2025/26

Registration Packet

2025/26 Registration

As a child-care program we are required by Connecticut state law to have specific information on file about your child. You must complete all forms and return them to Nature's Playground prior to your child attending.

Child's Name: _____
Child's Birth Date: _____ Grade: _____ Gender: _____
Child's Home Address: _____
_____

Parent/Guardian #1:
Name: _____
Cell Phone: _____
Email: _____
Work Phone: _____
Work Address: _____
Home Address: _____
_____

Parent/Guardian #2:
Name: _____
Cell Phone: _____
Email: _____
Work Phone: _____
Work Address: _____
Home Address: _____
_____

Forms Required:

- Early Childhood Health Assessment Record Part 1 (filled out by parents/guardians)
- Early Childhood Health Assessment Record Part 2 (filled out by doctor)
- Alternate Pick Up / Emergency Contact
- First Aid / Field Trip Permission
- Registration Form
- Medications / Allergies / Dietary Requirements (If necessary)

Please call or email with any questions.
Penny Leadbetter, Director
Email: penny@psdaycamp.org
Call: (860) 767 0848

Registration Form

Child's Full Name: _____ Birthdate: _____

Please enroll my child at the Nature's Playground After School Program for the following days of the week (please circle):

Monday **Tuesday** **Wednesday** **Thursday** **Friday**

By submitting this application, I agree to be bound to the terms, conditions, and regulations of the Incarnation Center. I also give permission for my child to participate in all Nature's Playground activities. Photos or videos in which my child appears, may be used for publicity purposes.

I understand that Incarnation Center will not accommodate children with severe behavior problems. Children with frequent violent or uncontrollable outbursts, an unwillingness to respond to supervision, or behavior that infringes upon the experience of others, will be asked to leave the program.

I understand that tuition is to be paid in full prior to each month's attendance and failure to do so may result in the dismissal of my child from the Nature's Playground after school program. Payement is due on the 15th of every month and a $25 late fee will be incurred if payment is handed in after the 20th of each month.

I understand that I must pickup my child from Nature's Playground by 6:00pm. If I am running late, I will make every effort to call the camp cell phone: 860-395-9794. After one late pickup, any other late pickups will be charged $3.00 per minute after 6:00pm.

Parent/Guardian's Signature: _____

Date: _____

2025/26 Alternate Pick Up/Emergency Contact

Child's Full Name: _____ Birthdate: _____

IN CASE OF EMERGENCY

After we have tried to reach parent/guardian #1 and #2 we will reach out to the emergency contact.

Name: _____ Phone: _____
Relationship to child: _____

ALTERNATE PICK-UP PERMISSION

In addition to the emergency contact, I authorize my child to be released to the following adults:

Name: _____ Phone: _____
Relationship to child: _____

Name: _____ Phone: _____
Relationship to child: _____

Name: _____ Phone: _____
Relationship to child: _____

Medical Information

Child's Full Name: _____ Birthdate: _____

MEDICATIONS

If the Nature's Playground Staff will be administering regularly scheduled medication(s), you must have your doctor complete the attached form. In addition, all medications must be in their original container with your child's name clearly marked on the label.

ALLERGIES

Please list your child's allergies below:

_____

_____

_____

_____

_____

DIETARY RESTRICTIONS

Please list your child's dietary restrictions below:

_____

_____

_____

_____

_____

PRIMARY CARE PROVIDER INFORMATION

Primary Care Provider: _____

Primary Care Phone Number: _____

Primary Care Provider Address: _____

_____

_____

First Aid / Field Trip Permission

Child's Full Name: _____ Birthdate: _____

I give Nature's Playground staff permission to administer basic first aid to my child: band aids, minor scrapes, ice packs, etc. I also understand and agree to staff calling 911 in case of emergencies with my child and pay any fees associated with such a call. Please note that we will always call 911 first, then a parent, in case of emergency.

Throughout the year we may use other spaces on site that are not inspected by the OEC, including out Nature Center, Farm, and Conference buildings, in addition to the outdoor spaces around the property.

I give my child permission to participate in field trips while at Nature's Playground After School to the following areas:

- Wigwam/Stream; where my child is allowed, with boots or old sneakers on, to play in the stream.
- Pond; where my child is allowed, with boots or old sneakers on, to fish, catch frogs, and play in the pond area (no swimming).
- Hiking trails on site of Incarnation Center
- Farm on site of Incarnation Center
- Activity areas on site of Incarnation Center

Our supervision policy in these field trip areas is as follows:

1. We will maintain a 1:6 staff to child ratio in these areas
2. 2. A certified lifeguard will be present at all times in these areas
3. 3. Non-swimmers will be required, by state law, to be identified to staff and lifeguards by wearing red wristbands.

Parent/Guardian's Signature: _____
Date: _____

Policies

Child's Full Name: _____ Birthdate: _____

Late pickup policy: If a child has not been picked up by 6:00pm, a staff member will attempt to call the child's caregivers at all numbers listed. If no family member can be reached, the staff member will attempt to call the emergency and alternate numbers listed in the child's registration packet. If nobody has been reached by 6:15pm, the Deep River police and/or Troop F in Westbrook will be called. 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.

Behavior and Discipline Policy: Behavior Management/ Discipline Policy of Nature's Playground advocates a positive guidance and discipline policy with an emphasis on positive reinforcement, redirection, prevention, and the development of self-discipline. Remind students that our rules are established for safety and to ensure that we have a common standard of behavior. As staff members, we need to show the students that we see the need for following the rules ourselves. Do not contradict the established guidelines.

Corrective discipline must be a creative, caring effort on the part of the staff member, and it must be seen as such by the student. Always suggest positive alternatives to unacceptable behavior before it gets out of control.

1. Discuss rules with students and identify out-of-bounds areas.
2. Discuss the possible consequences of breaking rules:
    a. Quiet time
    b. Restriction from activity
    c. Restriction to adult supervision
    d. Conference with director
    e. Conference with parent and director
    f. Removal from program
3. Enforce all rules at all times, without malice, and be consistent in application.
4. Inform the director of all disciplinary measures.
5. Never allow discipline to include depriving a student of sleep, food, or restroom privileges, placing a student alone without supervision, or subjecting a student to ridicule, shaming, threat, corporal punishment (striking, biting, kicking, squeezing), washing out the mouth, or physical exercise or restraint.
6. Conduct a periodic evaluation of the program/staff/student groups to ensure that the environment is not contributing to behavior problems.

Changes to your child's regularly scheduled day: If you wish to change your child's regular days, either temporarily or permanently, please contact the business office as soon as possible. This will ensure you do not get charged extra for drop-in days.
Email Luigi at lscalo@incarnationcenter.org to request any day changes or day cancellations. This information will then be passed on to the director and teachers. I have discussed these policies with the director in person or had the opportunity to discuss these policies with the director in person.

Parent/Guardian's Signature: _____ Date: _____

2025-26 Pricing / Vacation Days

Child's Full Name: _____ Birthdate: _____

2025/26 Rates

$20 per day enrolled for 4-5 days a week
$22 per day enrolled for 2-3 days a week
$25 per day enrolled for 1 day a week

Unscheduled Drop In Rate:
$30 per day

Half Day Rate:
Additional $25 per child ($50 total for drop ins)

Full Day School Vacation Rate:
$70 enrolled students/$75 non-enrolled students

Hours:

3pm - 6pm :School Days
1pm - 6pm: Half Days
8am - 6pm: Vacation Days

We are open on the following school vacation dates:
September 23rd (Tuesday)
October 2nd (Thursday)
October 10th (Friday)
October 13th (Monday)
January 19th (Monday)
*February 16th & 17th (Monday/Tuesday)
*April 13th - 17th (Full week)

*Run by our day camps, check website for pricing and information

Pricing Policy: Monthly payments are based on 10 equal installments. Monthly payments are due by the 15th of the month prior to care. For example, October 15th is the due date for your child's care in November. Payments remain the same regardless of weather related closings and absences .**Note that school holidays and half days are not part of the monthly tuition**; registration for school vacation /half days will be available as the year progresses.

Credit/Debit Card Authorization

Child's Full Name: _____ Birthdate: _____

This agreement may be terminated at any time upon written notice to Incarnation Center.

Child's Name: _____

Card Information

Type of Card: MasterCard Visa AMEX Discover

Card Number: _____

Card Expiration Date: _____

Security Code: _____

Card Holder's Name: _____

Card Holder's Signature: _____

Today's Date: _____

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 physician 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	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	❑ Black, not of Hispanic origin
	❑ American Indian/ Alaskan Native	❑ White, not of Hispanic origin
Primary Care Provider	❑ 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

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	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
Family History						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

To be maintained in the student's Cumulative School Health Record

HAR-3 REV. 4/2012

Part II — Medical Evaluation

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					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

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

❑ Referral made

***Auditory Screening**

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

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
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

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 4/2012

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 for 7th grade entry	
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	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
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** _____

Recertify Date _____ Recertify Date _____ Recertify Date _____

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 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. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

* **Verification of disease:** Confirmation in writing by a 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 nation-wide 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

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.)