

**TIS Digital Backpack  
May 8, 2023**



*Photo courtesy of M. Lachut*

**FROM THE PRINCIPAL'S OFFICE:**

This past week the TIS staff was treated to a lovely luncheon and an exciting and fun raffle to top off Teacher Appreciation Week. The luncheon was coordinated by Tabitha Cefaratti and included everything from wraps to desserts! TIS would like to thank everyone who contributed food and time to this event.



PTO President, Bethany Lescoe, showed off her talent when she put together this impressive prize board for the raffle:



## **Fifth Grade Promotion Ceremony**

We would like to take this opportunity to invite you to the Tolland Intermediate School Fifth Grade Promotion Ceremony. The ceremony will be on the last day of school, June 15, at 9:30 a.m. in our gymnasium. The promotion ceremony will be an opportunity to celebrate the children's completion of the elementary school chapter in their lives. Due to space constraints, we ask that no more than two people per family attend the ceremony.

## **SBAC Testing at Tolland Intermediate School**

Tolland Intermediate School students will begin SBAC testing on Monday, May 8. Testing for students in grades three through five will consist of an ELA test and two separate math assessments. Fifth grade students will also take the SBAC Next Generation Science Standards assessment. If your child's Chromebook is brought home each day, please make sure that it is fully charged in preparation for testing.

Dear Fifth Grade Families,

In just a few short months, your child will be getting ready to leave Tolland Intermediate School and continue their educational adventures as a middle schooler. As a culminating elementary school experience, we typically hold a Tolland Intermediate School Fifth Grade Promotion Ceremony. During the ceremony we present a slideshow to our fifth graders. The slideshow consists of student baby pictures, as well as candid photographs of the fifth graders.

In order to create the slideshow, we will need your help in supplying us with a picture of your child. Please submit a baby picture of your child to Mrs. Lachut, T.I.S. Secretary, by completing [THIS FORM](#) or by scanning the QR code below.

Should you have a problem submitting the photo through the form, please email - [mlachut@tolland.k12.ct.us](mailto:mlachut@tolland.k12.ct.us). Your child's name and teacher's name should be included **in the subject line** of the e-mail you send to Mrs. Lachut.

We will use your return email and/or photos submission as permission to include your child's baby picture in our Tolland Intermediate School Promotion Student Video. The slideshow will be shared with fifth grade families at the conclusion of the year.

Thank you.



Direct link to the submission form: <https://forms.gle/ehApbmyLm3DZSywh9>

# TIS CALENDAR



## MAY

- 9 Grade 4 Band Concert, 7 p.m. at TIS (see flyer)
- 18&19 Grade 5 Tours of TMS
- 18 Grade 3 Tolland Green Day
- 25 Rain date: Tolland Green Day
- 25 TMS will hold an incoming 6<sup>th</sup> grade student  
Parent orientation night (more info in May)

### ***Special calendar note:***

*The 2022-2023 school year has been shortened from 182 days to 180 days. The last day of school will remain June 15, 2023, as previously published.*

*This is an early dismissal day (12:40 p.m.)*

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# ITEMS FROM LAST WEEK'S D.B.

## WHAT'S NEW IN OUR CLASSROOMS

### GRADE 3

Students in Grade Three have been very busy! Keep up the great work!

In Language Arts, we are working on Unit 5 in the Journeys program. This unit starts with a story called Sarah, Plain and Tall, where we review the story structure and learn about the point of view. Some other skills that we are working on in this story about pioneer life are the prefix non and adverbs that compare. We move on to a non-fiction piece called The Journey: Stories of Migration, where students learn about the reasons for animal migration. In this piece, we explore the comprehension skills of comparing and contrasting, and the author's word choice. For grammar, third graders learn about word roots and making comparisons.

In Foundations classes we are working on Units 10 and 11. We've worked on r-controlled vowels and practiced the different spelling options. Students are doing wonderfully marking their words and syllables and we'll continue to work on these skills as we move on through the program. It is an exciting time of year for third graders, as they have learned most of their cursive letters and are being encouraged to practice writing in cursive.

We have wrapped up our Odd Motion science unit and have moved on to Tolland in the 1800s. Teachers are excited to teach about what life was like in Tolland during this period of change from farming to more specialized jobs in Tolland. We'll be learning about what a one-room schoolhouse was like, as well as the other jobs that families had in town during the 1800s. Third graders will receive the name of a child who lived in Tolland during this time and will learn what that child's family did in town. We are having Tolland Green Day on May 18th. Students will dress in colonial attire and visit the museums on the Tolland Green to get a first-hand experience of what life was like in the 1800s. Notices went out a few weeks ago letting you know the date and with some helpful hints on how to make an outfit for this day.

Our annual trip to Old Sturbridge Village is scheduled for June 8th. We encourage all parents or guardians to join us on this wonderful field trip. Parents are asked to drive to Old Sturbridge Village, as we don't have room on the buses. You will need to fill out a volunteer form whether you are an official chaperone or just joining your child for a day full of fun. Please be sure to do this form several weeks in advance. You can get the form on the Tolland Public Schools website.

As always, third-grade teachers are grateful for all the support that parents and the community give us. We appreciate your flexibility and willingness to help and support us. Thank you for all that you do!

## **GRADE 4**

Students have been reading nature selections in a variety of genres to help them understand various text structures. Our next reading unit will include historical fiction, informational text, newspaper articles, narrative nonfiction, fables, and poetry.

Fourth graders have been working with angles and using protractors. They have also been learning new strategies for multiplying and dividing and using them to solve area and perimeter problems. Soon they will be learning how to multiply fractions. We will culminate the year with practical application of all the skills learned throughout the school year.

We are very excited about planning a new field trip for our students. More information will be coming soon! Also, we are working with our high school graphic arts department to create red t-shirts, emblazoned with the Tolland Hawks logo, for all students who chose to order one.

## **GRADE 5**

Fifth Graders are very excited to attend our annual Freedom Trail Field Trip in Boston next week! This will be a review of our Social Studies curriculum, as well as some new topics that we will continue to explore in May and June.

Fifth Graders have been working hard on their monthly genre book reports. So far, we have covered realistic fiction, mystery, historical fiction, fantasy, graphic novel, biography, science fiction, and poetry. What has been your child's favorite so far? We will be exploring informational texts and graphic novels in May and June.

Students started our last module for fifth grade, "Breaking Barriers." In this module students will read the text, "We Are the Ship," by Kadir Nelson. In this text Kadir Nelson tells the incredible story of baseball's unsung heroes. Kadir Nelson shares the engaging story of Negro League baseball from its beginnings in the 1920s through its evolution, until after Jackie Robinson crossed over to the majors in 1947. This text also has many beautiful oil paintings. In this module, students will learn how sports affect how people view each other, to create opportunities for people, and to help people overcome and challenge barriers. Students will read and research a variety of informational texts about individual athletes, coaches, teams, and organizations to answer the question: How can sports influence individuals and societies?

In Social Studies, students continue to learn about the French and Indian War, as well as the American Revolution. We are excited to apply what we have learned thus far to our upcoming field trip to Boston. We will be using different resources to learn about these topics throughout the spring, such as IXL, book clubs, and videos.

In Math, students are finishing up Unit 5, Multiplying and Dividing Fractions. Students have built on their skills in the area of rectangles and scaling as they explored multiplication of fractions (including mixed numbers). Students also moved into understanding division of whole numbers and unit fractions. They have become fluent with fractions in all operations. Our next unit, Unit 6, focuses on Graphing Geometry and Volume. Students are continuing to use IXL and reflex for additional practice.

In Science, students are continuing to learn about many different water phenomena around the world through their virtual tour guide Brooke Riverton. We began at Bay of Fundy learning about tides. Then traveled to Yellowstone National Park to learn about mudpots, hot springs, and geysers - with a main focus on Old Faithful! We are now moved on to Abraham Lake in Canada to observe frozen methane gas bubbles that are present during the winter months.

# 4<sup>th</sup> Grade Band



## Spring Concert Information

- Concert date: Tuesday evening, **May 9, 2023**
- Place: Tolland Intermediate School APR (all-purpose room 2<sup>nd</sup> floor)
- Students arrive: 6:30 p.m. and report to Mrs. Marchesani's room #226
- Concert begins: 7 p.m. onstage in the APR
- Concert dress: Appropriate for a performance

Please contact me if you have any questions or concerns.

Thank you,

Mrs. Norma Marchesani [nmarchesani@tolland.k12.ct.us](mailto:nmarchesani@tolland.k12.ct.us) 860-870-6885 ext. 40226

Please cut on the line below and return the lower portion of this form by May 3, 2023.

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4<sup>th</sup> grade Band Concert Commitment Form  
**May 3, 2023**

Return to Mrs. Marchesani by:



**Yes,** \_\_\_\_\_ (please print first and last name of **student**),  
**will perform** at the TIS 4<sup>th</sup> grade Band Concert on **May 9, 2023**. I will report to room  
#226 at **6:30 p.m.** on Tuesday, **May 9, 2023**. I understand that my concert begins at  
**7:00 p.m.**

Proud band parent signature:

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**Please, return on or before May 9, 2023 to Mrs. Marchesani**

Please cut off this bottom portion and save the above pertinent concert information on  
the family bulletin board!

## **UPCOMING SPIRIT DAYS AT TIS**

|                 |                                                                   |
|-----------------|-------------------------------------------------------------------|
| <b>April 28</b> | <b>Favorite Character Day (Disney, cartoons, book characters)</b> |
| <b>May 5</b>    | <b>Tie Dye Day</b>                                                |
| <b>May 26</b>   | <b>Patriotic Day</b>                                              |
| <b>June 2</b>   | <b>Tourist/Sunglasses Day</b>                                     |

# HELP!



*We have racks and boxes (and boxes and racks!) of lost and found items from this school year. If you think your child may be missing a coat, hat, snow pants, gloves, water bottle or lunchbox, please come into school to look at our Lost and Found collection.*



Camp Invention®

# MAKE NEW DISCOVERIES THIS SUMMER



This year's all-new program inspires confidence as campers collaborate in creative problem-solving challenges led by qualified educators to bring their biggest ideas to life!

**SAVE \$15**

WITH CODE **WONDER15**

ENDS MAY 11, 2023

**SAVE \$30**

WITH CODE **SIBLOVE30**

FOR 2 PEOPLE

**SAVE \$40**

WITH CODE **SIBLOVE40**

FOR 2 OR MORE PEOPLE

## SECURE YOUR SPOT TODAY!

Register at [INVENT.ORG/CAMP](https://INVENT.ORG/CAMP) or 800-968-4332

Grades: K - 6th

Location: Tolland High School  
1 Eagle Hill Dr, Tolland, CT 06084

Date: July 31 - August 4, 2023

Time & Cost: 9:00 AM to 3:30 PM | \$285 (before discount)

Camp Director: Erica Yaglowski | [eyaglowski@tolland.k12.ct.us](mailto:eyaglowski@tolland.k12.ct.us) | (800) 870-6800

*Eligible Discount: Please note: this program is open to Tolland Public School students in grades K - 6th only.*

If these dates/times don't work for you, please visit [invent.org/camps](https://invent.org/camps) for other locations near you.

**REGISTER HERE!**

Camp Invention is a nonprofit program of the National Inventors Hall of Fame.



National Inventors  
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Inventors in Creativity and Invention

Army Educational Outreach Program  
Barbara D. Morgan Foundation  
General Motors  
Horizon Corporation Foundation

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Dunbrook Family Foundation  
United Way of Southern & Western  
U.S. Department of Defense (DoD) STEM  
Defense STEM Education Consortium (DSEC)  
Nathan Family Foundation

THS Booster Club

# Eagle Cornhole Tournament

Join us  
Saturday  
5•20•23  
1:30-5:30

\$50 entry per team  
Cash prize top 4 teams  
1st place \$500 visa aift card!



# CRANDALL'S SUMMER CAMP INFORMATION

## Registration Starts April 3, 2023



At Crandall's Summer Camp, we strive to engage your child in a variety of activities that include outdoor games, sports, nature, arts & crafts, creative games, water activities, and special events.

Children should bring a lunch, water bottle (please do not send glass), snacks, bathing suit and a towel each day. Please remember sunscreen and teach your child how to put it on properly.

Rainy days will be at the Tolland Recreation Center.

Register for camp online, by mail, or bring to the Recreation Office. Camp Runs Monday – Friday and is for children in grades K-8.

Participants are grouped by grade entering Fall 2023.

Deadline for registration is the Wednesday prior to the week you wish your child to attend by 12:00(noon).

**Maximum Enrollment: 60 participants per week**

### CRANDALL'S SUMMER CAMP SCHEDULE

Day: Monday – Friday Full day (8:00am-4:00pm)

Ages: Grades K – 8<sup>th</sup>

Date: Week 1: June 26 – June 30

Week 2: July 3 – July 7 (No July 4)

Week 3: July 10 - July 14

Week 4: July 17– July 21

Week 5: July 24 – July 28

Week 6: July 31 – August 4

Week 7: August 7– August 11

*Deadline for registration is the **Wednesday prior** to the week you wish your child to attend by 12:00(NOON).*

Location: Crandall Park (Rain location-Tolland Recreation Department)

### REGULAR DAY CAMP HOURS

Time: 8:00am - 4:00pm

(if you need extended hours you must also register for extended hours for each week)

Fee: \$100.00 Res. (discounted fee) / \$210.00 Non-Res Regular Day (5 Days)

### Week of July 4th Only

Fee: \$80.00 Res. (discounted fee) / \$170.00 Non-Res Regular Day (4 Days)

### EXTENDED DAY CAMP HOURS- (Must be registered for Regular day camp hours)

Time 4:00pm – 5:30pm

Fee: Additional \$15.00 Res. (discounted fee) / \$40.00 Non-Res.





# Tolland Family Resource Center

## Camp Hawk

### (SUMMER)

**What:** Tolland Family Resource Center Camp Hawk offers a high quality and exciting summer program for children ages five through twelve. Children must be five by September 1, 2023.

**Where:** Tolland Intermediate School

**Dates:** The summer program will run from Monday, June 19, 2023, to Friday, August 25, 2023. (No camp on Tuesday, July 4, 2023, in observance of the Independence Day holiday.)

**Hours:** The camp is offered Monday through Friday from 9:00 AM to 4:00 PM. Extended care is available for an additional fee from 7:00 AM-9:00 AM and/or 4:00 PM-6:00 PM. The one fee covers both am and pm extended care.

**Cost:**

Full Week tuition is \$190.00 per week from 9:00 AM-4:00 PM.

Full Week extended care is an additional \$45.00 per week for AM and/or PM care.

For Camp Hawk 2023 the FRC will cover the fees for field trips and special activities.

**Part Time Rate:**

All children must enroll for a minimum of 2 days per week.

The part time rate is \$45.00 per day from 9:00 AM-4:00 PM.

Part time extended care is an additional \$15.00 per day for AM care and/or PM care.

For Camp Hawk 2023 the FRC will cover the fees for field trips and special activities.

**Registration:** Registration begins March 1, 2023. The registration fee is \$50.00 per child or \$75.00 per family. A one-week security deposit is also due upon registration. You may register for as many weeks as you wish. Return completed registration forms to Tolland Family Resource Center, 247 Rhodes Road Tolland, CT 06084. Please make checks payable to the Tolland Board of Education.

**General Expectations:** For safety concerns, all campers are to follow Camp Hawk's expectations, guidelines, and policies as listed in our handbook. Handbooks will be available on our website by June 1, 2023. **Please make sure to read!**

**Program Components:**

**Quality Staff:** Our staff is experienced and qualified. Many of our staff work in the School Age Care Program, which provides continuity for the children. Staff members are first aid & CPR trained and medication certified.

**Meals:** Children need to bring their own lunch, a morning snack, an afternoon snack and a beverage in a self-cooled container. No microwave or refrigerator is available. Water is available for children throughout the day.

**Theme Weeks:** Each week has a fun theme! Children participate in planned activities geared toward the theme.

**Field Trips and Special Guests:** The children will have the opportunity to experience in-house field trips/special guests as well as in person trips throughout the summer. The camp will take hiking trips.

**Inclement weather:** At times when the weather does not allow the children to go outside (i.e., extreme heat or rain), the staff will plan special activities for the children inside.

**What to Bring:** Please put your child's name on every item brought to camp. Each child must bring the following: backpack, change of clothes, bathing suit, towel, lunch, and snacks (in self-cooled container), water bottle, sunscreen, and insect repellent (left in their locker). Please apply sunscreen before arriving each day. Children may reapply their own sunscreen as needed.

If you have any questions about any of the program components, please call the Family Resource Center at 860-870-6750 x5.



**Camp Hawk  
2023 Theme Weeks**

|                                                                                                                                      |                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <b>Week 1 (June 19*-23)</b><br><b>"Hello Summer"</b><br><b>Field Trip Friday – Sonny's Place</b>                                     | <b>Week 6 (July 24-28)</b><br><b>"Dinosaur Days"</b><br><b>Field Trip Friday – Dinosaur State Park</b>        |
| <b>Week 2 (June 26-30)</b><br><b>"Surf &amp; Sun"</b><br><b>Field Trip Friday - Hammonasset</b>                                      | <b>Week 7 (July 31-August 4)</b><br><b>"To Infinity &amp; Beyond"</b><br><b>Field Trip Friday - Ecotarium</b> |
| <b>Week 3 (July 3-July 7, closed Tuesday, 7/4)</b><br><b>"Rockin' in the USA"</b><br><b>Field Trip Friday - Hike a Tolland Trail</b> | <b>Week 8 (August 7-11)</b><br><b>"Around the World"</b><br><b>Field Trip Friday - Storyteller</b>            |
| <b>Week 4 (July 10-14)</b><br><b>"Anything Goes"</b><br><b>Field trip Wednesday – Mr. Gym</b>                                        | <b>Week 9 (August 14-18)</b><br><b>"Animal Kingdom"</b><br><b>Field Trip Friday - The Children's Museum</b>   |
| <b>Week 5 (July 17-21)</b><br><b>"Science Fun"</b><br><b>Field Trip Friday - Mad Science</b>                                         | <b>Week 10 (August 21-25)</b><br><b>"Goodbye Summer"</b><br><b>Field Trip Friday – Spare Time Bowling</b>     |

\*The start date of week 1 is dependent on the last day of school.  
The last day of camp is Friday, August 25<sup>th</sup>.

**Tolland Family Resource Center  
Camp Hawk**

**2023 Registration Form**

**Registrations must be submitted with applicable fees and required deposit to be complete.**

**CHILD/FAMILY INFORMATION: Please print clearly.**

|                          |         |
|--------------------------|---------|
| Child's Name:            | D.O.B:  |
| Grade in September 2023: | Gender: |

|                                                                                                                                                                                                                                                                                              |       |           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-----------|
| Home Address: Code:                                                                                                                                                                                                                                                                          | Town: | State/Zip |
| Ethnicity: not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/>                                                                                                                                                                                       |       |           |
| Race (select one or more of the following): American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/><br>Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> |       |           |

|                                                                                                                                                                                                                                                                                              |                |                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------------|
| Parent/Guardian Name:                                                                                                                                                                                                                                                                        | Gender:        | Relationship to Child: |
| Home Address: Code:                                                                                                                                                                                                                                                                          | Town:          | State/Zip              |
| Home #:                                                                                                                                                                                                                                                                                      | Work #:        | Cell #:                |
| Employer:                                                                                                                                                                                                                                                                                    | Email Address: |                        |
| Ethnicity: not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/>                                                                                                                                                                                       |                |                        |
| Race (select one or more of the following): American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/><br>Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> |                |                        |

|                                                                                                                                                                                                                                                                                              |                |              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------|
| Parent/Guardian Name: to Child:                                                                                                                                                                                                                                                              | Gender:        | Relationship |
| Home Address: Code:                                                                                                                                                                                                                                                                          | Town:          | State/Zip    |
| Home #:                                                                                                                                                                                                                                                                                      | Work #:        | Cell #:      |
| Employer:                                                                                                                                                                                                                                                                                    | Email Address: |              |
| Ethnicity: not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/>                                                                                                                                                                                       |                |              |
| Race (select one or more of the following): American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/><br>Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> |                |              |

**In case of emergency, which parent/guardian listed above should we contact first?**

\_\_\_\_\_

Unless informed otherwise, the Tolland Family Resource Center assumes both parents listed above may pick up the child. If a parent may not pick up the child, legal documentation of that fact is required. **It is your responsibility to let us know of changes in residency, billing, custody, & contact information.**

**EMERGENCY INFORMATION**

If the Tolland Family Resource Center staff **are unable to reach the parents/guardians**, the following individuals have permission to make decisions regarding the care of my child, including permission to pick up my child from the FRC in case of emergency.

|         |                        |         |
|---------|------------------------|---------|
| Name:   | Relationship to child: |         |
| Home #: | Cell #:                | Work #: |
| Name:   | Relationship to child: |         |
| Home #: | Cell #:                | Work #: |

**CHILD PICK UP AUTHORIZATION**

I give permission for my child to be released from the Family Resource Center program to the people listed below at any time. I understand that the FRC staff requires photo identification of authorized pick-up people before releasing my child.

|         |                        |         |
|---------|------------------------|---------|
| Name:   | Relationship to child: |         |
| Home #: | Cell #:                | Work #: |
| Name:   | Relationship to child: |         |
| Home #: | Cell #:                | Work #: |
| Name:   | Relationship to child: |         |
| Home #: | Cell #:                | Work #: |

**ADDITIONAL INFORMATION**

|                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| With whom does the child <b>primarily</b> reside? Both <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Split Custody <input type="checkbox"/> Other <input type="checkbox"/> |
| <i>If other selected for primary residence, please explain:</i>                                                                                                                                                       |
| Parent/Guardian Responsible for billing: Both <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other <input type="checkbox"/>                                                 |
| <i>If other selected for billing responsibility, please explain:</i>                                                                                                                                                  |
| Primary language spoken at home:                                                                                                                                                                                      |
| Additional languages spoken:                                                                                                                                                                                          |
| Siblings' Names & D.O.B.:                                                                                                                                                                                             |

**HEALTH/WELLNESS INFORMATION**

|                                                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Are your child's immunizations up to date? Y <input type="checkbox"/> N <input type="checkbox"/>                                                                                                                                             |
| Does your child take any prescribed or over-the-counter medication on a regular basis? Y <input type="checkbox"/> N <input type="checkbox"/>                                                                                                 |
| If yes, please list medication name(s):                                                                                                                                                                                                      |
| If your child requires medication during camp hours, it must be provided in the original container to the attending staff as well as accompanied by an Authorization for the Administration of Medication form, completed by your physician. |
| Does your child have any allergies (food, medication, seasonal, etc.)? Y <input type="checkbox"/> N <input type="checkbox"/>                                                                                                                 |
| If yes, please explain:                                                                                                                                                                                                                      |
| Does your child follow a special diet (gluten-free, vegetarian, vegan)? Y <input type="checkbox"/> N <input type="checkbox"/>                                                                                                                |
| If yes, please explain:                                                                                                                                                                                                                      |
| Does your child have any chronic health concerns (asthma, seizures, diabetes)? Y <input type="checkbox"/> N <input type="checkbox"/>                                                                                                         |
| If yes, please explain:                                                                                                                                                                                                                      |
| Has your child been diagnosed with any developmental disorders? Y <input type="checkbox"/> N <input type="checkbox"/>                                                                                                                        |
| ADD/ADHD <input type="checkbox"/> ASD <input type="checkbox"/> Hearing <input type="checkbox"/> Language/Speech <input type="checkbox"/> Vision <input type="checkbox"/> Other <input type="checkbox"/><br>None <input type="checkbox"/>     |
| Does your child receive any of the following services? Y <input type="checkbox"/> N <input type="checkbox"/>                                                                                                                                 |
| Special Education <input type="checkbox"/> 504 <input type="checkbox"/> IEP <input type="checkbox"/> 1:1 Aide <input type="checkbox"/> Other <input type="checkbox"/><br>None <input type="checkbox"/>                                       |

**Additional Health/Wellness Information** (special circumstances, sensitivities, social/emotional concerns, etc.)

|                                                                                                                         |                  |
|-------------------------------------------------------------------------------------------------------------------------|------------------|
| Is your child covered by any hospitalization/medical care policy? Y <input type="checkbox"/> N <input type="checkbox"/> |                  |
| Name of Insurance Company:                                                                                              | Phone #:         |
| Address:                                                                                                                | City: State/Zip: |
| Policy Holder's Name:                                                                                                   | Policy Number:   |
| Physician:                                                                                                              | Phone #:         |
| Please list a preferred hospital:                                                                                       |                  |

**Please review the information you have provided on this registration form to ensure accuracy.**

\_\_\_ I do / \_\_\_ do not give permission for my child to be photographed. (Pictures may be placed in the FRC/Camp Hawk photo album, scrapbook or displayed in the classroom. Pictures may also be displayed at other FRC/Camp Hawk events, such as the Open House, town childcare fair etc. Pictures will not be placed in the newspaper without prior written approval. Pictures will never be placed on social media.)

\_\_\_ I do / \_\_\_ do not give permission for my child to view PG movies occasionally.

\_\_\_ I do / \_\_\_ do not give permission for my child to self-apply sunscreen and insect repellent, as needed. **Parents are asked to check their child(ren) each day for ticks. The FRC is not responsible for any insect related illness.**

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**Camper's Name:** \_\_\_\_\_

Enrollment Options (Please check below):

**Full Week:**

\$190.00 per week

9:00 AM-4:00 PM \_\_\_\_\_

\*For Camp Hawk 2023 the FRC will cover the fees for field trips and special activities.

Additional \$45.00 per week for AM and/or PM extended care

7:00 AM-9:00 AM \_\_\_\_\_

4:00 PM-6:00 PM \_\_\_\_\_

**Please check the full week's options below:**

\_\_\_\_\_ I am enrolling my child for ALL TEN weeks of the summer program.

\_\_\_\_\_ I am enrolling my child for the following full weeks (please circle weeks attending):

|                                                          |                             |
|----------------------------------------------------------|-----------------------------|
| Week 1 (June 19 - 23)                                    | Week 6 (July 24 - 28)       |
| Week 2 (June 26 - 30)                                    | Week 7 (July 31 - August 4) |
| Week 3 (July 3 - 7) Closed Tuesday,<br>7/4, Prorated fee | Week 8 (August 7 - 11)      |
| Week 4 (July 10 - 14)                                    | Week 9 (August 14 - 18)     |
| Week 5 (July 17 - 21)                                    | Week 10 (August 21 - 25)    |

**Part Time:**

\$45.00 per day (minimum 2 days per week)

9:00 AM-4:00 PM \_\_\_\_\_

\*For Camp Hawk 2023 the FRC will cover the fees for field trips and special activities.

Additional \$15.00 per day for AM and/or PM extended care

7:00 AM-9:00 AM \_\_\_\_\_

4:00 PM-6:00 PM \_\_\_\_\_

**For children attending part time, please circle the days attending below:**

|                                  |                                                                          |
|----------------------------------|--------------------------------------------------------------------------|
| <b>Week 1 (June 19- 23)</b>      | <b>M T W Th F</b>                                                        |
| <b>Week 2 (June 26-30)</b>       | <b>M T W Th F</b>                                                        |
| <b>Week 3 (July 3-7)</b>         | <b>M T W Th F (Closed Tuesday 7/4 in observance of Independence Day)</b> |
| <b>Week 4 (July 10-14)</b>       | <b>M T W Th F</b>                                                        |
| <b>Week 5 (July 17-21)</b>       | <b>M T W Th F</b>                                                        |
| <b>Week 6 (July 24-28)</b>       | <b>M T W Th F</b>                                                        |
| <b>Week 7 (July 31-August 4)</b> | <b>M T W Th F</b>                                                        |
| <b>Week 8 (August 7-11)</b>      | <b>M T W Th F</b>                                                        |
| <b>Week 9 (August 14-18)</b>     | <b>M T W Th F</b>                                                        |

**SUMMER PROGRAM POLICIES:**

- Registration fees are non-refundable.
- Registrations will be accepted until June 1, 2023.
- A one-week tuition deposit (per child) is due upon registration, which will be applied to the last week of enrollment. The tuition for June, July and August will be due on the first of each month. A \$15.00 late fee will be assessed if payment is not received by the 5<sup>th</sup> of each month.
- Refunds of tuition deposits will be given only if your child is withdrawn **before June 1, 2023.** No tuition deposits will be refunded after this date.
- If requesting to withdraw from any enrolled week at Camp Hawk after June 1, 2023, families are responsible and required to pay the tuition for all registered weeks.
- Any change in registration requires a Change of Registration form found on the website.
- The summer program has a limited capacity and will be filled on a first come first served basis.
- The Tolland Family Resource Center must have a copy of the child's current health form on file by June 1, 2023.

- Please read our Summer Handbook for all program policies. The handbook will be available on our website ([tolland.k12.ct.us/community/family\\_resource\\_center](http://tolland.k12.ct.us/community/family_resource_center)) on June 1, 2023.

My child \_\_\_\_\_ will be attending the summer program at the Tolland Family Resource Center. I have enclosed a non-refundable registration fee of \$50.00 per child / \$75.00 per family and a one-week deposit per child. (Deposits will be applied to the last week of the program for which your child(ren) is/are enrolled.)

I have read and understood the above policies of the School Age Care Summer Camp Program.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please note: Families will receive a confirmation letter of enrollment. In the event the program is full at the time of your registration, you will receive notification and your check will be returned to you. A waiting list will be kept in the order in which the registrations are received.

Thank you for your registration for the  
Family Resource Center School Age Care Summer Camp Program.

|                       |
|-----------------------|
| For Office Use:       |
| Date received _____   |
| Check #: _____        |
| Amount received _____ |

## FOOD ALLERGY ALERT (FRC)

\_\_\_\_\_  
Child's Full Name

\_\_\_\_\_  
Allergic to:

Place recent photo here

Ingestion: YES NO UNKNOWN  
Contact: YES NO UNKNOWN  
Inhalation: YES NO UNKNOWN

Describe type of reaction:

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Medication(s) Prescribed:

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## 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 physi-

cian 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                                                                                                                | <input type="checkbox"/> Male <input type="checkbox"/> Female                                                                                                                                         |
| Address (Street, Town and ZIP code)                  |                                                                                                                           |                                                                                                                                                                                                       |
| Parent/Guardian Name (Last, First, Middle)           | Home Phone                                                                                                                | Cell Phone                                                                                                                                                                                            |
| School/Grade                                         | Race/Ethnicity<br><input type="checkbox"/> American Indian/<br>Alaskan Native<br><input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Black, not of Hispanic origin<br><input type="checkbox"/> White, not of Hispanic origin<br><input type="checkbox"/> Asian/Pacific Islander<br><input type="checkbox"/> Other |
| Primary Care Provider                                |                                                                                                                           |                                                                                                                                                                                                       |
| 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-HUSKY                                                                                                                                     |
| Does your child have dental insurance?               | Y N                                                                                                                       |                                                                                                                                                                                                       |

\* 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 |
| <b>Family History</b>                                                      |     |                                         |     | 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.

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Is there anything you want to discuss with the school nurse? Y N If yes, explain:

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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. | Date |
| Signature of Parent/Guardian                                                                                                                                                                                |      |

## Part 2 — Medical Evaluation

HAR-3 REV. 7/2018

**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 <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality:<br><input type="checkbox"/> Mild <input type="checkbox"/> Moderate<br><input type="checkbox"/> Marked <input type="checkbox"/> Referral made |        |                   |
| Genitalia/ hernia |        |                   |                                                                                                                                                                                                                                                   |        |                   |
| Skin              |        |                   |                                                                                                                                                                                                                                                   |        |                   |

### Screenings

| *Vision Screening                                                                                       | *Auditory Screening                                                                              | History of Lead level<br>≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes | Date |
|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------|
| Type: <span style="margin-left: 20px;">Right</span> <span style="margin-left: 20px;">Left</span>        | Type: <span style="margin-left: 20px;">Right</span> <span style="margin-left: 20px;">Left</span> |                                                                                            |      |
| With glasses <span style="margin-left: 20px;">20/</span> <span style="margin-left: 20px;">20/</span>    | <input type="checkbox"/> Pass <input type="checkbox"/> Pass                                      | *HCT/HGB:                                                                                  |      |
| Without glasses <span style="margin-left: 20px;">20/</span> <span style="margin-left: 20px;">20/</span> | <input type="checkbox"/> Fail <input type="checkbox"/> Fail                                      | *Speech (school entry only)                                                                |      |
| <input type="checkbox"/> Referral made                                                                  | <input type="checkbox"/> Referral made                                                           | 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 |
|-------------------------------------------------------|-------------|------------------------------------------------|

**Part 3 – Oral Health Assessment/Screening**  
**Health Care Provider must complete and sign the oral health assessment.**

HAR-3 REV. 7/2018

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      | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Address                               |            |                                                               |
| Parent/Guardian Name (Last, First, Middle) | Home Phone | Cell Phone                                                    |

|                                                                                                    |                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                    |                                                                                      |
|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| <b>Dental Examination</b><br>Completed by:<br><input type="checkbox"/> Dentist                     | <b>Visual Screening</b><br>Completed by:<br><input type="checkbox"/> MD/DO<br><input type="checkbox"/> APRN<br><input type="checkbox"/> PA<br><input type="checkbox"/> Dental Hygienist                                                                                          | <b>Normal</b><br><input type="checkbox"/> Yes<br><input type="checkbox"/> Abnormal (Describe)<br>_____<br>_____<br>_____<br>_____                                                                                                  | <b>Referral Made:</b><br><input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| <b>Risk Assessment</b>                                                                             | <b>Describe Risk Factors</b>                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                    |                                                                                      |
| <input type="checkbox"/> Low<br><input type="checkbox"/> Moderate<br><input type="checkbox"/> High | <input type="checkbox"/> Dental or orthodontic appliance<br><input type="checkbox"/> Saliva<br><input type="checkbox"/> Gingival condition<br><input type="checkbox"/> Visible plaque<br><input type="checkbox"/> Tooth demineralization<br><input type="checkbox"/> Other _____ | <input type="checkbox"/> Carious lesions<br><input type="checkbox"/> Restorations<br><input type="checkbox"/> Pain<br><input type="checkbox"/> Swelling<br><input type="checkbox"/> Trauma<br><input type="checkbox"/> 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**

- DTP: 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 the 1st 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 the 1st 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 |
|---------------------------------------------------------------|-------------|------------------------------------------------|

# **Tolland Family Resource Center**

## **School Age Care Program 2023-2024**

Dear Families,

It is a pleasure to have you join us at the Tolland Family Resource Center School Age Care Program (FRC SAC). The FRC staff members are CPR and first aid trained as well as medication certified. The program provides before and after school care at both Birch Grove Primary School and Tolland Intermediate School for children in kindergarten through grade six. Families that have children at both schools may choose to have their children attend the Tolland Intermediate School site in the morning and the Birch Grove site in the afternoon. Site location is determined by bussing availability. Children in 6<sup>th</sup> grade will be bussed to Tolland Intermediate School.

### **Policies and Procedures**

**Registration is not complete until the FRC receives the completed forms, registration fee and security deposit. You may email your completed registration forms to [tollandfrc@tolland.k12.ct.us](mailto:tollandfrc@tolland.k12.ct.us).**

It is **especially important** for the FRC staff to know when your child will be absent from the School Age Care Program on a scheduled day. If you call or send a note to your child's teacher to report his/her absence or early dismissal from school, **you must also notify the Family Resource Center by phone or email.**

- a) Birch Grove Primary School site: 860-870-6750 x 5
- b) Tolland Intermediate School site: 860-870-6885 x 3
- c) Email: [tollandfrc@tolland.k12.ct.us](mailto:tollandfrc@tolland.k12.ct.us)

- \* The hours of the Before School Program are 7:00 a.m. until the start of the school day.
- \* The hours of the After School Program are from the end of the school day until 6:00 p.m. A late fee will be charged after 6:00 p.m.
- \* **Monthly charges will be placed on your account in the accounting software system on the 15<sup>th</sup> of each month for the following month. All monthly invoices will be emailed on the first of the month. Please notify us if your email address changes.**
- \* Tuition payments are due by the 1<sup>st</sup> of the month. A late fee of \$15.00 will be charged if paid after the 5<sup>th</sup> of the month.
- \* Parents may verify their email address with our online software payment program for the option of paying online by credit card, debit card or ACH. If you pay with a credit or debit card there will be a convenience fee charged to your account. Parents choosing to pay us directly by check should place the check in the payment box located at each site or mail it to the Family Resource Center, 247 Rhodes Road, Tolland. Please make checks payable to the **Tolland Board of Education.**
- \* The center will be open during in-service/conference days and mid-winter/spring breaks. Advance registration is required for non-school days. Registration will be accepted on a first come first serve basis. Additional fees will be charged for these days. We must have 15 children enrolled to open.
- \* The program closes for all public school holidays, the winter break in December, and any closings due to inclement weather.

- \* **Should your childcare needs change and you would like to add additional days you must complete a Change in Registration Form. (Found on the website) Approval will be based on enrollment. If you need to withdraw your child from the program or decrease the number of days your child attends, one-month notice is required. Please complete the Change in Registration Form.**
- \* If you have any questions, please email Carol Hiller, Tolland Family Resource Center Coordinator at [chiller@tolland.k12.ct.us](mailto:chiller@tolland.k12.ct.us) or Kim Evans, Tolland Family Resource Center Program Manager at [kevans@tolland.k12.ct.us](mailto:kevans@tolland.k12.ct.us).

**MONTHLY TUITION FEES**

**Before School Care**

| <b>Days each week</b> | <b>Yearly rate</b> | <b>Rate per month</b> |
|-----------------------|--------------------|-----------------------|
| 5 Days                | \$1950.00          | \$195.00              |
| 4 Days                | \$1550.00          | \$155.00              |
| 3 Days                | \$1170.00          | \$117.00              |
| 2 Days                | \$780.00           | \$78.00               |

**After School Care**

| <b>Days each week</b> | <b>Yearly rate</b> | <b>Rate per month</b> |
|-----------------------|--------------------|-----------------------|
| 5 Days                | \$3030.00          | \$303.00              |
| 4 Days                | \$2430.00          | \$243.00              |
| 3 Days                | \$1830.00          | \$183.00              |
| 2 Days                | \$1240.00          | \$124.00              |

**If your child attends on Early Release Days an additional \$10.00 will be added to your next invoice.**

**Registration Fee: \$50.00 per child/ \$75.00 per family.**

**Tuition Rates are based on the 10-month school year. The yearly tuition is divided into 10 equal monthly payments for the school year. \*Please note that these fees may be subject to an increase.**

All vacations, teacher in-service/ conference days, and early release days are additional and are not included in your monthly charge.

**Security Deposit:**

50% of your **last month's tuition** must be submitted with the registration as a security deposit.

**If you decide to remove your child prior to the start of the program, you need to withdraw by August 1 in order to receive a full refund of your security deposit. If this notice is not given, the deposit will be forfeited.**

**Sibling Discount:**

FRC offers a 5% sibling discount. The sibling discount does NOT apply if the family is receiving financial assistance.

**Late Pick-Up Fee:**

There is a \$1.00 charge per minute per child for late arriving parents. Three late pick-ups from the program may result in dismissal.

**Late Payment Fee:**

A \$15.00 charge will be assessed to your account if payment is not received by the 5th of the month.

**Return Check Fee:**

A \$20.00 charge will be assessed to your account for checks returned for nonsufficient funds, "NSF".

**Financial Assistance:**

Assistance with childcare fees may be available to qualifying families. Please contact Carol Hiller at [chiller@tolland.k12.ct.us](mailto:chiller@tolland.k12.ct.us) for more information.

**Tolland Family Resource Center**

**School Age Care Program Registration 2023-2024**

**Registrations must be submitted with the registration fee and security deposit to be complete.**

**CHILD/FAMILY INFORMATION: Please print clearly**

|                                                                                   |                      |                 |
|-----------------------------------------------------------------------------------|----------------------|-----------------|
| Child's Name:                                                                     | D.O.B:               | Age:            |
| Gender:                                                                           | Grade in Sept. 2023: |                 |
| Home Address:                                                                     | Town:                | State/Zip Code: |
| In case of emergency, which parent/guardian listed below should we contact first? |                      |                 |

---

|                       |                        |
|-----------------------|------------------------|
| Parent/Guardian Name: | Relationship to Child: |
|-----------------------|------------------------|

|               |                |                 |
|---------------|----------------|-----------------|
| Home Address: | Town:          | State/Zip Code: |
| Home #:       | Work #:        | Cell #:         |
| Employer:     | Email Address: |                 |

|                       |                        |                 |
|-----------------------|------------------------|-----------------|
| Parent/Guardian Name: | Relationship to Child: |                 |
| Home Address:         | Town:                  | State/Zip Code: |
| Home #:               | Work #:                | Cell #:         |
| Employer:             | Email Address:         |                 |

Unless informed otherwise, the Tolland Family Resource Center assumes both parents listed above may pick up the child. If a parent may not pick up the child, legal documentation of that fact is required.

**It is your responsibility to let us know of changes in health, residency, billing, custody, & contact information.**

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#### SCHEDULE

Parents: Please **circle** the class and days for which you are enrolling your child:

|                                                     |
|-----------------------------------------------------|
| <b>Before School Care:</b> Mon. Tue. Wed. Thu. Fri. |
|-----------------------------------------------------|

|                                                    |
|----------------------------------------------------|
| <b>After School Care:</b> Mon. Tue. Wed. Thu. Fri. |
|----------------------------------------------------|

|                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------|
| <b>Site Attending:</b> Birch Grove <input type="checkbox"/> Tolland Intermediate School <input type="checkbox"/> |
|------------------------------------------------------------------------------------------------------------------|

|                             |
|-----------------------------|
| <b>Start date:</b><br>_____ |
|-----------------------------|

#### EMERGENCY INFORMATION

In case of emergency, and if the Tolland Family Resource Center staff **is unable to reach the parents/guardians**, the following individuals have permission to make decisions



regarding the care of my child, including permission to pick up my child from the FRC in case of emergency or early dismissal from the FRC.

|         |         |                        |
|---------|---------|------------------------|
| Name:   |         | Relationship to child: |
| Home #: | Cell #: | Work #:                |
| Name:   |         | Relationship to child: |
| Home #: | Cell #: | Work #:                |

**CHILD PICK UP AUTHORIZATION**

I give permission for my child to be released from the Family Resource Center program to the people listed below at any time. I understand that FRC staff require these people to furnish Photo Identification before releasing my child.

|         |         |                        |
|---------|---------|------------------------|
| Name:   |         | Relationship to child: |
| Home #: | Cell #: | Work #:                |
| Name:   |         | Relationship to child: |
| Home #: | Cell #: | Work #:                |
| Name:   |         | Relationship to child: |
| Home #: | Cell #: | Work #:                |

**ADDITIONAL INFORMATION**

|                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Ethnicity:</b> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/>                                                                                                                                                                           |
| <b>Race:</b> (please select one or more of the following): American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/><br>Black or African American <input type="checkbox"/> Hawaiian/Pacific Isl. <input type="checkbox"/> White <input type="checkbox"/> |
| With whom does the child <b>primarily</b> reside? Both <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Split Custody <input type="checkbox"/><br>Other <input type="checkbox"/>                                                                |
| <b>If other is selected for primary residence, please explain:</b>                                                                                                                                                                                                                      |
| Parent/Guardian Responsible for billing: Both <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other <input type="checkbox"/>                                                                                                                   |
| <b>If other selected for billing responsibility, please explain:</b>                                                                                                                                                                                                                    |
| <b>Languages</b> spoken at home:                                                                                                                                                                                                                                                        |

Siblings Names & D.O.B.:

**HEALTH INFORMATION** – Check boxes where they apply and explain as necessary in the space provided below.

|                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Physical:</b> Vision <input type="checkbox"/>   Hearing <input type="checkbox"/>   Seizures <input type="checkbox"/>   Other <input type="checkbox"/>                |
| <b>Premature Birth:</b> Yes <input type="checkbox"/>   No <input type="checkbox"/>                                                                                      |
| <b>Psychological:</b> ADD/ADHD <input type="checkbox"/>   Emotional <input type="checkbox"/>   Mental Illness <input type="checkbox"/>   Other <input type="checkbox"/> |
| <b>Allergies:</b> Foods <input type="checkbox"/>   Medications <input type="checkbox"/>   Seasonal <input type="checkbox"/>   Other <input type="checkbox"/>            |
| <b>Other:</b> <input type="checkbox"/> Please specify:                                                                                                                  |

**Additional Health Information** (Special circumstances, sun sensitivity, emotional sensitivity, etc.)

|                      |
|----------------------|
| <br><br><br><br><br> |
|----------------------|

|                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------|
| Is this child currently taking prescribed or over-the-counter medication? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Are you covered by any hospitalization/medical care policy? Yes <input type="checkbox"/> No <input type="checkbox"/>               |
| Please list a preferred hospital:                                                                                                  |

|                            |          |            |
|----------------------------|----------|------------|
| Name of Insurance Company: | Phone #: |            |
| Address:                   | City:    | State/Zip: |

|                                                                                                                                                                                                                           |                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| Policy Holder's Name:                                                                                                                                                                                                     | Policy Number: |
| Physician:                                                                                                                                                                                                                | Phone #:       |
| Special Services: Special Education B-3 <input type="checkbox"/> 504 <input type="checkbox"/> IEP <input type="checkbox"/> 1:1 Aide <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> |                |

Does your child have special needs that require a one-on-one aid? (Yes or No)  
 Enrollment may be delayed from the date of acceptance into the program to hire appropriate staff.

Does your child require medication while in the program? (Yes or No)  
 If your child does require medication, it must be provided in the original container to the attending staff and be accompanied by a completed Authorization of the Administration of Medication by your physician.

**Families enrolling children in School Age Care for the first time must provide the FRC with a copy of their child's health form and immunization record.**

**Please review the information you have provided on this registration form to ensure accuracy.**

**Carefully review the disclaimer and waiver provided on the next page. Sign and date below.**

**Thank you for choosing the Tolland Family Resource Center.**

The preceding information is correct, and the child herein described has permission to engage in all activities and field trips except as noted by me. In the event I cannot be reached in an emergency, I hereby give permission to the director of the program or designee to secure emergency medical services, including transportation and a physician. I also give permission to the attending physician to order injection, anesthesia, or surgery for my child as named above. I hereby release the Tolland Family Resource Center and the Tolland Board of Education from any claim arising out of the doctor's/hospital's actions. All medical expenses shall be the parent's responsibility.

I have read the Tolland Family Resource Center Tuition Policies and agree to abide by those policies. I understand that in the event of continued past due payment, late pick up of my child, or for any other compelling cause, the Tolland Family Resource Center reserves the right to remove my child from the program. I understand that if the FRC program is terminated because

enrollment is not sufficient or for any other reason given by the Tolland Board of Education, all money paid by me for the period after termination will be refunded to me.

\_\_\_ I do / \_\_\_ do not give permission for my child to be photographed for use by the FRC Programs (i.e., display boards, photo album, scrapbook) while attending the FRC SAC Program.

\_\_\_ I do / \_\_\_ do not give permission for my child to be photographed for use by the FRC marketing purposes such as the FRC web site, email, newsletter, and press releases to newspapers.

\_\_\_ I do / \_\_\_ do not give permission for my child to view G or PG movies occasionally.

\_\_\_ I do / \_\_\_ do not give permission for my child to apply sunscreen and insect repellent, as needed.

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

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**Office Use Only**

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Date Received \_\_\_\_\_ Registration Fee Paid? Y N amount \_\_\_\_\_

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---

Last Month's Tuition Paid? Y N amount \_\_\_\_\_

---

---

Total Fee Paid: **Total** \_\_\_\_\_ Check # \_\_\_\_\_

---

# FOOD ALLERGY ALERT (FRC)

Child's Full Name: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Place recent photo here

|             |     |    |         |
|-------------|-----|----|---------|
| Ingestion:  | YES | NO | UNKNOWN |
| Contact:    | YES | NO | UNKNOWN |
| Inhalation: | YES | NO | UNKNOWN |

Describe type of reaction:

\_\_\_\_\_

\_\_\_\_\_

Medication(s) Prescribed:

\_\_\_\_\_

\_\_\_\_\_

Tolland Family Resource Center  
247 Rhodes Rd.  
Tolland, CT 06084

The Tolland Family Resource Center's goal is to offer programming to all families regardless of financial status. Those families of school age children that require financial assistance may be eligible for tuition discounts based on the family eligibility for free or reduced meal benefits. The free and reduced meal benefit application is submitted to the Director of Food & Nutrition Services for students that have access to the school lunch program. Your benefit information can be shared with FRC or other programs **only** with your written permission by submitting a "sharing of information" form directly to the food service office. Free and reduced-price meal applications can be found on the food services page of the Tolland Board of Education webpage, [http://www.tolland.k12.ct.us/departments\\_new/food\\_services/free\\_and\\_reduced\\_price\\_meals](http://www.tolland.k12.ct.us/departments_new/food_services/free_and_reduced_price_meals) or are available in your school office or by contacting Food & Nutrition Services at 860-870-6854.

Preschool and other families that do not have access to school lunch, may fill out the FRC Financial Assistance Form to determine eligibility.

Sincerely,

Carol Hiller  
FRC Coordinator

Thomas Swanson  
Principal/FRC Director



# EARN CASH FOR YOUR SCHOOL

LITTLE BY LITTLE WE CAN MAKE A BIG DIFFERENCE.

The Box Tops mobile app uses state-of-the-art technology to scan your store receipt, find participating products and instantly add Box Tops to your school's earnings online.

LOOK  
FOR THE  
LABEL:



## HERE'S HOW IT WORKS:



### BUY BOX TOPS PRODUCTS

You can find Box Tops on hundreds of products throughout the store.



### SCAN YOUR RECEIPT

Use the app to snap a photo of your receipt within 14 days of purchase.



### EARN CASH FOR YOUR SCHOOL

Box Tops earnings are identified and automatically updated online.

## SHOPPING FOR GROCERIES ONLINE?

You can still earn Box Tops for your school with your e-receipt!  
See how at [BTFE.com/emailgroceryreceipts](https://www.btfec.com/emailgroceryreceipts)



## BOX TOPS CLIPS

You may occasionally find an old Box Tops clip on packages in stores. You can still clip them and send them to school, as long as each clip has a valid expiration date.

SEE PRODUCTS & LEARN MORE ABOUT  
THE BOX TOPS APP AT [BTFE.COM](https://www.btfec.com)

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APP YET? DOWNLOAD IT NOW:





*The End*

