



Stamford Jewish Community Center
O-la-mi 2010
POLICY ON PEANUTS

Dear Parents,

Please be aware that there are children in O-la-mi with serious peanut (and other nut) allergies. While the JCC is not a peanut-free environment, we respectfully ask your help in minimizing possible exposure.

- Please do not send any peanuts, peanut butter or foods containing peanuts or peanut butter to be eaten at lunch.
- We will not be doing any projects that involve peanut butter (like bird feeders or peanut shell art projects).
- If your child ate peanut butter for breakfast, we would greatly appreciate your making sure that his/her hands are washed with soap and water before leaving home. Water alone does not do the trick!

While we know this may be difficult for some and a learning process for many of you, we trust that you understand how deeply important it is to work together to keep the children safe and healthy. If throughout the course of the year, you have any questions or concerns about food-allergy-related issues, please do not hesitate to contact us.

Thank you for your cooperation.

Sincerely,

Sarah Evans
Director, O-la-mi



Stamford Jewish Community Center
O-la-mi 2010
PERMISSION AGREEMENT

- A. I/we grant permission for my child to use all the play equipment and participate in all of the activities of the Stamford JCC, unless exceptions are noted here:
-
-
- B. I/we grant permission for my child to leave the Stamford JCC premises under the supervision of a Staff Member for neighborhood walks or for field trips in an authorized vehicle.
- C. I/we grant permission for my child to be included in evaluations and pictures connected with the Stamford JCC Programs.
- D. I/we hereby grant permission for the Stamford JCC Staff to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to the following:
1. Administer first aid
 2. Call 911
 3. Attempt to contact a parent or guardian
 4. Attempt to contact the parent through any of the persons listed on the emergency information card completed for the Center. (Note: It is the parents responsibility to keep this card up to date.)
 5. Attempt to contact the child's physician
 6. If we cannot contact the parent or the child's physician or depending upon the nature of the situation, we may do any or all of the following:
 - a. Call another physician
 - b. Call an ambulance, 911
 - c. Have the child taken to an emergency hospital in the company of a Staff Member
 7. Any expenses incurred while trying to secure appropriate emergency medical attention will be borne by the child's family.
- E. The Stamford JCC will not be responsible for anything that may happen as a result of false information given at the time of enrollment.
- F. The Stamford JCC will not assume responsibility for a child who has not been signed in when he/she arrives for the day.

Signed _____ Date _____
(Parent or Legal Guardian)



Child's Name _____ **Age**

In order to get to know your child better, please answer the questions below. Answering all questions in detail will help us make your child's summer experience the best it can be. (All information you provide will be kept confidential between the O-la-mi directors and your child's counselors.)

- 1. Has your child had any previous group experiences? Was a parent present?**

- 2. How did your child handle this experience?**

- 3. What makes your child happiest?**

- 4. What, if anything, frightens your child?**

- 5. What is your child's favorite activity?**

- 6. What adjectives best describe your child?**

-over-

- 7. How does your child react in large crowds?/With people he/she is unfamiliar with?**

- 8. Is there another language spoken at home besides English?**

- 9. Please list all of your child's allergies and/or dietary restrictions.**

- 10. Does your child have any medical, behavioral, or physical conditions which may affect his or her performance at O-la-mi? Please explain.**

- 11. Does your child have any chronic or recurring illnesses?**

- 12. Are there any specific activities from which your child should be restricted?**

- 13. Is there anything else you would like us to know about your child?**

-OVER-

I give permission for my child to participate in the O-la-mi swim program at the Jewish Community Center.

I/we give permission to the O-la-mi Staff to make whatever emergency (e.g. first aid, disaster evacuation) measures as judged necessary for the care and protection of my child while under supervision of the Center.

In case of medical emergency, I/we understand that my child will be transported to a medical facility by the local emergency unit for treatment if the local emergency resource (police, rescue squad) deems it necessary.

It is understood that in some medical situations, the staff will need to contact a local emergency resource before the parent, a child's physician and/or other adult acting on the parent's behalf.

Parent's Name _____ Daytime Phone _____

Signature _____ Date _____

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the JCC to hospitalize and secure proper treatment for and order injection or anesthesia for surgery for the person named above.

Parent's Name _____ Daytime Phone _____

Signature _____ Date _____



**Stamford Jewish Community Center
O-la-mi 2010
PHOTO PERMISSION FORM**

I/we give permission and consent for

PRINT CHILD'S/CHILDREN'S NAME(S)

**to allow photographs to be taken of him/her during O-la-mi session
activities.**

Parent/Guardian Name (PLEASE PRINT CLEARLY)

Parent/Guardian Signature _____

**I further give permission and consent that any such photographs may be
published in Stamford Jewish Community Center materials and/or used for
the purpose of illustrating and promoting O-la-mi's program experience.**

Parent/Guardian Name (PLEASE PRINT CLEARLY)

Parent/Guardian Signature _____



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 | Question |
|-----|--------------------------|--------------------------|---|
| 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.

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

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 ¹		BLOOD PRESSURE ²
IN/CM	%ILE	LB/KG	%ILE	%ILE	IN/CM	%ILE	/

Screening/Test Results			
Screening Test	Result	Date	Abnormal/Comments
Vision² Test type: _____			
Hearing³ Test type: _____			
Lead⁴ Risk: Yes/No			
TB⁴ Risk: Yes/No			
Urinalysis (UA)⁴			
Anemia⁵ (HGB/HCT) Risk: Yes/No			
Developmental Assessment⁶ Test type: _____			
Has this child received dental care in the last 12 months? ⁷ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
* Chronic Disease Assessment:			Date of onset
Yes No			
<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			
<input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II			
<input type="checkbox"/> <input type="checkbox"/> Anaphylaxis: <input type="checkbox"/> med. <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex			
<input type="checkbox"/> <input type="checkbox"/> Seizures: Type _____			
<input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____			
Minimum requirements: ¹ Up to 2 years; ² annual at 3 years; ³ annual at 4 years; ⁴ as needed; ⁵ 9-12 months; ⁶ each visit through 5 years; ⁷ annual at 2-3 years. Federal requirements (eg, Head Start, WIC) may vary. *Prior to Public School Entry: Same as above and Hgb/hct.			

Immunization Record						
Vaccine (Month/Day/Year)						
	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP						
DTP/Hib						
DTaP						
DT/Td						
OPV						
IPV						
MMR						
Measles						
Mumps						
Rubella						
HIB						
Hep B						
Varicella						
PCV						Pneumococcal conjugate vaccine
Other Vaccines (Specify)						
Disease Hx of above _____ (Specify) _____ (Date mm/yy) _____ (Confirmed by)						
Exemption						
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): _____

EMERGENCY HEALTH CARE PLAN

Place
child's
picture
here

ALLERGY TO: _____

Child's Name: _____ DOB: _____ Child Care Provider _____

History of Asthma Yes (high risk for severe reaction) No

Signs of an allergic reaction include:

Systems

Symptoms

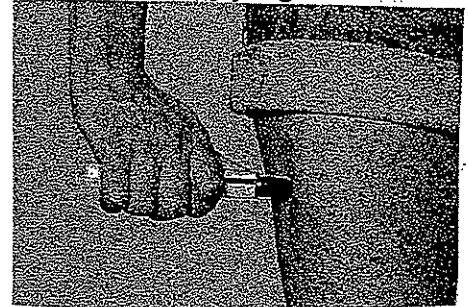
MOUTH
*THROAT
SKIN
GUT
*LUNG
*HEART

Itching & swelling of lips, tongue, or mouth
Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
Hives, itchy rash, and/or swelling about the face or extremities
Nausea, abdominal cramps, vomiting and/or diarrhea
Shortness of breath, repetitive coughing, and/or wheezing
"Thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:

If ingestion or insect sting is seen or suspected:
(prescriber should number in order all appropriate actions)



- _____ Observe child for severe symptoms
- _____ Administer EpiPen® before symptoms occur
- _____ Administer EpiPen® if symptoms occur
- _____ Administer Benadryl® (dose) _____ or Atarax® (dose) _____
- _____ Call 911 (and request a paramedic) and transport to ER if symptoms occur
- _____ Call 911 (and request a paramedic) and transport to ER if EpiPen® given

Preferred hospital: _____

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED!**

Parent Signature _____ Date _____ Prescriber Signature MD/APRN/PA _____ Date _____

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation: _____ Phone _____	1. _____ Room _____
2. _____ Relation: _____ Phone _____	2. _____ Room _____
3. _____ Relation: _____ Phone _____	3. _____ Room _____

For children with multiple allergies, use one form for each allergen

SUNSCREEN FORM

Parent/Guardian Authorization for the Administration of
Non-Prescription Topical Medications by Child Care Personnel

To Child Care Personnel:

I hereby request that the following non-prescription topical medications be administered to my child by a child care staff member of the Stamford JCC's Summer program, O-la-mi
(Name of child day care program)

I understand that I must supply the child care program with the non-prescription topical medication in the original container labeled with the child's name, name of the medication, and the directions of the medication administration.

This authorization is limited to the following topical medications:

1. Diaper changing or other ointments free of antibiotic, antifungal or steroidal medications
2. Medicated powders
3. Teething, gum, or lip medications

Name of Child: _____ Date of Birth: _____

Address: _____

Name of Medication: _____

Schedule of Administration: _____

Site of Administration: _____

Reason medication is being administered: _____

Medication shall be administered from: _____ to: _____

Name of Parent/Guardian _____ Date: _____

I have administered at least one dose of the above medication to my child without adverse side effects.

Signature: _____ Relationship to child: _____

Address: _____ Telephone: _____

Staff to complete:

Parent authorization form and medication received by: _____

(Signature of staff)

Medication Started: _____ (date and time)

Medication Ended: _____ (date and time)

Parent permission and medication administration record shall become part of the child's health record when the medication has ended.

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes 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 by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. 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. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____

Medication Name _____ Controlled Drug? YES NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration Start Date ____/____/____ Stop Date ____/____/____

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Signature _____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

Name of Day Care Program _____ Today's Date ____/____/____

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: Mother Father Guardian/Other explain: _____

Address _____ Town _____ Phone Number (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Childcare Personnel Receiving Written Authorization and Medication _____

Title/Position _____ **Signature (in ink)** _____

EMERGENCY HEALTH CARE PLAN

Place
child's
picture
here

ALLERGY TO: _____

Child's Name: _____ DOB: _____ Child Care Provider _____

History of Asthma Yes (high risk for severe reaction) No

Signs of an allergic reaction include:

Systems

Symptoms

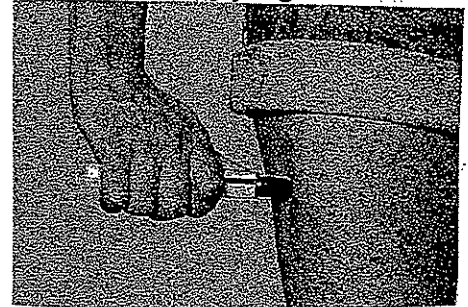
MOUTH
*THROAT
SKIN
GUT
*LUNG
*HEART

Itching & swelling of lips, tongue, or mouth
Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
Hives, itchy rash, and/or swelling about the face or extremities
Nausea, abdominal cramps, vomiting and/or diarrhea
Shortness of breath, repetitive coughing, and/or wheezing
"Thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:

If ingestion or insect sting is seen or suspected:
(prescriber should number in order all appropriate actions)



- _____ Observe child for severe symptoms
- _____ Administer EpiPen® before symptoms occur
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- _____ Call 911 (and request a paramedic) and transport to ER if symptoms occur
- _____ Call 911 (and request a paramedic) and transport to ER if EpiPen® given

Preferred hospital: _____

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED!**

Parent Signature _____ Date _____ Prescriber Signature MD/APRN/PA _____ Date _____

	Address		Phone
EMERGENCY CONTACTS		TRAINED STAFF MEMBERS	
1. _____ Relation: _____ Phone _____		1. _____ Room _____	
2. _____ Relation: _____ Phone _____		2. _____ Room _____	
3. _____ Relation: _____ Phone _____		3. _____ Room _____	

For children with multiple allergies, use one form for each allergen