Adventure Club Registration Form

Infant/Toddler Program_____Summer Program_____ After-School 2014-15_____Preschool 2014-15_____Extended Care_____

Child's Full Name		
Child's Nickname		
Date of Birth	Sex	Current Grade
Child's Home Address		
Child's Home Phone Number		
Family Primary Email Address:		

Parent/Guardian Information

Father's Name	Home Phone	
Father's Address	Cell Phone	
Father's Occupation and Place of Employment	Bus. Phone	

Is the Child's Father a Christian? Yes No	Does the Child's Father Attend Church? Yes No	If So, Where?

Mother's Name	Home Phone	
Mother's Address (if different from father's)	Cell Phone	
Mother's Occupation and Place of Employment	Bus Phone	

Is the Child's Mother a Christian? Yes No	Does the Child's Mother Attend Church? Yes No	If So, Where?

Family Information

Are the child's parents' divorced? Yes No	If yes, who does the child live with?

Please list any Siblings

Name	Brother	Sister	Age	Lives at home?

Please list any other family members living in the household and their relationship to the child.

Pick Up (please list all persons authorized to pick up your child)

Name	Relationship	Home Phone	Cell Phone	Work Phone

Personal/Medical History

Does your Child have any allergies? (If so, please list)

List any medications taken by your child on a regular basis and what the medications are for.

Are there any medical issues the program staff needs to be aware of? (If yes, please explain)

Are there any special food/eating instructions we should know about? (If yes, please explain)

Does your child have any bowel or bladder irregularities? (If yes, please explain)

The state requires all of the children in our program to participate in daily rest time on full days of care. Are there any special instructions we need regarding rest time?

What other information would you like to share regarding your child's communication skills, discipline, etc.?

Does your child attend church with either parent? If so, where?

Is there anything else you would like for us to know about your child?

Program Registration

Circle the days your child will be attending: Monday Tuesday Wednesday Thursday Friday

Each family is given **1 week of free vacation for January-December**. Will you be using your 1 week of free vacation during the school year? Yes No

If Yes, what dates will your vacation be?

Photo Permission

I, _____, hereby authorize adventure club staff to take my child's picture for use on the Adventure Club Web site and in promotional materials.

Parent's Signature and Date:

Office Use Only

Registration Fee Paid: Date _____ Amount _____ Check Number _____ Staff Initials _____

Required Documents: BC _____ Insurance _____ Immunization _____ Pay. Agr. _____

Authorization for Emergency Medical Care – Permission to Treat

Child's Name	Birth Date	
Child's Physician	Phone	
Address		
Child's Dentist	Phone	
Address		

Authorized Adults

Please indicate the names and contact information where you and other authorized persons can be reached in the event of an emergency/disaster. (Please put phone numbers in the order that you would like for us to call.)

Father's Name	Phone 1	Phone 2	Phone 3	Phone 4
Mother's Name	Phone 1	Phone 2	Phone 3	Phone 4
Other Authorized Person	Phone 1	Phone 2	Phone 3	Phone 4
Address				
Other Authorized Person	Phone 1	Phone 2	Phone 3	Phone 4
Address				

First Aid

In the event of an emergency, I authorize the staff of Adventure Club to provide any first aid care deemed necessary for my child.

Parent's Signature/Date

Emergency Care

In the event of an emergency in which I cannot be reached, the physician listed above or the local hospital are authorized to provide any emergency care deemed necessary for my child.

Parent's Signature/Date

Health Record Transfer

In the event of an emergency, I authorize the transfer of my child's health records to the appropriate medical team.

Parent's Signature/Date

Hospital

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital

Parent's Signature/Date

Insurance Information (a copy of your insurance card must also be on file with Adventure Club)

Insurance Company:

ID Number	Subscriber Name

Additional Instructions: Please list any allergies your child may have.

INSTRUCTIONS TO PARENT:
(1) Complete the following items, as appropriate, if your child has a condition(s), which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____Date of Birth: _____

Medical Condition(s):_____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Management Data:

Allergies/Reactions: Medications/Foods to be avoided and why:
1.
2.
3.

Procedures to be avoided and why:
1.
2.
3.

Immunizations

	Dates	**Dates**	**Dates**	**Dates**	**Dates**		**Dates**	**Dates**	**Dates**	**Dates**	**Dates**
DPT						**HEP B**					
CPV						**Varicella**					
MMR						**TB Status**					
HIB						**Other**					

EMERGENCY MEDICAL INSTRUCTIONS:
(1) Signs/symptoms to look for:
_____

(2) If signs/symptoms appear, do this:
_____

(3) To prevent incidents:
_____

CHILD CARE CHILD INFORMATION FORM –continued

THE FOLLOWING ARE EMERGENCY MEDICAL INSTRUCTIONS FOR A CHILD WITH SPECIAL NEEDS

Current Specialty Physician:		**Emergency Phone: Fax:**	
Current Specialty Physician:		**Emergency Phone: Fax:**	

Diagnoses/Past Procedures/Physical Exam:

1.	**Synopsis:**
2.	**Baseline physical findings:**
3.	**Baseline vital signs:**
4.	**Baseline neurological status:**
Medications: **1.**	**Significant baseline ancillary findings:** **(lab, x-ray, ECG)**
2.	
3.	**Special Equipment/Prostheses Appliances/Advanced Technology Devices:**
4.	
5.	

Antibiotic prophylaxis: **Indications:** **Medication and dose:**

Common Presenting Problems/Findings With Specific Suggested Managements:		
Problem	**Suggested Diagnostic Studies**	**Treatment Considerations**

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:

_____

COMMENTS ON CHILD, FAMILY OR SPECIFIC MEDICAL ISSUES:

_____

Note to Health Practitioner:
If you have reviewed the above information, please complete the following:

_____ _____
Name of Health Practitioner Date

_____ (____)_____
Signature of Health Practitioner Telephone Number