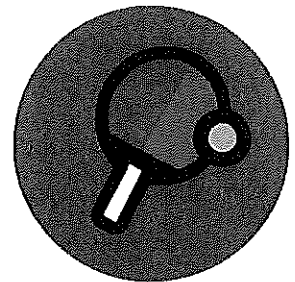
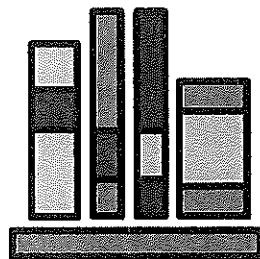
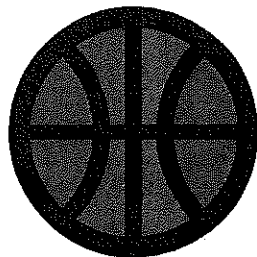


Windsor Recreation and Lesuire Services Presents

# **RISE AFTER SCHOOL GRADES 1-5**

RISE after school program offers a well supervised, engaging after-school experience. RISE after school is located at 330 Windsor Ave. Community Center. Transportation is provided from all Windsor Public Schools to the Community Center. RISE after school follows the Windsor School calendar. Come enjoy friends, fun, sports, games, arts and crafts, healthy snacks and homework help!



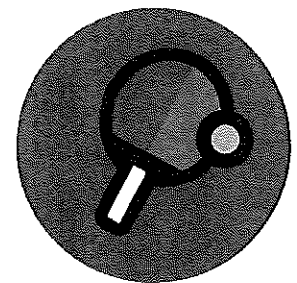
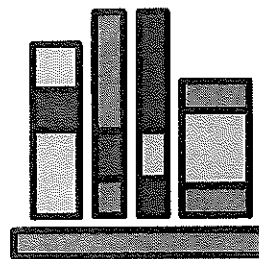
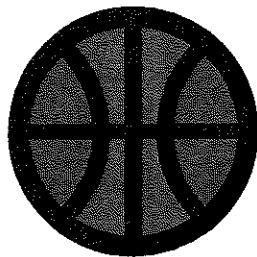
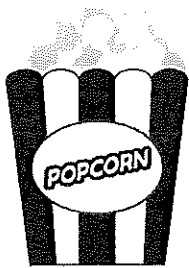
RISE after school program is \$185 per month. Students must be enrolled and payments must be made by the last Thursday of each month for the child to attend the next month,

**For more information contact  
Windsor Recreation Department  
at 860.285.1990**

Windsor Recreation and Lesuire Services Presents

# RISE ABOVE GRADES 6-7

RISE ABOVE program offers a well supervised, engaging after-school experience. RISE after school is located at 330 Windsor Ave. Community Center. Transportation is provided from all Windsor Public Schools to the Community Center. RISE after school follows the Windsor School calendar. Come enjoy friends, fun, sports, games, arts and crafts, healthy snacks and homework help!



RISE ABOVE is \$85 per month. Students must be enrolled and payments must be made by the last Thursday of each month for the child to attend the next month,

**For more information contact  
Windsor Recreation Department  
at 860.285.1990**

# R.I.S.E. & R.I.S.E. above after school program

Student's Name (Last Name, First Name)	School attending and Grade:
<b>Date of Birth:</b>  _____ Male    _____ Female                      Age: _____	Parent / Guardian Email address:
Address	Home Phone    Cell Phone
1. Parent/ Guardian Name	2. Parent/ Guardian Name
1. Parent/ Guardian Numbers * please circle best number to reach you during camp hours  Home Number:                      Cell Phone Number:  Work Number:	2. Parent/ Guardian Numbers * please circle best number to reach you during camp hours  Home Number:                      Cell Phone Number:  Work Number:

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

**Field Trips**

I hereby give permission for my child to participate in field trips, on foot or in an authorized vehicle as scheduled and posted by the R.I.S.E. after school program.

Parent's Signature: \_\_\_\_\_

**First Aid Treatment**

I hereby give permission for my child to receive first aid treatment for minor injuries from the R.I.S.E. after school program staff. Written permission is required for the application of any topical ointments.

Parent's Signature: \_\_\_\_\_

**Emergency Treatment**

I hereby give permission for my child to receive basic transportation and emergency treatment at the closest hospital.

Parent's Signature: \_\_\_\_\_

**Windsor Recreation Department  
R.I.S.E. after school**

Student Registration Information – Student’s Name: \_\_\_\_\_

Emergency Contact – Person other than Parent/ Guardian

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**People authorized to pick your child up from Summer Fun Camp other than yourself**

Last Name	First Name	Relationship	Phone # (    )

**Medical Information**

It is important for the Recreation Staff to be fully aware of any allergies, chronic or recurring illnesses, or physical limitations of your child as well as any medications your child is taking. For instance, it is important that we know whether your child has ever been stung, and if there was a reaction to the bee/wasp sting. Does your child require an inhaler for asthma?

Student’s Physician Name:	Phone # (    )
Student’s Dentist Name:	Phone # (    )

Please list and briefly explain the following:

Chronic or Serious Illness: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Has your child ever been stung ( if yes please explain if they had a reaction):  
Is your child allergic to bees: Yes or No

Prior Injuries: \_\_\_\_\_

Notes: \* anything else the Recreation Supervisor needs to know about your child?

If a child has not been picked up within fifteen (15) minutes of our closing time, a staff member will attempt to contact the parent / guardian at their work, cell, and home numbers. If parent / guardian cannot be reached, a staff member will call the emergency contacts and alternate people listed on the registration forms. In the event that we are unable to reach the parent / guardian, emergency contacts and alternate people listed on the registration form, the police will be contacted after one hour. At that time the child may be released to the police. Two staff members at least 18 years of age or older will remain with the child at all times.

**Windsor Public Schools**  
**Windsor Recreation and Leisure Services**  
**R.I.S.E. after school**

**Transportation Request**

- *Please note it will take 48 hours to secure your child a spot on the RISE transportation roster. Please contact your child's school to confirm that they are on the RISE bus roster, as we will do the same.*

My child: \_\_\_\_\_ will be participating in after school programs from the provider listed below during the 2018 - 2019 school year. I am requesting transportation to the

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

Provider's name: Town of Windsor Recreation and Leisure Services  
Address: 330 Windsor Ave.  
Telephone: 860-727-8684 / 860-285-1990

During the hours of 3:00 PM- 6:00 PM, I can be reached at this Telephone Number.

Telephone Number: \_\_\_\_\_

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

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

Return To: Shannon Blenis, Recreation Supervisor  
Windsor Recreation Services  
599 Matianuck Ave.  
Windsor, CT 06095

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

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

**Town of Windsor  
Recreation and Leisure Services**

**DISCIPLINE POLICY**

The goal of discipline is to help the child develop inner controls so that he/she may move toward appropriate social behavior. Methods for resolving conflicts are:

- Positive guidance
- Setting clear limits
- Redirection

R.I.S.E. after school program provides an environment where our participants are safe and encouraged to make new friends, try new things, learn, and to simply have fun. We believe our R.I.S.E. after school participants are entitled to a pleasant and harmonious environment while at the program. Windsor Recreation and Leisure Services cannot service children who display disruptive behavior. The Program Director and the Recreation Program Specialist reserve the right to remove a participant at any time for inappropriate behavior.

Windsor Recreation & Leisure Services programs adhere to the policy that any physical aggression to any of the program participants or staff will not be tolerated. Immediate suspension and or expulsion will take effect immediately.

Reasonable efforts will be made to assist children to adjust to the program setting. Disruptive behavior will be dealt with in the following manner:

1. The misbehaving child will be given a verbal warning and/or an activity break period, based on the severity of the action. This will be documented in the child's behavior log.
2. If a second activity break is given to a child in a single day, the child will be removed from the program activity, and a quiet alternative will be assigned. The child may also be asked to write letters of apology and/or descriptions of the events in question. This will be documented in the child's behavior log.
3. If a child receives three activity breaks in one day an incident report will be written by the staff this report will be given to the parent/guardian to sign and the child may be asked to take a day of suspension. This is to be determined by the Program Director and or Recreation Program Specialist
4. If the child receives three written incident reports; the child will be suspended effective immediately. The parents, Program Director, and Recreation Program Specialist will meet and determine the terms and conditions of reinstatement into the program. Parents/Guardian will be responsible for the payment of the tuition during the period of suspension, or until the child is withdrawn from the program.
5. The Program Director / Recreation Program Specialist have the right to remove a child at anytime for inappropriate behavior. In the event of inappropriate behavior that endangers the safety of the child, other children, or staff members in the program, the parents will be notified, and the child will be discharged effective immediately.

If a child cannot adjust to the program setting and behave appropriately, then the child will be asked to leave the program.

Staff shall not be abusive, neglectful, or use physical, corporal, humiliating or frightening punishment under any circumstances. No child shall be physically restrained unless it is necessary to protect the safety and health of the child or another child or adult.

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



# 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, licensed pursuant to chapter 378, a physi-

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

\* 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
<b>Family History</b>						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





## Part II — Medical Evaluation

HAR-3 REV. 4/2017

**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			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

### Screenings

*Vision Screening	*Auditory Screening	History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	Date
Type: Right Left	Type: Right Left		
With glasses 20/ 20/	<input type="checkbox"/> Pass <input type="checkbox"/> Pass	*HCT/HGB:	
Without glasses 20/ 20/	<input type="checkbox"/> Fail <input type="checkbox"/> Fail	*Speech (school entry only)	
<input type="checkbox"/> Referral made	<input type="checkbox"/> Referral made	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
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Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ HAR-3 REV. 4/2017

## 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 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. 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 the 1st 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