of Birth:</u></b>	<b><u>Phone #</u></b>
<b><u>School:</u></b>	<b><u>Grade</u></b>
<b><u>Parents/Guardians Name:</u></b>	
<b><u>Emergency Contact:</u></b>	<b><u>Phone #</u></b>
<b><u>Starting Date:</u></b>	

In consideration of being allowed to participate in the Town of Windsor Recreation activities, the undersigned acknowledges, and agrees that: The risk of injury from the activities involved in this program may be significant, including the potential for permanent paralysis and death, and while particular rules, equipment and personal discipline may reduce this risk, the risk of serious injury does exist; and I knowingly and freely assume all such risk, both known and unknown.

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin. I hereby release and hold harmless the Town of Windsor Recreation Department, its employees, volunteers, commissioners, sponsoring agencies, sponsors and advertisers with respect to any and all injury, disability, or death incurred while traveling to or from or participating in the above mentioned trips or activities.

**ADA**  
American Disabilities Act  
Individuals with disabilities who require accommodation to participate in a program should request accommodation from the Recreation Department upon or before registration. Documentation supporting the need and the extent of the accommodation may be required.

Office Phone: 860-285-1990  
**Office Hours**  
Monday – Friday      8am-5pm  
Saturday                8am-12pm



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

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

Make checks payable to: Town of Windsor  
Return to: Windsor Recreation and Leisure Services  
599 Matianuck Ave.  
Windsor, CT 06095

**Windsor Public Schools  
Windsor Recreation Services**

**Transportation Request**

My child: \_\_\_\_\_ will be participating in after school programs from the provider listed below during the 2011-2012 school year. I am requesting transportation to the

**Community Center at 330 Windsor Ave., Windsor CT**

Provider's name: Town of Windsor Recreation Services  
Address: 330 Windsor Ave.  
Telephone: 860-727-8684

During the hours of 3:00 PM- 6:00 PM, I can be reached at \_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Return To: Debbie Anderson, Recreation Program Specialist  
Windsor Recreation Services  
599 Matianuck Ave.  
Windsor, CT 06095

Telephone: 860-285-1990  
Fax: 860-285-1950

School: \_\_\_\_\_

**Windsor Recreation and Leisure Services**  
**Authorization & Consent Form**

The following authorizations are necessary for the staff to act in your child's best interest at all times. Please complete and sign for each child.

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_

***Pick-Up Authorization***

I hereby authorize the following persons to pick up my child from the Romp and Learn program. If these names change, I will let the R.I.S.E. Director know by a written notice.

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Name	Relationship	Phone #
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Name	Relationship	Phone #
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Name	Relationship	Phone #
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Parent / Guardian Signature	Date
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# State of 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 Number	Birth Date	Sex
Address (Street)		Race/Ethnicity		
(Town and ZIP code)		<input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Other		
Parent/Guardian (Last, First, Middle)		Home Phone Number	Work/Cell Phone Number	
Early Childhood Program			Program Phone Number	
Primary Health Care Provider	Preferred Hospital	Health Insurance Company/Number* or Medicaid/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, development or behavior?  |
| 2.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizure disorder <input type="checkbox"/> other _____ |
| 3.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)? Please specify: _____  |
| 4.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (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, major illness or injury, or significant accident?  |
| 7.  | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?   |
| 8.  | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?   |
| 9.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a dental examination in the last 12 months?  |
| 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/coordinator?   |

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

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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	Date
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## Part II — Health Evaluation

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

Child's Name Birth Date (mm/dd/yy) Date of History/Physical Exam (mm/dd/yy)

LENGTH/HEIGHT		WEIGHT		WT FOR HT/BMI	HEAD CIRCUMFERENCE <sup>1</sup>		BLOOD PRESSURE <sup>2</sup>
IN/CM	%ILE	LB/KG	%ILE	%ILE	IN/CM	%ILE	/

Screening/Test Results				Immunization Record											
Screening Test	Result	Date	Abnormal/Comments	Vaccine (Month/Day/Year)											
<b>Vision<sup>2</sup></b> Test type: _____				Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6						
<b>Hearing<sup>3</sup></b> Test type: _____				<b>DTP</b>											
<b>Lead<sup>4</sup></b> Risk: Yes/No				<b>DTP/Hib</b>											
<b>TB<sup>4</sup></b> Risk: Yes/No				<b>DTaP</b>											
<b>Urinalysis (UA)<sup>4</sup></b>				<b>DT/Td</b>											
<b>Anemia<sup>5</sup></b> (HGB/HCT) Risk: Yes/No				<b>OPV</b>											
<b>Developmental Assessment<sup>6</sup></b> Test type: _____				<b>IPV</b>											
<b>Has this child received dental care in the last 12 months?<sup>7</sup></b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				<b>MMR</b>											
<b>* Chronic Disease Assessment:</b> Yes No <span style="float: right;">Date of onset</span>				<b>Measles</b>											
<input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified				<b>Mumps</b>											
<input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II				<b>Rubella</b>											
<input type="checkbox"/> <input type="checkbox"/> Anaphylaxis: <input type="checkbox"/> med. <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex				<b>HIB</b>											
<input type="checkbox"/> <input type="checkbox"/> Seizures: Type _____				<b>Hep B</b>											
<input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____				<b>Varicella</b>											
<b>Minimum requirements:</b> <sup>1</sup> Up to 2 years; <sup>2</sup> annual at 3 years; <sup>3</sup> annual at 4 years; <sup>4</sup> as needed; <sup>5</sup> 9–12 months; <sup>6</sup> each visit through 5 years; <sup>7</sup> annual at 2–3 years. <b>Federal requirements (eg, Head Start, WIC) may vary.</b> <b>*Prior to Public School Entry: Same as above and Hgb/hct.</b>				<b>PCV</b>											
															Pneumococcal conjugate vaccine
				<b>Other Vaccines (Specify)</b>											
				<b>Disease Hx of above</b> _____ (Specify) (Date mm/yy) (Confirmed by)											
				<b>Exemption</b>											
				Religious _____ Medical: Permanent _____ Temporary _____ Date _____											
				Recertify Date _____ Recertify Date _____ Recertify Date _____											

This child has the following problems which may adversely affect his or her educational experience:

Vision     Auditory     Speech/Language     Physical Dysfunction     Emotional/Social     Behavior  
 The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. *Specify:* \_\_\_\_\_

- Yes  No This child has 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 Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.  
 The child may fully participate in the program.  
 The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) \_\_\_\_\_

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 NP PA	Name (Please type or print.)	Phone number
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Address: \_\_\_\_\_

Yes  No Is this the child's Medical Home?    Next Appointment (mm/yy): \_\_\_\_\_    Next Immunization Appointment (mm/yy): \_\_\_\_\_