BOYS & GIRLS CLUB
OF MILFORD

Membership Disclaimer

After School 2020-2021

I have reviewed the completed registration 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 the 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, School based Satellite site 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 for 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 this box. ☐

☐ **Yes, I fully understand the Refund Policy located in the Parent Handbook.**

☐ **Yes, I fully understand the Late Policy located in the Parent Handbook.**

_____

Parent/Guardian Signature Date

_____

Member Signature Date

Household Certification Form

Participant Name:	☐ Male ☐ Female
Address	
Number of Person(s) in the Household: [ ] Female Headed Household Yes ☐ No ☐	Number of Children under the Age of 18: [ ]
Number of Persons 62 years of Age or Older: [ ]	Household with Disabled Person: [ ]
Student Status: Name_____ F/T ☐ or P/T ☐ Age: Name_____ F/T ☐ or P/T ☐ Age:	

Please Provide Household Race/Ethnicity (*Check one per household).*

Native Hawaiin/ Other Pacific Islar

Household Income

The program participant checks the income level that meets, but does not exceed, the total household adjusted gross income (AGI). A household income includes persons related, and unrelated, over the age of 18 and living in the home for 6 months or more. The program manager may request additional income documentation when required.

Total Household Income (Check one box)	Household Income Level (AGI)
○	$47,600
○	$54,400
○	$61,200
○	$68,000
○	$73,450
○	$78,900
○	$84,350
○	$89,800

CERTIFICATION:

I/We hereby certify that the information on this form is complete and correct to the best of my knowledge.

Participant Signature _____ Date _____

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.

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 Boys & Girls Club of Milford 20-21' 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 **Boys & Girls Club of Milford 20-21' 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 **Boys & Girls Club of Milford 2020 – 2021 After School Program** may 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 **Boys & Girls Club of Milford 20-21' After School Program** or participation **Boys & Girls Club of Milford 20-21' 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 **Boys & Girls Club of Milford 20-21' After School Program.**

Signature of Parent/Guardian Date

Name of Parent/Guardian Name of After School Participant(s)

INFORMED CONSENT

(this form may be used for staff and parents of children enrolled at a youth camp during the COVID-19 declared emergency)

I hereby attest that I have been informed of the following pertaining to the coronavirus:

- People who are 65 years and older and people of any age who have serious underlying medical conditions or are at higher risk for severe illness from COVID-19 are recommended to stay at home. A list of medical conditions associated with a higher risk for severe illness from COVID-19 can be found in CDC's guidance.[1] Individuals and families should consult their healthcare provider to determine whether they have medical conditions that place them at risk.

- Staff and children living in households with individuals who are 65 years and older OR have higher risk for severe illness from COVID-19 are recommended to stay home.

Signature of Staff or Parent/Guardian

Printed Name

Child's Name (if a parent/guardian)

Date

[1] Includes chronic lung disease or moderate to severe asthma, serious heart conditions, immunocompromised (cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications), severe obesity (body mass index [BMI] of 40 or higher), diabetes, chronic kidney disease undergoing dialysis and liver disease. Individuals should consult their healthcare provide to determine whether they have medical conditions that place them at increased risk for severe illness from COVID-19.

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

In Connecticut schools, licensed Child Care Centers and Group Care Homes, licensed Family 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 with the exception of emergency medications to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ___/___/___

Parent /Guardian's Address _____Town_____State____

Home Phone # (____) _____-_____ Work Phone # (____) _____-_____ Cell Phone # (____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____ (Signature) _____ (Date)

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____ (Signature) _____ (Date)

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____ (Signature) _____ (Date)

Today's Date _____Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink or electronic) _____

Note: This form is in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

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 in original container

☐ Medication is appropriately labeled

☐ 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.

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