HOJA DE MATRICULA Y PERMISO DE EMERGENCIA

Fecha de Aplicación: __________ **Fecha de Matricula:** __________ **Ultimo día de Matricula:** __________
Nombre del Niño(a): ______________________________ Fecha de Nacimiento del Niño(a): ______________
Dirección del Nino(a): ____________________________ Ciudad: _________________ Código Postal: ________
Nombre de la Madre: ______________________________ Dirección: ______________________________
Ciudad: ____________________ Código Postal: __________ e-mail: ______________________________
Número de Teléfono del Hogar #: (_____) _______________ Número del Celular #: (_____) _______________
Empleo de la Madre: ______________________________ Teléfono del Empleo #: (_____) _________________
Dirección del Empleo de la Madre: _________________________ Ciudad: ___________ Código Postal: ________
Nombre del Padre: _______________________________ Dirección: ______________________________
Ciudad: ____________________ Código Postal: __________ e-mail: ______________________________
Número de Teléfono del Hogar #: (_____) _______________ Número del Celular #: (_____) __________________
Empleo del Padre: _________________________________ Teléfono del Empleo #: (_____) _________________
Dirección del Empleo del Padre: _____________________ Ciudad: _______________ Código Postal ________
****

Horarios Semanal: (por favor incluya las horas del cuido proveído para cada día)
Domingo: ________________________
Lunes: ___________________________
Martes: __________________________
Miércoles: _______________________
Jueves: __________________________
Viernes: _________________________
Sábado: __________________________

Personas permitidas remover el niño del cuidado de niños en vez de los padres. (Utiliza la parte atrás para nombres adicionales)
Nombre: ____________________________________
Número de Teléfono #: ____________Relación ________
****

<u>En caso de una emergencia, adultos con quien comunicarse si los padres no pueden ser alcanzados y a quien les dan permiso recoger el niño(a).</u>
<u>(Use la parte atras para escribir .)</u>

Nombre: ____________________________________
Número de Teléfono #: ____________Relación: ________

Alergias: ____________________________ Ultima fecha de vacuna contra el Tétanos: ____________________
Seguro Médico: ____ ID de Seguro: ____________________
Hospital: ____ Número de Teléfono: (____) ________________

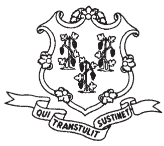
Medico: Nombre: _______________________ Número de Teléfono: (_____) ___________
Dirección: _______________________ Ciudad: ___________ Código Postal: _______
Dentista: Nombre: _______________________ Número de Teléfono: (_____) ___________
Dirección: _______________________ Ciudad: __________ Código Postal: ________

Doy mi consentimiento para que el siguiente proveedor de cuidado de niños **(nombre del proveedor)** ______________________, y **(si aplicable, nombre de substituto aprobado)** ____________________ para comunicarse con el médico o dentista notado anterior si mi niño(a) tiene una emergencia médica. Yo entiendo que, si el médico o dentista no está disponible, otro médico o dentista puede ser contactado en un caso de emergencia. También, doy mi consentimiento para que el proveedor de cuidado de niños busque atención médica en una emergencia en ________________________________. Yo me hare responsable por todos los cargos médicos.
(nombre del hospital o clínica)
(Nombre del Proveedor) ___________________ y **(si aplicable, nombre del sustituto aprobado)** ____________________ tiene mi permiso de transportar mi hijo(a) del cuido como parte del programa del cuidado de niños.

¿Es su hijo(a) relacionado con la persona que provee su cuidado de niños? ☐No☐Si…¿Cómo son relacionados? _______
Las disposiciones expuestas en este formulario han sido elaboradas en consulta conmigo y tienen mi aprobación.
Firma del Padre/Encargado: __________________________________ **Fecha:** ____________________

Firma del Padre/Encargado: __________________________________ **Fecha:** ____________________

<u>Atención Proveedor</u>: Esta información debe mantenerse actualizada en todo momento. Lleve una copia de este formulario y del Registro de Salud Infantil durante cualquier actividad de cuidado de niños fuera del establecimiento. Por favor, verifique con el centro de atención médica de emergencia para asegurar que este formulario es aceptable. Este formulario debe mantenerse en archivo durante un año después de que el niño ya no esté inscrito en el cuidado de niños.



State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity	
Primary Health Care Provider: Name of Dentist:	❑ American Indian/Alaskan Native ❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin	❑ Hispanic/Latino ❑ Asian/Pacific Islander ❑ Other
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY 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	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name ____ Birth Date _____________ (mm/dd/yyyy) Date of Exam _____________ (mm/dd/yyyy)

❑ 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.

***HT** ____ in/cm ____% ***Weight** ____ lbs. ____ oz / ____% **BMI** ____ / ____% ***HC** ____ in/cm ____% (Birth – 24 months) ***Blood Pressure** ____ / ____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**

❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)

❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess

❑ Referral made to: __________________

***Hearing Screening**

❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)

❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

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

❑ Unable to assess

❑ Referral made to: __________________

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

Lead poisoning (≥ 10ug/dL)

❑ No ❑ Yes

*Result/Level: *Date

Other:

***TB:** High-risk group? ❑ No ❑ Yes

Test done: ❑ No ❑ Yes Date: _______

Results: ____________________________

Treatment: __________________________

***Dental Concerns** ❑ No ❑ Yes

❑ Referral made to: __________________

Has this child received dental care in the last 6 months? ❑ No ❑ Yes

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

***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 an **Asthma Action Plan***

❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: ____

Epi Pen required: ❑ No ❑ Yes

History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source

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

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II

Seizures ❑ No ❑ Yes: Type: ________________

Other Chronic Disease: ____________________________________

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:*__________________________

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑ No ❑ Yes This child may fully participate in the program.

❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

____

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

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

Child's Name: ______________________________ **Birth Date:** ____________________ REV. 8/2011

Immunization Record

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

Vaccine (Month/Day/Year) ______________________________

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) ______________________________

(Date) (Confirmed by)

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

†Recertify Date _________ †Recertify Date _________ †Recertify Date ________

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2-3 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

____

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

CHILD CARE LOG/REGISTRO PARA NIÑOS MATRICULADOS EN EL CUIDADO DE NIÑOS

CHILD'S NAME (NOMBRE DEL NIÑO/A): ______________________________

Important: The purpose of this log is to record accidents, illnesses, unusual behaviors that occur at the facility, observations of the child made by the provider and important discussions with parents.

Importante: El propósito de este registro es para documentar accidentes, enfermedades, comportamientos inusuales que ocurren en el programa, observaciones del proveedor del niño y comunicación importantes entre padre y proveedor.

Date/Fecha	Time/Hora del incidente	Person Present/Persona Presente	Description/Descripción