PARISH NURSE MINISTRY

OBESITY AND JOINT PAIN

Obesity is defined as having an excessive amount of body fat. Obesity is more than just a cosmetic concern. It increases your risk of diseases and health problems such as heart disease, diabetes and high blood pressure. But many people never make the connection between obesity and joint disease.

As evidenced by the recent surge of media attention and advertising, it is generally agreed that a large percentage of Americans are overweight. In fact hundreds of thousands of Americans are morbidly obese. In various studies conducted by the Mayo Clinic, the conclusion was that many people who are obese have several serious health related conditions as noted above, and many health care dollars are spent treating these conditions. The studies also found that a condition that most people do not think about when referring to obesity is joint disease. While there is some controversy as to whether being overweight or obese is a direct cause of arthritis, it is generally agreed that excess weight can affect joint health. A person with obesity is about 60 percent more likely to develop arthritis than someone of normal body weight.

Your joints are the connections in the body where your bones come together. The joints of the body that hold us up when we stand and carry the mass of our body are called “weight-bearing joints.” The primary weight-bearing joints are the ankles, knees and hips. Joints of the feet, pelvis and low back and spine are also weight-bearing.

Osteoarthritis (OA), also know as degenerative joint disease, is the most common type of joint disease in the world. In the United States alone, more than 27 million adults have a diagnosis of OA. While OA can develop due to wear and tear on any joint, those that bear our weight are the most susceptible because of the mechanical force placed on them. For this reason, the more you weigh the more stress is placed on your weight-bearing joints and the more likely you are to develop OA. In the Framingham study of obesity of more than 1,400 people who were tracked for thirty-five years, 33% were found to have OA of the knee. Those with higher body mass indexes had a higher percentage of OA not only in the knee but in other weight-bearing joints.

While the mechanism is not completely understood, being overweight or obese seems to greatly increase the development of Rheumatoid Arthritis (RA). Rheumatoid Arthritis is a systemic autoimmune disease that causes inflammation and can damage many systems of the body, but it is most know for causing a painful joint-deforming arthritis. It appears that adipose cells (the cells in the body that store fat) make inflammatory chemicals that can irritate body tissues like joint tissue, and can also affect immune system function. Whatever the cause, for those who are prone to developing RA, having excess body weight may be a factor in whether they actually develop the disease or how severe it becomes.

We know that weight gain has a negative impact on joint health and function, and we also know the reverse to be true. In general, weight loss can have a very positive impact on joint health. Again referring to the Framingham Study, it was shown that being even slightly overweight significantly increased the incidence of OA in women. They also found that losing 11 pounds reduced their risk of developing knee OA by half.

Many people suffer from chronic back pain. The British Journal of Pain cites many studies relating the affects of obesity and back pain. These studies have also demonstrated that weight loss, even in small measures, can aid in the relief of back pain.

Overall, your body is significantly connected to the health of your joints. One benefit of maintaining lower weight is clearly a reduced risk of all forms of joint disease. If you are overweight and suffer from arthritis, even small amounts of weight loss may significantly improve the health and function of your joints.

SOW SEEDS OF FAITH THROUGH RELIGIOUS ED

Do you feel called to serve the youth of Saint Paul Church? Volunteers are needed in a variety of roles, including:

Teachers, Co-teachers, Substitute Teachers, Classroom Aides, Office Assistants, Hall Monitors and Event Assistants.

For more information, contact Robin Veronesi at religioused@stpaulkensington.org.

To volunteer, go to www.stpaulkensington.org, choose Catechists from the Religious Ed drop-down tab and then click on the 2014-2015 Teacher Registration Form on the left side of page.

REMINDER: Registration for the Religious Ed 2014—2015 school year is due by June 14th. Register on our web, www.stpaulkensington.org.

Find the Gospel Words:

A	T	I	Y	R	O	H	T	U	A
N	A	M	T	I	R	I	P	S	M
S	N	O	I	T	A	N	E	P	E
R	B	N	R	A	E	T	M	R	A
E	A	M	O	U	N	T	A	I	N
H	P	E	H	S	H	R	N	E	F
T	T	I	T	P	F	A	V	N	A
A	I	R	U	A	V	E	N	S	T
F	Z	S	A	B	L	O	L	R	H
N	E	V	A	E	H	F	E	L	E

FELL
EARTH
NAME
SPIRIT
MOUNTAIN
HEAVEN
BAPTIZE
SON
ELEVEN
AUTHORITY
NATIONS
FATHER

SPSC

SAINT PAUL SUMMER CAMP

Website and Other Publications
Photo Permission Guidelines

Dear Parent or Guardian,

Occasionally we wish to post a picture of a particular summer camp activity. This may involve posting a picture showing a child, a group of children, or a sample of a child's work. We may also use these photos in brochures, posters, and various other means of publication.

If a child's pictures or works are used:

- Personal information will not be published.
- Documents will not include information that indicates the physical location of any child at a given time other than attendance at a particular camp activity.

Before posting pictures of children or their work, we require that the parent(s)/guardian(s) sign the permission form below. We will keep this signed form on file for the summer.

Photo Permission Form

(Please check all that apply below)

____I **grant** Saint Paul Summer Camp permission to use photo images of my son/daughter or a sample of his/her work on Saint Paul School's or St. Paul Parish's website, or in other print or electronic media.

OR:

Please check the blanks below to indicate which permission(s) you grant and then sign and date as indicated.

____ Saint Paul Summer Camp has permission to post samples of my son/daughter's work in its media.

____ Saint Paul Summer Camp has permission to post a picture of my son/daughter in its media.

OR:

____I **do not grant** Saint Paul Sumer Camp permission to use photo images of my son/daughter or a sample of his/her work such as a poem, story, artwork, etc. on the Saint Paul School or Parish websites, or in other print or electronic media.

Print Name of Child____

Print Name of Parent/Guardian____

Signature of Parent/or Guardian____Date__________________

NOTE: This agreement will be in effect as of the date signed and may be revoked at any time by contacting the Camp Director.

State of Connecticut Department of Education

Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

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

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name ______________________ Birth Date __________ Date of Exam __________

☐ I have reviewed the health history information provided in Part I 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
Neurologic		
HEENT		
*Gross Dental		
Lymphatic		
Heart		
Lungs		
Abdomen		
Genitalia/ hernia		
Skin		

Ortho	Normal	Describe Abnormal
Neck		
Shoulders		
Arms/Hands		
Hips		
Knees		
Feet/Ankles		

***Postural** ☐ No spinal abnormality ☐ Spine abnormality: ☐ Mild ☐ Moderate ☐ Marked ☐ Referral made

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐ Referral made

***Auditory Screening**

Type:	Right	Left
	☐ Pass	☐ Pass
	☐ Fail	☐ Fail

☐ Referral made

	Date
Lead:	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ☐ No ☐ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

☐ Up to Date or ☐ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ☐ No ☐ Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis Allergies ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ☐ No ☐ Yes Epi Pen required ☐ No ☐ Yes

Diabetes ☐ No ☐ Yes: ☐ Type I ☐ Type II **Other Chronic Disease:**

Seizures ☐ No ☐ Yes, type:

☐ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: ______________________

Daily Medications (*specify*): ______________________

This student may: ☐ **participate fully in the school program**
☐ participate in the school program with the following restriction/adaptation: ______________________

This student may: ☐ **participate fully in athletic activities and competitive sports**
☐ participate in athletic activities and competitive sports with the following restriction/adaptation: ______________________

☐ Yes ☐ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.

Is this the student's medical home? ☐ Yes ☐ No ☐ I would like to discuss information in this report with the school nurse.

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

Student Name: ______________________________ **Birth Date:** __________________ HAR-3 REV. 4/2011

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 for 7th grade entry	
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	*	*			PK and K (born 1/1/2007 or later)	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			2 doses required for K & 7th grade as of 8/1/2011	
PCV	*				PK and K (born 1/1/2007 or later)	
Meningococcal	*				Required for 7th grade entry	
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** _____

Recertify Date _________ Recertify Date _________ Recertify Date _________

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN

- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 day apart – 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after 1st birthday (Children 5 years and older do not need proof of Hib vaccination).
- Pneumococcal: 1 dose on or after 1st birthday (born 1/1/2007 or later and less than 5 years old).
- Hep A: 2 doses given six months apart-1st dose on or after 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students enrolled before August 1, 2011, 1 dose given on or after 1st birthday; for students enrolled on or after August 1, 2011 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 1-6

- DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 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. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses – the last dose on or after 24 weeks of age.
- Varicella: 1 dose on or after the 1st birthday or verification of disease*.

GRADE 7

- Tdap/Td: 1 dose of Tdap for students 11 yrs. or older enrolled in 7th grade who completed their primary DTaP series; For those students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are needed, one of which **must** be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart – 1st dose on or after the 1st birthday.
- Meningococcal: one dose for students enrolled in 7th grade.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: 2 doses given 3 months apart – 1st dose on or after 1st birthday or verification of disease*.

GRADES 8-12

- Td: At least 3 doses. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine one of which should be Tdap.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday.
- MMR: 2 doses given at least 28 days apart-1st dose on or after the 1st birthday.
- Hep B: 3 doses-the last dose on or after 24 weeks of age.
- Varicella: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart or verification of disease*.

* **Verification of disease:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

____

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

CAMPER'S NAME:____ AGE:______________

Single day camp fees: $57.00 per day

Camp hours: Single Day Sessions: 9 a.m. – 3:30 p.m. (includes before and after care services 7:00a.m.- 9a.m. and 3:30p.m.-6p.m.)
***Please note: Before care and after care services *must be requested at time of registration* to ensure adequate staff and supplies are provided.**

****All full and single day campers must bring a mid-morning snack, a lunch, a late afternoon snack (if staying for after-care) and a beverage. Refrigeration will be provided.**

SINGLE-DAY REGISTRATION FORM

PLEASE CIRCLE DAYS(S) YOU ARE REGISTERING FOR. *PLEASE NOTE: **A SEPARATE REGISTRATION IS NEEDED FOR EACH CHILD**

DATE	6-23	6-24	6-25	6-26	6-27	6-30	7-1	7-2	7-3	7-7	7-8	7-9	7-10	7-11	7-14	7-15	7-16	7-17	7-18	7-21	7-22
BEFORE CARE?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
IF YES, TIME NEEDED?																					
AFTER CARE?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
IF YES, TIME NEEDED?																					
DATE	7-23	7-24	7-25	7-28	7-29	7-30	7-31	8-1	8-4	8-5	8-6	8-7	8-8	8-11	8-12	8-13	8-14	8-15			
BEFORE CARE?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
IF YES, TIME NEEDED?																					
AFTER CARE?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
IF YES, TIME NEEDED?																					

# of days:__________ x $57.00 = __________ Deposit due ($10.00 per day):__________ Balance due:__________

Please return completed forms and deposits to: Saint Paul School 461 Alling Street Kensington, CT 06037
For questions and concerns: summercamp@stpaulkensington.org * www.stpaulkensington.org * 860-828-4343

FULL-DAY & HALF-DAY REGISTRATION FORM

CAMPER'S NAME:____ AGE:_____________

Full Day: $255 per session Half Day: $160 per session *Please note: Session #2 is a 4-day session and is pro-rated.

Camp hours: Full Day: 9a.m. - 3:30 (includes Before Care services 7:00a.m. - 9a.m. and After Care services 3:30p.m. - 6:00p.m.)
Half Day: 9a.m. – noon (includes Before Care services 7:00a.m. – 9a.m.)

***Please note: Before and After Care services *must be requested at time of registration* to ensure adequate staffing.**

All full-day campers must bring a mid-morning snack, a lunch, an afternoon snack and beverages.
All half-day campers must bring a mid-morning snack and a beverage. Refrigeration will be provided.

PLEASE CIRCLE SESSION(S) YOU ARE REGISTERING FOR D	SESSION 1 JUNE 23-27	SESSION 2 JUNE 30-JULY 3	SESSION 3 JULY 7-11	SESSION 4 JULY 14-18	SESSION 5 JULY 21-25	SESSION 6 JULY 28-AUG 1	SESSION 7 AUG 4-8	SESSION 8 AUG 11-15	TOTAL FEES DUE	DEPOSIT ENCLOSED ($50.00 PER SESSION)	BALANCE DUE (MUST BE PAID IN FULL BY JUNE 9TH)
CIRCLE ONE:	FULL DAY HALF DAY	FULL DAY HALF DAY	FULL DAY HALF DAY	FULL DAY HALF DAY	FULL DAY HALF DAY	FULL DAY HALF DAY	FULL DAY HALF DAY	FULL DAY HALF DAY			
SESSION FEE: HALF DAY FULL DAY	$160 $255	$130 $205	$160 $255	$160 $255	$160 $255	$160 $255	$160 $255	$160 $255			
BEFORE CARE	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			
IF YES, TIME NEEDED? (BE SPECIFIC – EX: 7:30 -9)											
AFTER CARE	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N			
IF YES, TIME NEEDED? (BE SPECIFIC – EX: 3:30 -6)											

***PLEASE NOTE: A SEPARATE REGISTRATION IS REQUIRED FOR EACH CHILD**

For questions and concerns: summercamp@stpaulkensington.org * www.stpaulkensington.org * 860-828-4343

JAS3/14