

THE WHOLE CHILD ®, Inc.

2 Maple Ave., Upton, MA 211 Main Street, Upton, MA
508-603-1711

www.thewholechildmatters.org

PROGRAM ENROLLMENT FORM

DATE: _____

Updated: DATE: _____ **Initial:** _____

Participant's First Name: _____ M.I.: _____ Last Name: _____

Date of Birth: _____ Grade as of Sept. 2019: _____ Current age: _____

My child is enrolled as a (Check one) _____ PARTICIPANT or a _____ PEER BUDDY (typical child/no objectives).

Guardian 1 Name: _____

Email: _____ Address: _____

Telephone: (____) _____ Can this person sign-out the child: Yes No

Guardian 2 Name: _____

Email: _____ Address: _____

Telephone: (____) _____ Can this person sign-out the child: Yes No

Emergency Contacts (In order to be contacted, IF PARENT/GUARDIAN IS UNREACHABLE)

1. Name: _____

Address: _____

Relationship to Child: _____

Phone #1: _____ Phone #2: _____

Do you give permission for the child to be released to this person? Yes No

2. Name: _____

Address: _____

Relationship to Child: _____

Phone #1: _____ Phone #2: _____

Do you give permission for the child to be released to this person? Yes No

Waiver and Release

In consideration of the acceptance of my request for my child's participation in programs and activities at The Whole Child, I hereby waive, release, and discharge any and all claims for damages for personal injury and/or property damages of which may hereafter occur to my child as a result of participation in said program or related activities. This release is intended to discharge in advance The Whole Child, Inc., its officials, officers, employees, volunteers and agents from liability, even though that liability may arise out of perceived negligence on the part of persons mentioned above. It is understood that some recreational activities involve an element of risk or danger of accidents, and knowing those risks, I hereby assume those risks. It is further understood and agreed that this waiver, release and assumption of risk is to be binding on my heirs and assignees.

Parental Consent

(Complete if participant is under 18)

I give consent for my child _____ to participate in the above activities, and I execute the above liability release on their behalf.

Consent for Treatment

I hereby give my consent to have the above applicant treated by emergency medical personnel, a physician, or surgeon, in case of sudden illness or injury while participating in the above activity. It is understood that The Whole Child, Inc. will provide no medical insurance for such treatment, and that the cost thereof will be at my expense. I have read and understood the foregoing registration liability release and parental consent form, and agree to all of its terms and conditions.

Restrictions

_____ I have reviewed the program and activities of the program and feel that the participant may participate **without** restrictions.

_____ I have reviewed the program and activities of the program and feel that the participant may participate **with the following** restrictions or adaptations: (please write on back)

PARENT SIGNATURE

DATE

Authorization for Photography:

I give my consent for any photographs in which my child may appear to be used by The Whole Child, Inc. in:

_____ TWC program activities

_____ TWC literature, marketing materials, website

At times we **video** portions of our groups for the purpose of review of child progress for staff training and we sometimes use video modeling for the children to review as a group. We may use videos to show potential and existing funders a glimpse of our program.

_____ I give my consent for video of my child for the above stated purposes only.

PARENT SIGNATURE

DATE

THE WHOLE CHILD, INC. - PROGRAM MEMBER HEALTH HISTORY FORM

Member Name: _____ Date of Birth: _____

Parent/guardian name: _____ contact #: _____

Health-Care Providers:

Name of member's primary doctor(s): _____ phone: _____

Immunization History: If you know your child is up to date on their physical and immunizations, please check in the box below and sign. If not, please explain what they have or have not been immunized for:

my child is up to date with medical physicals and immunizations

Health insurance company: _____

Insurance Subscriber: _____ Group #: _____

Allergies

No Known Allergies ____

This member is allergic to: ____ Food ____ Medicine ____ The Environment ____ Other

Please describe below what the member is allergic to and previous reactions seen:

* _____ The participant has an **Epi-Pen**. TWC, Inc. staff is asked to administer the Epi-Pen as directed upon the following presentation by participant (i.e.: hives, swelling, rash):

Prescribed Medication

We ask for this information so that it can be shared with emergency personnel if needed.

Name of Medication	Date Started	Reason for taking it	When it is given (time)	Amount or dose given	How it is given
*					
*					
*					

What Have We Forgotten to Ask?

Below, please provide any additional information about the participant's health that you think is important or that may affect your child's ability to fully participate in the program. (Please write on back)

All of the information provided is true to the best of my knowledge at this time.

parent/guardian signature

Date.