The Hospital for Special Care Ivan Lendl Adaptive Sports Camp, a program of Hospital for Special Care Community Services, Inc., will be held at Berlin High School, Berlin, Connecticut: July 29 – August 2, 2024.

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, 2024. 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 24, 2024.

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
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 ☐ Elimination ☐ 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: __________________________

<table>
<thead>
<tr>
<th>Additional Forms</th>
<th>Date Sent</th>
<th>Date Rec’vd</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aquatic Rehab Center Registration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC Confidentiality Agreement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC CRUISER Liability Waiver/Registration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC Liability Waiver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC Photo Release</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC Ivan Lendl Camp Medical Form</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC Ivan Lendl Camp Waiver/Photo Release</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC Ivan Lendl Camp Medical Authorization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC Ivan Lendl Camp Prescription Authorization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Revised 2/2019
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) ________________________________

__________________________    ______________________

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

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.
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

<table>
<thead>
<tr>
<th>Student Name (Last, First, Middle)</th>
<th>Birth Date</th>
<th>☐ Male ☐ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street, Town and ZIP code)</td>
<td>Home Phone</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>Parent/Guardian Name (Last, First, Middle)</td>
<td>Race/Ethnicity</td>
<td>☐ Black, not of Hispanic origin</td>
</tr>
<tr>
<td>☐ American Indian/Alaskan Native ☐ Hispanic/Latino</td>
<td>☐ White, not of Hispanic origin</td>
<td></td>
</tr>
<tr>
<td>School/Grade</td>
<td>☐ Asian/Pacific Islander</td>
<td>☐ Other</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>Health Insurance Company/Number* or Medicaid/Number*</td>
<td></td>
</tr>
<tr>
<td>Does your child have health insurance? Y N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your child have dental insurance? Y N</td>
<td>If your child does not have health insurance, call 1-877-CT-HUSKY</td>
<td></td>
</tr>
</tbody>
</table>

* 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.

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

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

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Birth Date</th>
<th>Date of Exam</th>
</tr>
</thead>
</table>

- 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*

<table>
<thead>
<tr>
<th><em>Height</em> in.</th>
<th><em>Weight</em> lbs.</th>
<th><em>BMI</em></th>
<th>% Pulse</th>
<th><em>Blood Pressure</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Normal</th>
<th>Describe Abnormal</th>
<th>Ortho</th>
<th>Normal</th>
<th>Describe Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurologic</td>
<td></td>
<td>Neck</td>
<td>Shoulders</td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
<td>Arms/Hands</td>
<td></td>
</tr>
<tr>
<td><em>Gross Dental</em></td>
<td></td>
<td></td>
<td>Hips</td>
<td></td>
</tr>
<tr>
<td>Lymphatic</td>
<td></td>
<td></td>
<td>Knees</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td>Feet/Ankles</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia/ hernia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Screenings

**Vision Screening**

<table>
<thead>
<tr>
<th>Type:</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>With glasses</td>
<td>20/</td>
<td>20/</td>
</tr>
<tr>
<td>Without glasses</td>
<td>20/</td>
<td>20/</td>
</tr>
</tbody>
</table>

- Referral made

**Auditory Screening**

<table>
<thead>
<tr>
<th>Type:</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass</td>
<td>Pass</td>
<td></td>
</tr>
<tr>
<td>Fail</td>
<td>Fail</td>
<td></td>
</tr>
</tbody>
</table>

- Referral made

- No spinal abnormality
- Spine abnormality: 
  - Mild
  - Moderate
  - Marked
  - Referral made

### Immunizations

- **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

*If yes, please provide a copy of the Emergency Allergy Plan to School*

- **Allergies**
  - History of Anaphylaxis
  - No
  - Yes
  - Epi Pen required

- **Diabetes**
  - No
  - Yes:
    - Type I
    - Type II

- **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

Completed by:

- Dentist
- MD/DO
- APRN
- PA
- Dental Hygienist

Visual Screening

Completed by:

- Dental or orthodontic appliance
- Saliva
- Gingival condition
- Visible plaque
- Tooth demineralization
- Other

Normal

- Yes
- Abnormal (Describe)

Referral Made:

- Yes
- No

Risk Assessment

- Low
- Moderate
- High

Describe Risk Factors

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

**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.*

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

**Disease Hx of above:** (Specify) (Date) (Confirmed by)

**Religious Exemption:**

**Medical Exemption:**

---

**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.
- 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: 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.
- Meninococcal: 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.

**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.
Hospital for Special Care and Affiliates

Release of Liability

I UNDERSTAND and agree that I will be using equipment owned by Hospital for Special Care (the “Equipment”) for The Hospital for Special Care Ivan Lendl Adaptive Sports Camp to be held on or about July 29 – August 2, 2024.

I UNDERSTAND and agree that using the Equipment involves certain inherent risks, dangers and hazards which can result in serious personal injury and that personal injuries and damage to property are a common and ordinary occurrence in the use of such Equipment. I hereby agree to freely and expressly assume any and all risks of injury to myself or damage to my property while using the Equipment.

I UNDERSTAND that there is absolutely NO GUARANTEE OF MY SAFETY.

I UNDERSTAND that I am responsible for any damage to the Equipment while it is in my possession. This includes, but is not limited to, theft or loss.

I UNDERSTAND there are NO WARRANTIES, expressed or implied, and that I use said Equipment AS IS.

I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby agree to indemnify and hold harmless, and to release and forever discharge the Hospital for Special Care, HSC Community Services, Inc. and their parent entity, and the respective directors, officers, employees, and affiliates of each such entity (“Releasees”), with respect to all and any injury, disability, death, or loss or damage to person or property, whether arising from the negligence of the Releasees or otherwise, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK (“RELEASE”), FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I WILL BE GIVING UP RIGHTS BY SIGNING THIS AGREEMENT, AND SIGN IT FREELY AND VOLUNTARILY.

I ATTEST THAT I AM AT LEAST 18 YEARS OLD AS OF THE DATE I SIGN THIS RELEASE.

___________________________________   _____________________
Participant’s Name      Date:

___________________________________
Signature of Participant (or Parent/Guardian or Personal Representative)
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.

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
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.

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.
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.
<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Signature</th>
<th>Date Signed</th>
<th>Printed Name</th>
<th>Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IVAN LENDL ADAPTIVE SPORTS CAMP
Authorized Designated Drop Off/Pick-up and Policies Consent Form

Camper Name: ________________________________ Age: ___________ Dates of Camp: July 29 – August 2, 2024

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/Pickup 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: _________________________________________________________
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________________________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Dosage</th>
<th>Remarks</th>
<th>Was This Medication Self Administered?</th>
<th>Signature of Person Observing or Administering Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

*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 _____/_____/______
Participant Name:___________________________

IVAN LENDL ADAPTIVE SPORTS CAMP
RELEASE OF LIABILITY

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 Berlin high School, Berlin, 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 of an 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: 5/7/2024