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. 2018: ___ Current age:_______

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

12.27.19 kk