HOSPITAL FOR SPECIAL CARE

Adaptive Sports Program

The Hospital for Special Care Ivan Lendl Adaptive Sports Camp, a program of Hospital for Special Care Community Services, Inc., **will be held at Quinnipiac University, Hamden, Connecticut: August 7 - 11, 2023**.

Camp, offered free-of-charge to youth ages 6-19 living with physical disabilities, is held Monday – Friday from 9:00a.m. to 4:00p.m. Instruction is provided in a variety of sports such as tennis, basketball, boccia, and soccer. No previous sport experience is necessary. Campers are asked to bring their own wheelchair and other personalized adaptive equipment for greatest success. A number of sport wheelchairs will be available for trial use during camp, but are to be shared equally among all campers.

The HSC Sports & Community Program Manager serves as the Camp Director, providing leadership and oversight. Support staff include: a registered nurse, coaches and program specialists with experience in adaptive sports and recreation and counselors who themselves are athletes living with physical disabilities. Additionally, camp relies heavily on volunteers from the community, of whom many have been associated with the camp since its inception.

REGISTRATION is easy. Please follow these steps:

- Step 1: **Space is limited.** Reserve your spot today by calling (860-832-6220) or emailing me that you are requesting a place so that I can reserve a spot for you: (jconnolly@hfsc.org)
- Step 2: Complete and return the Registration Form and Liability Release ASAP. ***(Registration is on a first-come, first-serve basis).***
- Step 3: Complete and return the enclosed health/exam record ***by July 22, 2023.*** Note: Health Exam records are good for 3 years so if you have one dated within this time frame, you may use it. Campers who will be bringing medication to camp are required to complete an Authorization for medication administration form in addition to the medical form. ***Placement is contingent upon receipt of a completed Health Exam form signed by a physician, PA or APRN or RN.***
- Step 4: Return all additional forms ***no later than JULY 27, 2023.***

All registrants will receive a confirmation email that includes details such as acceptance, list of what to bring, a sample schedule and updated guidelines for the week of camp.

Hospital for Special Care is very proud of the HFSC Ivan Lendl Adaptive Sports Camp. It is so much more than sports skills acquisition. It's about relationships, independence and leadership skills that are acquired and the many positive memories that are made. Don't miss out on your opportunity to be involved.

Reach out with any questions that you may have.

Sincerely,

Janet

Janet Connolly, MS, CTRS
Sports & Community Program Manager
jconnolly@hfsc.org
Phone: (860)832-6220

HOSPITAL FOR SPECIAL CARE

Adaptive Sports Program

Date: _____

Participant Registration Form

Program(s): *(Check all that apply)*

- ☐ Chargers Indoor Wheelchair Soccer Team
- ☐ Cruisers Track & Field and Racing Team
- ☐ Hospital for Special Care Ivan Lendl Adaptive Sports Camp
- ☐ Spokebenders Wheelchair Basketball Team
- ☐ Junior Wheelchair Basketball with Ryan Martin Foundation
- ☐ Inclusive Recreation Events
- ☐ Wave Swim Team

Role(s): *(Check all that apply)*

- ☐ Athlete
- ☐ Coach
- ☐ Volunteer
- ☐ Student Observer
- ☐ Professional
- ☐ Other: _____

PARTICIPANT INFORMATION

_____

Name of participant – last, first, middle

Date of birth: ___/___/___ Age: _____ Height: _____ Weight: _____ Gender: ☐ M ☐ F

_____

Home address Number and street City/State/Zip

(_____) _____ (_____) _____ _____

Home phone Cell phone Email address

PARENT INFORMATION *(required for participants under 18)*

_____(_____)_____(_____)_____

Mother/legal guardian name Cell phone Other

_____(_____)_____(_____)_____

Father/legal guardian name Cell phone Other

EMERGENCY CONTACT *(other than parent/guardian)*

_____(_____)_____

Name Phone Relationship to participant

Primary care physician name _____ Phone (_____)_____

Insurance company name _____

Policy number _____ Policy holder's name _____

HEALTH HISTORY

Primary diagnosis _____ Date of onset _____

Secondary diagnosis _____ Date of onset _____

Please check and provide an explanation for any present or past conditions that apply below:

☐ Allergies	☐ Communication	☐ Health	☐ Seizures	☐ Vision
☐ Behavioral	☐ Digestion	☐ Hearing	☐ Sensation	☐ Other *(please list below)*
☐ Bone/joint	☐ Elimination	☐ Heart	☐ Special diet	
☐ Breathing	☐ Emotional/ mental	☐ Muscular	☐ Thinking/ cognition	
☐ Circulation		☐ Pain		

Explanation

_____

_____

Date of last tetanus shot/booster _____

Significant Medical Procedures *(Describe procedure and date)*

_____

_____

Medications *(Include name, dose, frequency for all prescriptions, emergency and over-the counter medications)*

_____

_____

Adverse Reactions *(Please list any adverse reactions to medications or environmental stimuli that could affect individual's participation)*

_____

_____

DESCRIBE YOUR ABILITIES/DIFFICULTIES IN THE FOLLOWING AREAS (*include assistance required or equipment needed)*

Physical Function *(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

_____

_____

Activity Restrictions

_____

_____

Psycho/Social Function *(i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)*

_____

_____

Toileting

Urinary: ☐ Continent ☐ Incontinent Bowel: ☐ Continent ☐ Incontinent

Assistance required by participant/devices used

_____

Barrier(s) to participation *(Check all that apply)*

- ☐ Adaptive Equipment
- ☐ Aide / "Buddy"
- ☐ Financial
- ☐ Overnight Lodging
- ☐ Transportation

GENERAL INFORMATION

How did you hear of Hospital for Special Care Adaptive Sports /Mentorship Programs? *(Check all that apply)*

☐ Web site ☐ Newspaper ☐ Friend ☐ Brochure ☐ Therapy clinic ☐ School ☐ Physician office

☐ Other _____

Have you participated in Hospital for Special Care programs before? ☐ Yes ☐ No

Do you participate in adaptive sports or mentorship programs outside of Hospital for Special Care programs?

☐ Yes ☐ No If yes, what programs _____

What are your strengths? _____

Is there a special goal this year you would like to achieve while participating? _____

_____

Do you have any concerns about participating? _____

_____

DEMOGRAPHIC INFORMATION *(requested on many grant applications that help fund the programs)*

Which category best describes participant's race or ethnicity?

☐ African American (not of Hispanic origin) ☐ Asian American or Pacific Islander

☐ Caucasian/White (not of Hispanic origin) ☐ Hispanic ☐ Multiracial ☐ Other _____

Is participant a veteran? ☐ Yes ☐ No

What category best describes participant's annual household income? *(Optional)*

☐ Less than $24,999 ☐ $25,000 to $49,999 ☐ $50,000 to 99,999 ☐ $100,000 or more

Please return completed registration form to:

Janet Connolly, MS, CTRS, Sports & Community Program Manager
Hospital for Special Care Adaptive Sports
2150 Corbin Avenue
New Britain, Connecticut 06053

For questions please contact Janet Connolly:

Email: JConnolly@hfsc.org
Fax: 860.612.6368
Phone: 860.832.6220

FOR OFFICE USE ONLY

Date rec'vd: _____

Additional Forms	Date Sent	Date Rec'vd	Update
Aquatic Rehab Center Registration	_____	_____	_____
HSC Confidentiality Agreement	_____	_____	_____
HSC CRUISER Liability Waiver/Registration	_____	_____	_____
HSC Liability Waiver	_____	_____	_____
HSC Photo Release	_____	_____	_____
HSC Ivan Lendl Camp Medical Form	_____	_____	_____
HSC Ivan Lendl Camp Waiver/Photo Release	_____	_____	_____
HSC Ivan Lendl Camp Medical Authorization	_____	_____	_____
HSC Ivan Lendl Camp Prescription Authorization	_____	_____	_____

Revised 2/2019

Participant Name:_____

HOSPITAL FOR SPECIAL CARE
Adaptive Sports Program

IVAN LENDL ADAPTIVE SPORTS CAMP
RELEASE OF LIABILTY

AND

AUTHORIZATION TO USE AND DISCLOSE PHOTOGRAPHS AND RECORDINGS AND RELATED PERSONAL INFORMATION OF PARTICIPANT

I, the undersigned, give full permission for _____ (Name of Participant) to be observed and have photographic images taken of him/her while participating in activities of the **Hospital for Special Care Ivan Lendl Adaptive Sports Camp** (the "Camp") held on the campus of Quinnipiac University, Hamden, Connecticut.

I understand that photographic images may include still photographs, digital images, video filming or audio recordings, and other similar formats.

I further give permission to use and disclose my name and my child's/ward's name, as indicated: ____ full name, ____ first name only, and/or ____ initials only (hereinafter "name").

I further give permission to use or disclose to authorized third parties, including members of the public, such photographic image(s) and name for the following purposes:

- ☐ fundraising materials
- ☐ written publication(s) (for example, the entity's Annual Report)
- ☐ television or radio coverage
- ☐ advertising/marketing materials
- ☐ use on the entity's website
- ☐ public relations/media requests
- ☐ publication of research/education materials
- ☐ social media page (for example, Facebook)
- ☐ other:_____

Provide further details of intended use, if any: _____

If the purpose of this Authorization involves taking of photographic images for journalistic and/or media purposes (including print, television or electronic media), I further authorize representatives of the news media involved to observe the activities being conducted, and to discuss them with the Camp staff. I realize that the result of this observation may be publication or broadcast of facts concerning my child's/ward's medical condition.

I expressly waive any right to control copying, reproduction, or distribution of any photographic images taken in accordance with this authorization, and I expressly waive any right to any compensation whatsoever for any use of such photographic images.

I understand that this authorization is only for the specific, stated purposes. I understand that this authorization is valid and enforceable for a period of five (5) years from the date it is signed, but it may be revoked by me at any time upon written request to the Camp, except to the extent that action has been taken in reliance on this authorization.

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury while participating in activities at the Camp, I authorize representatives of Hospital for Special Care Ivan Lendl Adaptive Sports Camp to secure and retain medical treatment and transportation if needed.

I certify that I am over eighteen (18) years of age and have the legal right and authority to sign this form on my behalf or that of the Participant/child/ward named herein. I understand the meaning of this form, and I hereby release Hospital for Special Care Ivan Lendl Adaptive Sports Camp and its parent organization and affiliates (including Hospital for Special Care and Hospital for Special Care Foundation, Inc.), and their respective agents, servants, employees, physicians, officers, directors, and consultants from any claim or liability whatsoever in connection with the taking or use of photographic images and related observation, and any accompanying disclosures, publication, or broadcast of photographic images and/or the Participant's name or related health information or related material.

I further release and forever discharge and agree to indemnify and hold harmless Hospital for Special Care Ivan Lendl Adaptive Sports Camp and its parent organization and affiliates (including Hospital for Special Care and Hospital for Special Care Foundation, Inc.), and their respective agents, servants, employees, physicians, officers, directors, and consultants from any claims and demands of any and every kind and character for any injury to myself, my child's/ward's person or damage to property as a result of participation in activities of the Camp.

_____ _____

Signature of Participant (or Parent/Guardian or Personal Representative) Date

Relationship to the Participant, if applicable: _____

_____ _____

Witness: (If Participant is physically unable to sign) Date

Updated: 5/9/2023

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

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

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

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

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

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

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

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

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

Screenings

***Vision Screening**

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

❑ Referral made

***Auditory Screening**

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

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

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

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

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian — Date

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	Date Signed	Printed/Stamped ***Provider*** Name and Phone Number

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

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

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

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

Renew Date: _____ _____ _____ _____

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

CONCUSSION Information Sheet

This sheet has information to help protect your children or teens from concussion or other serious brain injury. Use this information at your children's or teens' games and practices to learn how to spot a concussion and what to do if a concussion occurs.

What Is a Concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

How Can I Help Keep My Children or Teens Safe?

Sports are a great way for children and teens to stay healthy and can help them do well in school. To help lower your children's or teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - Work with their coach to teach ways to lower the chances of getting a concussion.
  - Talk with your children or teens about concussion and ask if they have concerns about reporting a concussion. Talk with them about their concerns; emphasize the importance of reporting concussions and taking time to recover from one.
  - Ensure that they follow their coach's rules for safety and the rules of the sport.
  - Tell your children or teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your children or teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. However, there is no "concussion-proof" helmet. So, even with a helmet, it is important for children and teens to avoid hits to the head.

Plan ahead. What do you want your child or teen to know about concussion?

How Can I Spot a Possible Concussion?

Children and teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

Signs Observed by Parents or Coaches

- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness *(even briefly)*.
- Shows mood, behavior, or personality changes.
- Can't recall events *prior to* or *after* a hit or fall.

Symptoms Reported by Children and Teens

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not "feeling right," or "feeling down."

Talk with your children and teens about concussion. Tell them to report their concussion symptoms to you and their coach right away. Some children and teens think concussions aren't serious or worry that if they report a concussion they will lose their position on the team or look weak. Be sure to remind them that *it's better to miss one game than the whole season.*

To learn more, go to www.cdc.gov/HEADSUP

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Concussions affect each child and teen differently. While most children and teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your children's or teens' health care provider if their concussion symptoms do not go away or if they get worse after they return to their regular activities.

HEADS UP CONCUSSION

What Are Some More Serious Danger Signs to Look Out For?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or take your child or teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other.
- Drowsiness or inability to wake up.
- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching).
- Unusual behavior, increased confusion, restlessness, or agitation.
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously.

Children and teens who continue to play while having concussion symptoms or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious and can affect a child or teen for a lifetime. It can even be fatal.

What Should I Do If My Child or Teen Has a Possible Concussion?

As a parent, if you think your child or teen may have a concussion, you should:

1. Remove your child or teen from play.
2. Keep your child or teen out of play the day of the injury. Your child or teen should be seen by a health care provider and only return to play with permission from a health care provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's health care provider for written instructions on helping your child or teen return to school. You can give the instructions to your child's or teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a health care provider should assess a child or teen for a possible concussion. Concussion signs and symptoms often show up soon after the injury. But you may not know how serious the concussion is at first, and some symptoms may not show up for hours or days.

The brain needs time to heal after a concussion. A child's or teen's return to school and sports should be a gradual process that is carefully managed and monitored by a health care provider.

To learn more, go to www.cdc.gov/HEADSUP

You can also download the CDC *HEADS UP* app to get concussion information at your fingertips. Just scan the QR code pictured at left with your smartphone.

Revised 5/2015

Discuss the risks of concussion and other serious brain injury with your child or teen and have each person sign below.

Detach the section below and keep this information sheet to use at your children's or teens' games and practices to help protect them from concussion or other serious brain injury.

○ I learned about concussion and talked with my parent or coach about what to do if I have a concussion or other serious brain injury.

Athlete Name Printed: _____ Date: _____

Athlete Signature: _____

○ I have read this fact sheet for parents on concussion with my child or teen and talked about what to do if they have a concussion or other serious brain injury.

Parent or Legal Guardian Name Printed: _____ Date: _____

Parent or Legal Guardian Signature: _____

HOSPITAL FOR SPECIAL CARE

Adaptive Sports Program

IVAN LENDL ADAPTIVE SPORTS CAMP
Authorized Designated Drop Off/Pick-up and Policies Consent Form

Camper Name: _____ Age: _____ Dates of Camp: August 7 - 11, 2023

If Parent or Legal Guardian are not able to Drop Off/Pick up camper, the following individuals are authorized to do so:

Main Drop Off/Pickup
Designee's Name: _____ Phone: _____ Relation to Camper: _____

Alternate Drop Off/Pickup
Designee's Name: _____ Phone: _____ Relation to Camper: _____

Hospital for Special Care Ivan Lendl Adaptive Sports Camp Drop off/Pick up Policy

- As a preventative measure, Hospital for Special Care requires all on-site program participants without a parent/guardian present to have a signed **Authorized Designated Drop off/Pickup Consent Form**, so we have knowledge of who is authorized to transport each camper.
- Hospital for Special Care Ivan Lendl Adaptive Sports Camp requires **ALL parents/guardians or those individuals Authorized above to sign-in and sign-out campers** at the registration area each day. Campers age 18 and over are allowed to sign themselves in and out.

Hospital for Special Care Ivan Lendl Adaptive Sports Camp is designed to promote a healthy, safe and educational environment for all children to enjoy a summer camp experience. These policies are in place so that all campers know they are expected to behave well, listen to the camp counselors and contribute to a positive and fun environment for everyone.

Sick Policy: For the safety and health of all of our summer campers and staff, all camp participants must come to camp healthy and stay home if they are sick. Any child, attending camp that appears visibly ill upon check in or during the course of the day, will be sent home immediately. Please **do not** bring your child to camp if he or she has any of the following ailments or illnesses.

- Any contagious diseases such as Pink Eye, Chicken Pox, Measles, etc.
- Excessive Coughing, Excessive Runny Nose or Sore Throat
- Fever/Chills (99°or higher)
- Vomiting
- Skin rash* or open sores* (*unless we have doctor's written clearance that condition is not contagious,)

Signature of Parent/Legal Guardian:_____

Printed Name of Above Individual:_____

HOSPITAL FOR SPECIAL CARE

Adaptive Sports Program

IVAN LENDL ADAPTIVE SPORTS CAMP

NON-PRESCRIPTION, TOPICAL MEDICATION AUTHORIZATION FORM

(To be completed by parent or Legal Guardian of minor)

☐ Camper ☐ Staff ☐ Volunteer

Name _____ Date _____

Parent/Guardian _____ Phone _____

Topical Medication or Sunscreen _____

If sunscreen, all types/brands allowed? _____YES _____ NO (If NO, camper will be expected to provide their own)

Conditions of Application (when to apply, area of body) _____

Length of time for application: Start Date___**8/7/2023**____ End Date __**8/11/2023**_____

Specific Instructions _____

Please note:

- Label instructions must be followed unless a note from camp participant's healthcare provider is provided.
- **A separate form is required for each non-prescription, topical medication or sunscreen.**

_____ _____

Signature of Participant over the age of 18 or Parent/Legal Guardian Date

Hospital for Special Care
Ivan Lendl Adaptive Sports Camp
2150 Corbin Avenue, New Britain, CT 06053 860-832-6220

HOSPITAL FOR SPECIAL CARE

Adaptive Sports Program

Ivan Lendl Adaptive Sports Camp
Authorization for the Administration of Medication

In Connecticut, licensed Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the CT State Statutes and Regulations. Parents/guardians requesting medication administration to their child while at camp 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. All unused medication shall be destroyed if not picked up within one week following the camper's departure at the end of camp.

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

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

Address _____ Town _____ Phone Number (_____) _____

Medication Name _____ Controlled Drug? ☐ YES ☐ NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration: Start Date _____/_____/_____ Stop Date _____/_____/_____

Is this medication to be self-administered by the child? ☐ Yes ☐ No

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 _____

Prescriber's Signature _____ Today's Date ____/____/____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above.

Name of Parent/Guardian Authorizing Administration of Medication as described and directed above:

First Name _____ Last Name _____

Address _____ Town _____ Phone Number (_____) _____

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

Signature of Parent/Guardian _____ Today's Date _____/_____/_____

Name of camp staff receiving written authorization and medication _____

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

Medication Administration Record (MAR)

Name of Child _____ **Date of Birth** _____/_____/_____

Pharmacy Name _____ **Prescription Number** _____

Medication Order _____

Date	Time	Dosage	Remarks	Was This Medication Self Administered?	Signature of Person Observing or Administering Medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ **Authorization form is complete**

☐ **Medication is appropriately labeled**

☐ **Medication is in original container**

☐ **Date on label is current**

Person Accepting Medication (print name) _____ **Date** _____/_____/_____

IVAN LENDL

Individual Plan of Care for a Child

With Special Health Care Needs or Disabilities

Child's Name:_____ Date of Birth____/____/_____

Special health care need or disability:

Plan for appropriate care of the child in a medical emergency. An individual Plan of Care is necessary when a child has a special health care need or disability and it is necessary that special care be taken or provided while the child is at the youth camp.

Other relevant information: (e.g. precautions to be taken to prevent a medical or other emergency)

Signature(s) of the Parent(s): Date Signed:

_____ ____/____/____

_____ ____/____/____

NOTE: Section 428-3(a) requires a child's health record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities. The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Such plan of care shall include appropriate care of the camper in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the camper.

Please use the reverse side of this form for signature(s) of all staff responsible for the care of this child.

Signature of the staff responsible for ______________________________________(name of child)

Printed Name	Signature	Date Signed	Printed Name	Signature	Date Signed