Connecticut Center for Arts and Technology

CONNCAT

SUMMER 2016 Program • FULL APPLICATION

Youth Information

NAME OF APPLICANT ______________________________

Last name, First Name

ADDRESS: ______________________________

Street Unit City Zip

GRADE (during 2016 - 2017) 5 6 7 8 9 10 11 **AGE:** **SCHOOL NAME:** ______________________________

DATE OF BIRTH: ______________ Male Female Youth M Youth L S M L XL

Month/Day/ Year **Gender** **T- shirt Size**

SIBLING(S): Does your child have a sibling applying for Summer '16? ☐ Yes ☐No

If YES, please write sibling's name(s): ______________________________

ETHNICITY RACE: Do you consider yourself to be Hispanic/Latino? * ☐ Yes ☐No

☐ Black or African American ☐ White/Caucasian ☐ American Indian or Alaskan Native

☐ Multi-Racial ☐ Asian/Pacific Islander ☐ Other

Parent/Guardian Information

NAME OF PARENT/GUARDIAN 1 ______________________________

Last name, First Name

ADDRESS: ______________________________

Street Unit City Zip

DAYTIME CONTACT INFORMATION ( ) @ ______________________________

Telephone number Active Email Address

CURRENT CELLPHONE NUMBER ( ) ______________________________

Cellphone number

*Would you like to receive text notifications for emergencies/occasional updates? YES or NO

.-

NAME OF PARENT /GUARDIAN 2 ______________________________

Last name, First Name

ADDRESS: ______________________________

(if different) Street Unit City Zip

DAYTIME CONTACT INFORMATION ( ) @ ______________________________

Telephone number Active Email Address

Return completed forms to 4 Science Park, New Haven, CT 06511 Attention: Youth Programming

Connecticut Center for Arts and Technology

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Emergency Contact and Medical Information for a Child

Child's Name _____ Date of Birth _____ M F Sex

Parent's/Guardian's Name _____ Parent's/Guardian's Name _____

( ) _____ ( ) _____ ( ) _____ ( ) _____

Home Phone Work Phone Home Phone Work Phone

Address _____ Address _____

City, ST ZIP Code _____ City, ST ZIP Code _____

Alternative Emergency Contacts

Primary Emergency Contact _____ Secondary Emergency Contact _____

( ) _____ ( ) _____ ( ) _____ ( ) _____

Home Phone Work Phone Home Phone Work Phone

Address _____ Address _____

City, ST ZIP Code _____ City, ST ZIP Code _____

Medical Information

Hospital/Clinic Preference _____

Physician's Name _____ Phone Number _____

Insurance Company _____ Policy Number _____

Allergies/Special Health Considerations _____

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature _____ Date _____

I give permission for my child to go on field trips. I release ConnCAT and individuals from liability in case of accident during activities related to ConnCAT, as long as normal safety procedures have been taken.

Parent's/Guardian's Signature _____ Date _____

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SUMMER PROGRAM COMMITMENTS

CONNCAT COMMITMENT

Align and extend the strategic learning goals of the public schools by helping to improve attendance and behavior.
Create an environment that is a safe, nurturing environment for creative expression.
Create a culture that instills pride, personal value and hope and celebrates success.
Communicate regularly with parent and school for the benefit of the child's progress.

PARENT COMMITMENT

Parents/Guardians must attend an Orientation at ConnCAT.
Parents/Guardians will provide a copy of child's most recent physical exam
Parents/Guardians will complete a pre and post survey.
Parents/Guardians are expected to attend student art exhibitions (i.e., Summer Showcase 8/11/16)
Parents/Guardians must arrange transportation for child to and from ConnCAT.
Remain in contact with ConnCAT pertaining to all matters concerning child participation in the summer program.

PARTICIPANT COMMITMENT

Participants are expected to participate FULLY in ALL courses and the Summer Showcase (8/11/16)
Excessive absences (2 or more) will result in termination from the program. (See code of conduct)
Participants are expected to adhere to the ConnCAT code of conduct at all times.
Participants will complete a pre and post survey.

We have read the summer program commitments for ConnCAT and agree to abide by them.

Participant Signature: _____
Participant Print:_____

Parent/Guardian Signature: _____
Parent Guardian Print:_____

Code of Conduct

Note: Youth that are granted the opportunity to participate in ConnCAT will be expected to be familiar with our Core Values and to abide by the program rules and regulations which are as follows:

- Participants are expected to arrive on time.
- Workshop facilitators must know where participants are at all times.
- Once participants are dropped off at ConnCAT, they must remain on the premises with youth staff until they are properly dismissed (walking to nearby stores is not permitted).
- Use of foul language is unacceptable and will not be tolerated. The participant's involvement in the program can be terminated if violation of this rule occurs at any point in during the program.
- Appropriately dress is required. Clothing must not be revealing. (Half shirts, short skirts, pants below the waist, etc. are not permitted) Clothing with profanity or negative images is not permitted.
- Bandanas, do-rags, and hats are not permitted.
- **Keep your hands to yourself!** No play fighting, fighting, kissing, or inappropriate touching. Participants may be removed from the program immediately if a violation of this rule occurs.
- Participants must actively participate in hands on activities, ice breakers, and workshops. Negative attitudes and lack of enthusiasm hinder the growth process. Refusal to participate will result in removal from the program.
- Cell phones and electronic devices are strictly prohibited during class time. **STUDENTS SEEN WITH A CELL PHONE WILL BE ASKED ONCE TO PUT IT AWAY. IF THE CELL PHONE IS SEEN AGAIN IT WILL BE TAKEN BY THE INSTRUCTOR AND MUST BE PICKED UP BY THE PARENT OR GUARDIAN AT DISMISSAL.**
- Absences must be followed by a phone call or a note from the parent or guardian. Parents must call/text/email in advance if it is a planned absence (203)823-9823. ***NO MORE THAN 2 ABSENCES ARE ALLOWED DURING THE SUMMER PROGRAM – MORE THAN 2 ABSENCES IN WILL RESULT IN DISMISSAL FROM THE PROGRAM**
- All participants must maintain a respectful attitude toward one another and authority figures.
- Participants will not initiate or accept any communication from workshop facilitators or instructors outside of program hours or sanctioned ConnCAT activities. This includes, but is not limited to Facebook, Twitter, and email.

We have read the rules and regulations for ConnCAT and agree to abide by them.

Participant Signature: _____

Participant Print:_____

Parent/Guardian Signature: _____

Parent Guardian Print:_____

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PARENT QUESTIONNAIRE

1) Does your child have an **IEP** or **receive special services** at school? ☐YES ☐NO

If yes, please share details that will help us provide a productive experience for him/her. _____

_____

_____

_____

2) Is there anything you would like to share about your child that will help us provide a productive experience for him/her? If yes, please explain. _____

_____

_____

_____

3) The summer program runs **Monday through Friday.** Is there any reason that your child may not be able to attend on a regular and consistent basis? If yes, please explain. _____

_____

_____

4) How did you first hear about ConnCAT Youth Programs? Check all that apply

- ☐ Facebook, Instagram, or other social media
- ☐ TV Advertisement
- ☐ School Announcement
- ☐ Family Member/Friend
- ☐ Existing ConnCAT Participant
- ☐ ConnCAT Adult Program Info Session

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Form for Media Recording

I, the parent/guardian of _____, do hereby consent and agree that ConnCAT, its employees, or agents have the right to take photographs, videotape, or digital recordings of my child and to use these in any and all media, now or hereafter known, and exclusively for ConnCAT's official purposes. I further consent that my child's name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to ConnCAT, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my child's identity or likeness in whatever media used.
I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand that ConnCAT is not responsible for any expense or liability incurred as a result of my child's participation in this recording, including medical expenses due to any sickness or injury incurred as a result.
I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Parent/ Guardian Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Signature: _____ Date: _____

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Parent's Authorization for Summer Program Pickup/Dismissal

Participant's Name _____
LAST NAME FIRST NAME

☐ My son/daughter has permission to walk or take public transportation upon dismissal from the summer program.

****This option is not available for rising 5th graders unless accompanied by an older sibling/participant**

☐ My son/daughter will be picked up from the summer program.

The following people have permission to pick up my child/ren from the summer program. I understand that only the people on this list may pick up my child/ren.

I understand that proof of Identification will be requested.

Name	Relationship to Student	Current/Active Phone Number

_____ _____
Father's/Guardian's Signature Father's/Guardian's Printed Name

_____
Phone Number

_____ _____
Mother's/Guardian's Signature Mother's/Guardian's Printed Name

_____
Phone Number

REVISED 3/28/16

Connecticut Center for Arts and Technology
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DEMOGRAPHIC SURVEY – YOUTH SUMMER PROGRAM 2016

ANONYMOUS INFORMATION DO NOT SAVE IN PARTICIPANT FILE***

This information is collected anonymously and used for reporting requirements to ConnCAT funders and grantors.

STUDENT Information Only

1) Child's Age: _____ 2) Grade in Fall '16: _____ 3) School:_____

4) Gender (circle one): MALE FEMALE

5) Race/Ethnicity:

- ☐ Amer. Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Hispanic or Latino
- ☐ Other _____

7) Does your child receive free/reduced price lunch?

YES NO

PARENT/GUARDIAN Information Only

1) Highest academic level achieved (circle one)

Mother	Grade school	GED	High School	Some college	Bachelors	Masters	Doctorate

Father	Grade school	GED	High School	Some college	Bachelors	Masters	Doctorate

Please complete the back page

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DEMOGRAPHIC SURVEY – YOUTH SUMMER PROGRAM 2016

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HOUSEHOLD INCOME SURVEY

1)

Annual Income for your household	Check the box that applies to your household
$11,670 - $15,729	
$15,730 - $19,789	
$19,790 - $23,849	
$23,850 - $27, 909	
$27,910 - $31,969	
$31,970 - $31,969	
$36,030 - $40,089	
$40,090 - $44,149	
$44,150 - $48,209	
$48,210 - $52,269	
$52,270 - $56,329	
$56,330 - $60,339	
$60,340 - higher	

2)

Number of people in your household	Check the box that applies to your household
1	
2	
3	
4	
5	
6	
7	
8	
9 or more ***Please indicate how many are in your household >>*	

3)

Which parents live in your household?	Check all that apply
Mother	
Father	

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 I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

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, a physician assistant or the school medical advisor 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 ❑ Hispanic/Latino	❑ White, not of Hispanic origin ❑ 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 I — 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 II — 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 I 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 ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

	Date
Lead:	
***HCT/HGB:**	
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

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						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

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

Exemption

Religious _____ Medical: Permanent _____ Temporary _____ Date _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN
DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6
DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12
Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

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