BOYS & GIRLS CLUB
OF MILFORD

Membership Disclaimer

After School 2022-2023

I have reviewed the completed application and acknowledge that the information provided is true and accurate to the best of my knowledge.

I also acknowledge that I have read the Parent Handbook, understand the rules contained in the Parent Handbook and explain ed the Rules to my child. I request that my child be admitted into membership of the Boys & Girls Club of Milford and I give permission for my child to participate in all club activities.

I further acknowledge that failure by me or my child to follow the rules may result in my child's suspension or expulsion from the Club. I agree that the Club will not be responsible for any accident to my child on the Club's premises or while engaged in any of its activities.

If I agree that photos of my child may be used in public relations materials, I give my consent for any photographs in which my child may appear to be used in any way the Club may choose to use them of that purpose.

☐ Yes, I give my child permission to be used in public relations material.

☐ No, I do not give my child permission to be used in public relations material.

I acknowledge that the Boys & Girls Club of Milford is not a peanut free facility, and some snacks may contain nuts.

If you would like to opt out of the Snack Program, please check the circle ☐

Parent Signature Date

Member Signature Date

Certification Form

Participant Name:_____ Student? F/T ☐ or P/T ☐ Age: _____
Co- Participant Name:_____ Student? F/T ☐ or P/T ☐ Age: _____
Current Address: _____ Relocate/New Address: _____

Assistance requested for: Security Deposit ____ Rent / Mortgage _____ Public Service Agency _____

Number of Person(s) in the Household: [ ] Number of Children under the Age of 18: [ ]

Female Headed Household Yes ____ No _____ Male ☐ Female [☐]

Number of Persons 62 years of Age or Older: [ ] Household with Disabled Person: [ ]

U. S. Citizen? Yes ☐ No ☐ If no, please advise immigration status_____

Do you receive a HUD Housing Choice Voucher? Yes ☐ No ☐

Have you received CARES Act funds for a housing expense? If yes, please give date and expense type._____

_____

Household Member Name_____ Student? F/T ☐ or P/T ☐ Age: _____

Household Member Name_____ Student? F/T ☐ or P/T ☐ Age: _____

Household Member Name_____ Student: F/T ☐ or P/T ☐ Age: _____

Household Member Name_____ Student F/T ☐ or P/T ☐ Age: _____

Household Ethnicity (*Check one box).*

☐ White
☐ African American
☐ American Indian/Alaskan Native
☐ America Indian/Alaskan Native & White
☐ Other or Multi-Ethnic
☐ Hispanic/Latino
☐ Asian
☐ American Indian/Alaskan Native & African American
☐ Native Hawaiian/Other Pacific Islander

Household Annual Income Certification (*Check one box*).
Please combine Annual Adjusted Gross Income (AGI) before deductions for each household member over 18 years of age. Do not include Full-time student income.

Range of Total Household Income (Check one box)	**HUD Income Limits by Household Size** Based on 80%, 50%, 30% Area Median Income 4/26/22
	$0 to $34,100
	$34,101 to $39,600
	$39,601 to $56,800
	$56,801 to $62,600
	$62,601 to $89,400
	$89,401 to $118,050

Summary of Need _____

_____

_____

CERTIFICATION:
On behalf of my/our household, I/we hereby certify the information provided is complete and correct to the best of my/our knowledge.

Participant Signature _____ Date _____

This information is required to receive Federal funds to assist this organization to continue to offer this program or activity. The information on this form is confidential and will not be shared with an agency other than the Grantor, the Department of Community Development, which regulates use of Community Development Block Grant funds for the City of Milford. This information is used to determine program eligibility and the statistical information of the participant to ensure that CDBG funds assist low and moderate-income individuals and families.

Department of Economic & Community Development
70 West River Street, Milford, CT 06460
Direct line (203) 701-4479

Tiffany copy

FY 2022 Income Limits Documentation System

FY 2022 Income Limits Summary

Selecting any of the buttons labeled "Click for More Detail" will display detailed calculation steps for each of the various parameters.

FY 2022 Income Limit Area	Median Family Income	FY 2022 Income Limit Category	Persons in Family 1	2	3	4	5	6	7	8
Milford-Ansonia-Seymour, CT HUD Metro FMR Area	$113,600	Very Low (50%) Income Limits ($) Click for More Detail	39,800	45,450	51,150	**56,800**	61,350	65,900	70,450	75,000
		Extremely Low Income Limits ($)* Click for More Detail	23,900	27,300	30,700	**34,100**	36,850	39,600	42,300	46,630
		Low (80%) Income Limits ($) Click for More Detail	62,600	71,550	80,500	**89,400**	96,600	103,750	110,900	118,050

NOTE: Milford town is part of the **Milford-Ansonia-Seymour, CT HUD Metro FMR Area**, so all information presented here applies to all of the **Milford-Ansonia-Seymour, CT HUD Metro FMR Area**. HUD generally uses the Office of Management and Budget (OMB) area definitions in the calculation of income limit program parameters. However, to ensure that program parameters do not vary significantly due to area definition changes, HUD has used custom geographic definitions for the **Milford-Ansonia-Seymour, CT HUD Metro FMR Area**.

BOYS & GIRLS CLUB
OF MILFORD

PICK-UP LIST

Child's Name: _____

Please add the following names to my child's pick-up list:

First / Last Name	Phone	Relationship to Member

I give permission for my child to be picked up by those names listed above. If there are any changes to this list, I will be sure to inform The Boys & Girls Club of Milford.

_____

Print Name

_____ _____

Signature Date

BOYS & GIRLS CLUBS
OF MILFORD

Assumption of the Risk and Waiver if Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Boys & Girls Club of Milford has put in place preventative measures to reduce the spread of COVID-19; however, we **cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, **attending the 2022-2023 Boys & Girls Club of Milford After School Program could increase** your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by **attending the 2022-2023 Boys & Girls Club of Milford After School Program** and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at the **2022-2023 Boys & Girls Club of Milford After School Program** result from the actions, omissions, or negligence of myself and others, including, but not limited to, employees, volunteers, and program participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s **attendance at the 2022-2023 Boys & Girls Club of Milford After School Program** or participation at the **2022-2023 Boys & Girls Club of Milford After School Program**. On my behalf, and on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless **Boys & Girls Club of Milford**, its employees, Board of Directors, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of **Boys & Girls Club of Milford**, its employees, Board of Directors, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in the **2022-2023 Boys & Girls Club of Milford After School Program.**

Signature of Parent/Guardian Date

Name of Parent/Guardian Name of Camp Participant(s)

BOYS & GIRLS CLUB
OF MILFORD

Permission to Leave the Building

For Middle School and High School Members

I give my Child _____ permission to leave the Boys & Girls Club of Milford on their own, after they have signed into the club.

Once members leave the building they will be considered signed out for the day and will not be able to re-enter unless they are accompanied by their parent or guardian.

I understand that the Boys & Girls Club of Milford is not responsible for my child while they are outside the building without supervision.

Comments:

Parent Signature: _____ Date: _____

Emergency Phone Number: _____

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child 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.

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

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____
Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____
Prescriber's Signature _____ Date ____/____/_____

School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child/student as described and directed above

☐ I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____
E-mail: _____ Cell Phone # (_____) _____-_____ Other Phone # (_____) _____-_____

SELF ADMINISTRATION AND /OR POSSESSION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber (when applicable) and school nurse (when applicable) and must be authorized by parent/guardian in accordance with board policy. In a school: 1. inhalers for asthma and cartridge injectors for life-threatening allergies require authorization by the prescriber and parent/guardian only; 2. students may possess, self-administer or possess and self-administer medications for medically-diagnosed life-threatening allergies; and 3. students who are six years of age or older may possess and self-apply an over-the-counter sunscreen product with only the parent/guardian written authorization.

1. Student to self-administer medication specified on this form: _____ YES _____NO
2. Student to possess medication specified on this form: _____ YES _____NO

Prescriber's Authorization and Signature: _____ Date:_____

Parent/Guardian Authorization and Signature: _____ Date: _____

School nurse (RN) Approval of self-administration (if applicable): _____ Date: _____

Printed Name of Individual Receiving Written Authorization and Medication _____
Title/Position/ _____ Date: _____

Medication Administration Record (MAR)

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

Pharmacy Name _____ **Prescription Number** _____

Medication Order_____

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

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

☐ **Authorization form is complete** ☐ **Medication is appropriately labeled**

☐ **Medication is in original container** ☐ **Date on label is current**

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

Sample Form

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.