PROJECT CHILDD

Registration and Emergency Contact Form Please send all forms to:
Email: projectchildd@gmail.com

Please bring your child 15 minutes prior to the start time to settle them in. All parents are expected to pick up promptly at the end of the session.

Child's Name: ____

Age: ____________ Grade: ______________ M/F_____

Parent/Guardian Name: ______________________________________

Address: ____

____

Telephone: home_______________________cell__________________

Brief Medical History (see attached medical form)

____

____

____

Allergies:____

Pediatrician's Name and Telephone: ___________________________

____

Emergency Contact Name and Telephone Number:

____

Restrictions/Special Instructions: (use back of form if necessary)

____

____

PERMISSION FORM

Date _________________

(A) I hereby give permission for my child ___________________ to participate in Project CHILDD at ________________________. I will not hold Project CHILDD, Project Community, Inc. (PCI) or ___________________ responsible for any accidents or injuries to my child while he/she is participating in Project CHILDD activities.

__________________________ Parent/Guardian Signature

B) I hereby give permission for my child _____________________ to be photographed and/or videotaped during his/her participation in Project CHILDD. I understand that all photographs and/or videotapes will become the property of Project CHILDD.

__________________________ Parent/Guardian Signature

PROJECT CHILDD
Medical Form
(copy of recent physical may be used)

Physician: ____

Child's Name: ____

Address: ____

____

Date of Last Physical Exam: ____________________________

Physical Exam (inc. Scoliosis screening)

Serious Illnesses: _____________________________________

Allergies: ____

Medications: (if any see attached) ______________________

Does this child (or any other member of the household) have an infectious disease? If

yes, explain ____

____

Restrictions in Activities: ______________________________

Immunization Record:
DPT/DT: ______________________________________
OPV: ____
HIB: ____
Measles: ______________________________________
Mumps: _______________________________________
Rubella: _______________________________________
Hep. B: _______________________________________
Tuberculin: ____________________________________
TD: ____
Developmental Status:
Cognitive: _______________________
Physical: ________________________
Disability: _______________________
Special Needs: ___________________
HT: ________ WT: ________ BP: ________

Medications/Additional Medical Information

Name of Medication __________________ RX# _________________

Dosage ___________________________ Time Given:____________

How Given_____________________________

Side effects _____________________________

Purpose ________________________________

Prescribing Physician _________________ Phone # ______________

Name of Medication _____________________ RX# _______________

Dosage _____________________________ Time Given:____________

How Given_____________________________

Side effects _____________________________

Purpose ________________________________

Prescribing Physician ________________ Phone # ________________

Name of Medication ___________________ RX# _________________

Dosage _____________________________ Time Given:____________

How Given_____________________________

Side effects _____________________________

Purpose ________________________________

Prescribing Physician ________________ Phone # ________________