



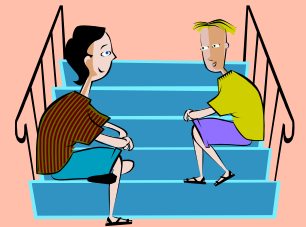
### OPMAD / Kennelly School "What's Cool After - School?"

The OPMAD After – School Program will begin 8/29/2022 and end on the last day of school. Program hours are Monday through 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)**  
**\$20/Month (\$16/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 4:00 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](http://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



# 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](mailto: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 make sure your child has the best educational experience, school personnel need information on your child's health needs. This form requests information from you that is needed to help us help your child in the classroom. Please return this form to the completion of the school evaluation (Part II).  
This form requests confidential information regarding your child's health status. It is a legally mandated document of students, as defined in Section 10-203a(c) of the General Statutes. It is not to be shared with anyone outside of the school district. This form will be used to determine if your child is eligible for special services, if needed, and to determine if your child is eligible for special services, if needed, and to determine if your child is eligible for special services, if needed.

**To Student:**  
This information is developed to help you, a school medical officer, or a highly qualified professional of medicine, establish a personal medical history or a physical assessment of any student. You may use this information to help you determine if your child is eligible for special services, if needed, and to determine if your child is eligible for special services, if needed.

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"/> Hispanic/Latino
Health Insurance Company Number* or Medicaid Number*		
Does your child have health insurance? Y N	If your child does not have health insurance, call 1-877-CT-HEALTH	
Does your child have dental insurance? Y N	If your child does not have dental insurance, call 1-877-CT-HEALTH	

\* 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 "No" for "No" or "Other" if "yes" answers to the questions below

Any health conditions	Y N	Disorientation or confusion from test	Y N	Concussion	Y N
Allergic to food or drug allergy	Y N	Any broken bones or dislocations	Y N	Fainting or blacking out	Y N
Allergic to medications	Y N	Any neck or joint injuries	Y N	1st eye injury	Y N
Any other allergies	Y N	Any work or back injuries	Y N	2nd eye injury	Y N
Any problems with vision	Y N	Fracture (missing)	Y N	High blood pressure	Y N
Any problems with hearing	Y N	Other injury to head	Y N	Any problems with breathing	Y N
Use contact or glasses	Y N	Eye and 1st injury or work	Y N	Fracture (missing or swelling)	Y N
Any problems hearing	Y N	Excessive weight gain/loss	Y N	Any weakness	Y N
Any problems with speech	Y N	Dental braces, caps, or bridges	Y N	Adverse reaction (past 3 years)	Y N

**Family History**

Any relative ever has a sudden unexpected death (less than 30 years old)	Y N	Diabetes	Y N
Any immediate family members have high cholesterol	Y N	LDL-C (LDL)	Y N

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

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. Be specific.

All medications names and dosages a separate Medication Information Form signed by a health care provider and parent/guardian.

I give permission to school and release of information on the form. Name the school nurse and health care provider who collected me or having my child's health information used in school.

Signature of Parent/Guardian Date

Signature of Student Date

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