



## 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 explained 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*).

- |   |  |
|---|--|
| <input type="checkbox"/> White                                  | <input type="checkbox"/> Hispanic/Latino                                   |
| <input type="checkbox"/> African American                       | <input type="checkbox"/> Asian   |
| <input type="checkbox"/> American Indian/Alaskan Native         | <input type="checkbox"/> American Indian/Alaskan Native & African American |
| <input type="checkbox"/> American Indian/Alaskan Native & White | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander            |
| <input type="checkbox"/> Other or Multi-Ethnic                  |  |

**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)	<b>HUD Income Limits by Household Size</b> Based on 80%, 50%, 30% Area Median Income 4/26/22
<input type="checkbox"/>	\$0 to \$34,100
<input type="checkbox"/>	\$34,101 to \$39,600
<input type="checkbox"/>	\$39,601 to \$56,800
<input type="checkbox"/>	\$56,801 to \$62,600
<input type="checkbox"/>	\$62,601 to \$89,400
<input type="checkbox"/>	\$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



# FY 2022 INCOME LIMITS DOCUMENTATION SYSTEM

[HUD.gov](#) [HUD User Home](#) [Data Sets](#) [Fair Market Rents](#) [Section 8 Income Limits](#) [MTSP Income Limits](#) [HUD LIHTC Database](#)

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



# PICK-UP LIST

Child's Name: \_\_\_\_\_

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

<u>First / Last Name</u>	<u>Phone</u>	<u>Relationship to Member</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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)



## **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
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> 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 \_\_\_\_/\_\_\_\_/\_\_\_\_



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.