



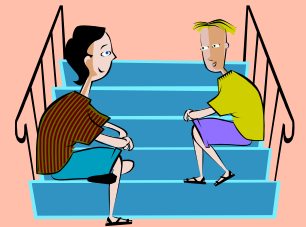
OPMAD / Kennelly School "What's Cool After - School?"

The OPMAD After – School Program will begin 8/31/2020 and end on the last day of school. Program hours are Monday thru Friday from 3:25 pm – 6:00 pm.

We are open on Early Dismissal Days! 12:15 pm – 6 pm

If your child is accepted in the program, you will receive a Blue Confirmation Form. Do not send payment in unless you receive a Blue Confirmation Form!

Morning Program (7:05 am-8:15pm) \$85
Afternoon Program (3:25pm-6:00pm) Based on household annual Income
\$20/Month (\$16/Month Siblings)
\$60/Month (\$56/Month Siblings)



OPMAD offers a wide variety of fun – filled educational programs. Your child will enjoy learning through hands on activities and games. Children will have a designated time to focus on homework followed by various enrichment activities. Dinner will be provided at 5:00 pm. OPMAD also offers parent workshops and trainings throughout the school year.

Information on these events will be available to you at our Sign-Out table at pick up time. For more information, call the On – Site Coordinator.



This site is funded by a 21CCLC Grant. No student will be denied participation based on inability to pay.

Please see Annette Santana for financial information or you can reach her at 860-548-0301 ext. 108. Please visit us @ www.opmad.org



Kennelly School
 Sign up & Permission Slip Form for **Pre-K – 8th Grade**

Student Name: _____ Grade entering: _____ Date of Birth: _____
 (Please Print)

Ethnicity: _____ Room #: _____ Teacher's Name: _____

Check the box next to the program you wish your child to attend.

- Morning Program (7:05 am – 8:15 am) Afternoon Program (3:25 pm - 6:00 pm)

How will your child get home? Walk ____ (no child under 12 may walk home) Pick Up ____

If your child is being picked up, by whom? (Please list ALL persons authorized to pick up your child including their phone #. We will not release your child to any person not listed!)

1. Name/Relationship/Phone #: _____
2. Name/Relationship/Phone#: _____
3. Name/Relationship/Phone#: _____
4. Name/Relationship/Phone#: _____
5. Name/Relationship/Phone#: _____

Parent/Guardian name: _____ Employer _____

Email Address: _____
 (Please Print)

Address _____ Zip Code _____

Home # _____ Work # _____ Cell # _____ Emergency # _____

Please notify the On-Site Coordinator of any changes in attendance, phone numbers, or address IMMEDIATELY.

Does your child have any medical conditions that would restrict him/her from participating in the program?

Yes ____ No ____ or take any medications or have allergies? Yes ____ No ____

If **yes** to any questions, please explain:

I understand in the event of an emergency, every effort will be made to contact the parent/guardian. In the event the parent/guardian cannot be reached, I appoint OPMAD and their authorized personnel to represent me with full authority and I hereby authorize any emergency treatment facility to perform necessary emergency procedures and medical treatment on the above named student. I hereby agree that I will not hold OPMAD or any employee of OPMAD liable for injuries and/or illness incurred by my child while a participant of the OPMAD program.

- If possible, I prefer my child to be taken to _____ Hospital in the event of an emergency.
- I understand that all photographs taken are property of OPMAD and may be used to promote the organization or its partners.
- I give my permission for school records to be shared with OPMAD for educational support, assistance and program evaluation.
- When your child is accepted into a class, she/he will receive a blue **CONFIRMATION SLIP, which must be returned the first day of class. We cannot accept a child without a confirmation slip.** If your child does not receive a confirmation slip, the class is full and your child will be put on a waiting list.

Parent/Guardian Signature: _____ **Date:** _____

-----TO BE FILLED OUT BY THE ONSITE COORDINATOR-----

[] Confirmation packet received [] SASID [] Health form [] Entered into Cayen




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ATTENTION PARENTS!



Please attach a copy of your child's Blue Health Assessment Record with our OPMAD permission slip.

Your child will not be able to attend our OPMAD Before and After School program unless these forms are received.

If you have any questions please feel free to contact Annette Santana at Annette.santana@opmad.org or (860)416-5937.

Thank You,

Annette Santana

On-Site Coordinator

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:
To enable us provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you that is needed to allow us to help your child meet these needs. It is to be completed by the student or guardian (Part I).
This form requests information about your child's health history. It is to be completed by a health care professional (Part II). An official physical is required for all students. An official physical is required for all students participating in sports teams.

To Student:
This form requests information about your child's health history. It is to be completed by the student or guardian (Part I).
This form requests information about your child's health history. It is to be completed by a health care professional (Part II). An official physical is required for all students. An official physical is required for all students participating in sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town, ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School Grade	Race/Ethnicity	<input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Other
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaska Native	<input type="checkbox"/> Puerto Rican
Health Insurance Company Number* or Medicaid Number*	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Other

Does your child have health insurance? Yes No If your child does not have health insurance, call 1-877-638-8834

Does your child have dental insurance? Yes No

*If applicable

Part I - To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please indicate "Y" for "yes" or "N" for "no". "I" indicates "I just" answers to the questions below.

Any health conditions	<input type="checkbox"/> Y <input type="checkbox"/> N	Disorientation or confusion from time to time	<input type="checkbox"/> Y <input type="checkbox"/> N	Concussion	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergic to food or drug allergy	<input type="checkbox"/> Y <input type="checkbox"/> N	Any broken bones or dislocations	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting or blacking out	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergic to medications	<input type="checkbox"/> Y <input type="checkbox"/> N	Any neck or joint injuries	<input type="checkbox"/> Y <input type="checkbox"/> N	1st eye injury	<input type="checkbox"/> Y <input type="checkbox"/> N
Any other allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Any work or back injuries	<input type="checkbox"/> Y <input type="checkbox"/> N	Head injuries	<input type="checkbox"/> Y <input type="checkbox"/> N
Any daily medications	<input type="checkbox"/> Y <input type="checkbox"/> N	Fracture (wound)	<input type="checkbox"/> Y <input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
Any problems with vision	<input type="checkbox"/> Y <input type="checkbox"/> N	"Shaky" (jitters) or tremor	<input type="checkbox"/> Y <input type="checkbox"/> N	Any other health conditions reported	<input type="checkbox"/> Y <input type="checkbox"/> N
Uses contact or glasses	<input type="checkbox"/> Y <input type="checkbox"/> N	Has and / or history of stroke	<input type="checkbox"/> Y <input type="checkbox"/> N	Fracture (healing or complete)	<input type="checkbox"/> Y <input type="checkbox"/> N
Any problems hearing	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive weight gain/loss	<input type="checkbox"/> Y <input type="checkbox"/> N	Any weakness	<input type="checkbox"/> Y <input type="checkbox"/> N
Any problems with speech	<input type="checkbox"/> Y <input type="checkbox"/> N	Dental braces, caps, or bridges	<input type="checkbox"/> Y <input type="checkbox"/> N	Adolescent (within past 12 months)	<input type="checkbox"/> Y <input type="checkbox"/> N

Family History

Any relative ever had a sudden unexpected death (less than 30 years old)	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N
Any immediate family members have high cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	LDL (LDL-C)	<input type="checkbox"/> Y <input type="checkbox"/> N

Please explain all "Yes" answers here. Use the reverse side of this form for your child's sign-off the form.

Is there anything you want to discuss with the school nurse? Yes No If yes, explain:

Please list any medications your child will need to take. Be specific.

All medications must be listed on a separate Medication Information Form signed by a health care provider and parent/guardian.

I am a parent or guardian and I agree to allow my child to participate in the Literacy Based After-School Enrichment Programs. I understand that my child's health and educational needs in school will be met by the school's health and educational staff.

Signature of Parent/Guardian _____ Date _____

To be submitted to the student's Cumulative School Health Record