Nutmeg Volleyball Camps

Thank you for registering for the 2024 Nutmeg Volleyball Camps at Loomis Chaffee School.

We hope that this will be a memorable and exciting experience for you. The information in this packet is very important, so please read it thoroughly, fill out the enclosed forms, and feel free to call or email with any questions.

Payment:

Full payment of camp fees must be made upon registration.

Venmo payment to @Jeff-Dyreson
or **checks only made out to: Nutmeg Volleyball Camps**
Once payment is received a payment confirmation will be sent

Please contact Director Jeff Dyreson for any questions or issues.
You acknowledge and agree to assume and be fully responsible for all property or other damage to the room or any other facility used at Nutmeg Volleyball Camps at Loomis Chaffee School. Lost keys are $50.

Cancellation policy:

Hopefully, you will not have to cancel, but if you must, please do so as early as possible.
Cancellations prior to July 1st will be fully refunded.
Cancellations after July 1st will be charged a $200 deposit fee with any remainder refunded or applied to future camp.

Mailing address for checks:
Nutmeg Volleyball Camps
4 Batchelder Rd
Windsor, CT 06095
Attn : Jeff Dyreson

Registration:

Session I: Check in is on Sunday, July 28th (9 am – 11 am)
Session II: Check in is on Thursday, Aug. 1st (9am – 11am)
Once at Loomis Chaffee School, please look for signs that will guide you to the registration table at the dormitories next to the athletic center.
Camp introduction begins at 11:30 am. 1st meal provided will be lunch with first volleyball instruction starting after lunch.

*$20 for evening snacks (covers 3 nights) will be collected at registration (cash preferred)

Camp Ends:
Session I: Camp concludes on Wed, July 31st at 3 pm in the Olcott Athletic Center
Session II: Camp concludes on Sunday, Aug. 4th at 3 pm in the Olcott Athletic Center
Family are invited to come any time after 1:30 pm to watch.
Make sure your child has checked out with the appropriate camp staff.

Camp Address and Phone:
Nutmeg Volleyball Camp at Loomis Chaffee School
4 Batchelder Road
Windsor, CT 06095
Director Cell phone: (860) 833-4725
Campus Security: (860) 687-6325

Health Forms:
The health forms must be completed and brought to camp on the first day. CAMPERS WILL NOT BE ADMITTED WITHOUT THESE FORMS AND THE APPROPRIATE SIGNATURES.

- ✓ Connecticut Health Exam Form
- ✓ Authorization for administering medication
- ✓ Authorization for Self-Medication (per decision of parents and physician)

Health & Safety:
Health services always include a physician on call and a certified medical director on staff on campus during camp.
Loomis Chaffee School employs campus security always during camp.
PLEASE NOTE THAT ALL MEDICATION WILL BE KEPT WITH THE CAMP FIRST AID DIRECTOR AND ALL PRESCRIPTION MEDICATION MUST HAVE THE ORIGINAL PRESCRIPTION LABEL.
*__Covid-19 protocols will be in place based on CDC, Windsor Dept. of Public Health, and Loomis Chaffee School. Details of that protocol will be assessed and modified with notifications sent to all families throughout the summer leading up to camp.__

Nutmeg Volleyball staff are certified with first aid/CPR and medical administration but are not licensed medical professionals. But does employ an MD on call.

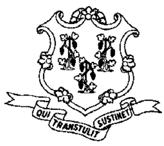
Roommates and Dorm supervision:
Campers stay 1, 2, or 3 (no guarantees) per room and are assigned by age and roommate requests. If there isn't a roommate request, the camper may be placed with a roommate. We try to best accommodate each camper and their requests.
Campers are under constant supervision of coaches/staff that stay in the dorms while camp is in session.

Room Key Loss:
Keys will be issued to campers upon request. Campers will be charged $50/key for lost keys. Checks to be payable to The Loomis Chaffee School.

Spending Money and Snacks:
We recommend $20 spending money for emergencies. Items are available for purchase in the school bookstore.
Campers will not be allowed to order food for delivery during camp.

Checklist of Items to bring:
Below is a suggested list of clothing, equipment, and personal items. We recommend that you do not send unnecessary clothing, or expensive items such as jewelry, watches, Ipods/MP3 players, and expensive cameras.
Volleyball Items:
- ✓ 10-12 T-shirts
- ✓ 4-6 shorts
- ✓ 1 pair of athletic court shoes, well broken-in
- ✓ 1-2 pairs of knee pads
- ✓ 10-12 pairs of socks
- ✓ water bottle (1 liter size recommended)

Non-Volleyball Items:
- ✓ Comfortable pants, shirts, and shorts
- ✓ PJs and Bathrobe
- ✓ Underwear and socks
- ✓ Comfortable shoes
- ✓ Bathing Suit
- ✓ Pillow, linens, blanket and or sleeping bag
- ✓ Washcloth, towels and toiletries/personal items
- ✓ Laundry bag
- ✓ Alarm clock
- ✓ Fan



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 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

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-HUSKY**

* If applicable

Part 1 — 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

Part 2 — 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 1 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			*Postural ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made		
Genitalia/ hernia					
Skin					

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 Allergies ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source
*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

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) __________ __________ __________ __________ __________	❑ Yes ❑ No
Risk Assessment	**Describe Risk Factors**		
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other __________		❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other __________

Recommendation(s) by health care provider: ______________________________

____

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

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	Date Signed	Printed/Stamped ***Provider*** Name and Phone Number

Student Name: ______________________ **Birth Date:** ______________ HAR-3 REV. 7/2018

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 7th-12th grade	
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	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
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:** ________

Renew Date: ________ ________ ________ ________

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 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, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an 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 nationwide 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 Day Care Centers and Group Day Care Homes, licensed Family Day 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: ____

Dosage _____Method /Route_____ Time of Administration ________ Start Date ____/____/____ End Date ____/____/____

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 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) ____

Note: This form is a sample form 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 appropriately labeled**

☐ **Medication is in original container** ☐ **Date on label is current**

Person Accepting Medication (print name) _________________________________ **Date** _____/_____/____

YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF
Physical Exams Are Valid For 3 Years
From Date of Last Examination

☐ Camper
☐ Staff

Please Return Completed Form to the Camp

Name____ Date of Birth______________ Phone__________________________

Guardian________________________________ Address____

Emergency Contact____ Telephone______________________

Date of Arrival at Camp: __________________________________ Departure Date: ____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Date of Exam ____/____/____

May participate in all camp activities ☐ YES ☐ NO

May participate except for: ____

Does the individual have any known medical or emotional illness or disorder that poses a risk to other children or which affects the individual's functional ability to participate safely in a youth camp? ☐ YES ☐ NO

If yes, please explain ____

____

Are there any prescription or over the counter medication(s) this individual needs to take while at camp? ☐ YES ☐ NO

If yes, indicate names of medication(s):____

NOTE: A written authorization and parent permission for the administration of medication at camp are required.

Does the individual have any disabilities or special health care needs such as allergies, special dietary needs? ☐ YES ☐ NO

If yes, please explain ____

____

NOTE: If the camper has a special health care need or disability that requires special care be taken or provided during the time the individual is at camp, an individual plan of care shall be developed with the parent and health care provider and updated as necessary. The plan shall include appropriate care of the camper in the event of a medical or other emergency and signed by the parent and staff responsible for the care of the camper.

If camper/staff is school aged or younger, have they been immunized in accordance with the schedule adopted by the Commissioner of Public Health pursuant to section 19a-7f of the Connecticut General Statutes? ☐ YES ☐ NO

Additional Comments:

____

____

Printed Name of Health Care Provider: ____

Address: ____ Phone: __________________________

Signature of Physician, PA, APRN or RN ____________________________________ Date Form Signed: __________________