"What's Cool After – School?"

The OPMAD After – School Program will begin the first day of school and end on the last day of school.

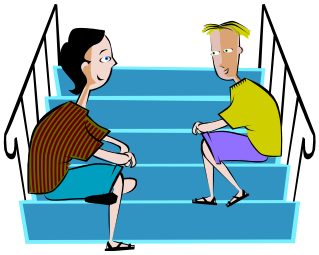
Program hours are Monday thru Friday from 3:25 pm – 6:00 pm.

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 Conformation Form!

Morning Program (7:05 am-8:15pm) $100
Afternoon Program (3:25pm-6:00pm)
Payments are due by the 7th of each month



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 during pick up time. For more information please feel free to contact the Program Coordinator.

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

Juliet Pabon (860) 984 0984
Please visit us @ www.opmad.org

home contact us search OPMAD

Organized Parents Make A Difference

Literacy Based After-School Enrichment Programs.

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 Juliet Pabon at juliet.pabon@opmad.org or (860) 984-0984.

Thank you,

Juliet
Program Coordinator

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 in 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 ☐ American Indian/ Alaskan Native ☐ Hispanic/Latino	☐ Black, not of Hispanic origin ☐ White, not of Hispanic origin ☐ Asian/Pacific Islander ☐ Other
Primary Care Provider		

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-BUSKY

* 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 wounds or head 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 with vision	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Vision" (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 on school property 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

Organized Parents Make A Difference, Inc.
Kennelly After-School Program Registration Form

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

Ethnicity: _____ Gender: ____ Teacher's Name: _____ SASID #: _____

Please Select □ **Morning** (7:05am-8:15am) □ **Afternoon** (3:25pm-6:00pm)

How will your child get home? (No child under 10 may walk home) Walk: _____ Pick-up: _____

If your child is, being picked up, by whom? Please list ALL persons authorized to pick-up your children. Including their phone #, we will not release your child to any person NOT listed below!

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

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__
Does your child have any medications or have any allergies? Yes__ No__
If yes to any of the above questions, please explain: _____

Method of Payment:

We accept multiple payment options through opmad.org as well as check or money order
Payments are **non-refundable** if your child is dismissed during the program.

I hereby consent to the use and/or reproduction of any photographs/videos of my child.
I understand in the event of an emergency; every effort will be made to contact a parent/guardian. In the event a parent/guardian cannot be reached, I designate and appoint OPMAD and its authorized personnel or agents to represent me in full authority and hereby authorize any hospital and their emergency room, emergency treatment facility or unit to perform emergency procedures and medical treatment as necessary and appropriate on the above-named child. I have supplied accurate emergency numbers and information. If possible, I prefer my child to be taken to _____ hospital in the event of an emergency I hereby agree that I will not hold OPMAD or any employee and agents of OPMAD liable for injuries or illness contracted by my child while he/she is a participant in the OPMAD program. I give my permission for school records to be shared with OPMAD for educational support, assistance and program evaluation

Names of siblings being enrolled: _____
(Must fill out a form for each child)

Parent Name (Please Print): _____Date: _____

Parent/Guardian Signature: _____

Address: _____ Zip code: _____

Cell Phone #: _____Work Phone #: _____

Employer:_____ E-mail: _____

Organized Parents Make A Difference, Inc. (OPMAD)
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OFFICE USE ONLY

[ ] Deposit Paid [ ] Paid Full Fee [ ] Confirmation packet received [ ] Entered into Transact