Child Participant Form

Today's Date: __________ New Family: _____ Updated Family: ________

Participant's Full Name: ______________________________ Nickname: ____________________

Gender: ☐ M ☐ F Date of Birth: ________________ Age: ____ Weight: _____ lbs Height:_____

Name of School: ______________________________________ Grade/Year: _______________________

Home Address: ____ Apt. #: __________________

City: ____ State: ______ Zip Code: _______________

Participant Lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Guardian ☐ Foster family

Do you have a church you attend regularly? __________ If so, where?_________________________________

Family Information

Custodial Parent/Guardian:____

Street Address: ____ Apt. #: ___________________

City: ____ State: ______ Zip Code: ________________

Phone: _______________________ Cell: _________________ E-mail: ______________________________

Second Custodial Parent/Guardian: ____

Street Address: ____ Apt. #: ___________________

City: ____ State: ______ Zip Code: ________________

Phone: _______________________ Cell: ______________ E-mail: _________________________________

Marriage Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Siblings Living at Home:

#1 - Last Name: ____________________ First Name: _______________________ Nickname: ___________

Gender: M ☐ F ☐ Age: ________________

#2 - Last Name: ____________________ First Name: _______________________ Nickname: ___________

Gender: M ☐ F ☐ Age: ________________

#3 - Last Name: ____________________ First Name: _______________________ Nickname: ___________

Gender: M ☐ F ☐ Age: ________________

#4 - Last Name: ____________________ First Name: _______________________ Nickname: ___________

Gender: M ☐ F ☐ Age: ________________

Comment on Child's Learning Style/How does he/she learn best:

____

____

____

Nature of Disability

Participant's Medical Diagnosis/Type(s) of Disability

Diagnosis   Severity (Mild, Moderate or Profound)

____

____

____

Please describe the participant's disability: ____

____

____

Mobility:

☐ walks independently ☐ uses walker ☐ uses crutches ☐ wears AFO's

☐ Uses Wheelchair and pushes/controls self ☐ Uses wheelchair and needs assistance

Transfers: ☐ Transfers Independently ☐ Can bear weight when standing ☐ Needs assistance

If assistance needed please explain: ____

____

Communication:

☐ Verbally Speaks ☐ Uses communications device ☐ Uses sign language ☐ Other: ______________

Words/Meaning: ____

____

Gestures/Meaning: ____

____

Explanation/Specifics of Communication:____

____

Eating:

☐ Eats independently ☐ Assistance needed ☐ Special utensils used ☐ G-tube

Explanation/Specifics: ____

____

Toileting:

☐ Independent ☐ Needs assistance ☐ Needs reminders ☐ Disposable undergarment

☐On a schedule How often &Times?: ____

Explanations/Specifics: ____

____

Dressing:

☐ Independent ☐ Partial assistance ☐ Total assistance

Explanation/Specifics: ____

Social & Behavioral Information

Please list things/activities the participant enjoys:

The participant responds to separation from parents/guardians by: ______________________________________

____

The participant is best comforted by: ____

____

Please list activities or things the participant is afraid of or any activities they may not participate in:

Activity:	Reason/Explanation (if needed):

Does the participant have any behavioral issues? (biting, scratching, aggressive behavior, etc) ☐ Yes ☐ No

If yes, please describe the behavior & effective behavior management strategies (our goal is to be consistent with other environments):

Behaviors:	Behavior Management Strategies from home/school:

When do/does the behavior(s) most commonly occur?: ____

____

____

____

____

Medical Information

Participant's Primary Care Physician: ________________________________ Phone Number: _______________

Address: ____ City, State, ZIP: ____________________

Medications **(please be specific as to the name of med, what it is for, dosage and time given):**

Medication	Dosage	Frequency	Purpose
___________________	___________________	___________________	___________________
___________________	___________________	___________________	___________________
___________________	___________________	___________________	___________________
___________________	___________________	___________________	___________________

Seizures: ☐ Yes ☐ No Type: _____________________ Frequency: ______________________________

Explanation/Specifics for seizure:

☐ Before: ____

____

☐ During: ____

____

☐ After: ____

____

Allergies: ☐ None ☐ Lotions ☐ Penicillin ☐ Asthma ☐ Insect Stings

☐ Food: ___________________________ ☐ Other: ___________________________

☐ Epi Pen (*Guardian must provide Epi Pen)

Please describe allergic reactions: ____

____

Describe steps to be taken: ____

____

Does the child have a shunt? ☐ Yes ☐ No Specifics: ____

Has the participant ever required any psychiatric treatment/counseling or hospitalizations? ☐ Yes ☐ No

Please Summarize (include dates): ____

____

Other Specific Medical Instructions:

☐ G-Tube: ____

____

☐ Positioning: ____

____

☐ Other: ____

____

Does your child have a DNR (Do Not Resuscitate) Order? ☐ Yes ☐ No

Alternate Emergency Contacts:

Contact #1: _____________________________________ Relationship to Participant: ___________________

Phone: (___) ______________________________ Cell: (___)____

Contact #2: _____________________________________ Relationship to Participant: ___________________

Phone: (___) ______________________________ Cell: (___)____

Hospital Preference (If applicable at the time): ☐ Yes ☐ No If Yes, Please list:________________________

Permission/Authorization Agreement

Please read the following statements carefully and initial in the designated space indicating that you have read, understand, and agree to the provisions.

______ I have fully disclosed to Fellowship Community Church all pertinent information about my child's special needs and accept full responsibility for missing information.

______ I will supply special food, drinks, snacks, and diapers/wipes for my child as necessary.

______ I understand the nature of the program and do hereby release Fellowship Community Church and its representatives from any liability due to accident or injury incurred by my child.

I have read and initialed the above permission/authorization statements and agree to the terms designated in each:

___________________________ ______________________________ __________________

Printed Parent or Guardian Signed Parent or Guardian Date

Emergency Medical Transport & Treatment Consent

Do we have permission to allow your child/adult to be transported by EMS to medical facility if we are unable to reach parent/guardian or emergency contact? ☐ Yes ☐ No

I hereby give consent for any necessary medical treatment that may be given by medical personnel in case of an accident or illness. By my signature below, I understand that expenses for medical care will be my responsibility. I agree not to hold Fellowship Community Church, their staff, Unlimited Ministry, or its volunteers responsible or liable for any injury or accident that may occur while participating in any event or activities sponsored by FCC or Unlimited Ministry.

___________________________ ______________________________ __________________

Printed Parent or Guardian Signed Parent or Guardian Date

How did you hear about Unlimited? ☐ FCC ☐ Flyer/Ad ☐ Website ☐ Friend ☐ Other: _______________

What area(s) of Unlimited Ministry are you interested in learning more about or participating in?

❒ Unlimited Buddy: ❒ North Campus ❒ Salem Campus ❒ Southwest Campus

❒ Unlimited Kids (Monthly respite for children & sibs)

❒ Unlimited Kids Camp (annual respite weekend for children & sibs)

UNLIMITED Office Use Only

Date Participant Info Form Received: ______________ **Date Picture Consent received:** ________________

Entered into database: Date: _______________ Initials: _________________

Programs Participating in:

☐ Unlimited Buddy Program: Campus - __________________

☐ Unlimited Kids: Campus - ___________ ☐ Unlimited Kids Camp: Initial year - _________________________

Notes: ____

____

Unlimited & Kid's Life Ministry

Authorization to Reproduce Physical Likeness

I grant Fellowship Community Church the right to photograph my child and use his/her picture, silhouette, or other reproductions of my child's physical likeness in connection with advertisements, publications, and/or videos of Fellowship Community Church. These reproductions may include an exhibition, Internet webpage, incorporation into a publication, church advertisement or promotion, or any other use of videos.

My signature below indicates that I have read and understand the meaning and effect of this release form.

_________________________________ _________________________________

Child's Name (please print) Relationship to child

Agreed and Accepted: (See below if you do not agree)

_________________________________ _________________________________

Signature of Parent/Guardian Date

I **DO NOT WISH** to have my child's, ___________________________________, physical likeness used in connection with advertisements, publications, and/or videos of Fellowship Community Church. These reproductions may include an exhibition, Internet webpage, incorporation into a publication, church advertisement or promotion, or any other use of videos.

**Note: This information will be in force until such time as the parent notifies the church in writing that they want the information to be changed.

_________________________________ _________________________________

Child's Name (please print) Relationship to child

_________________________________ _________________________________

Signature of Parent/Guardian Date

Parent/Legal Guardian Sick Policy Agreement

Sick Policy Agreement-

If your child is experiencing any of the following conditions or illnesses listed below 24 hours prior to arrival, he or she **cannot** attend In His Image respite events:

1. Fever equal to or greater than 100 degrees. He or she must be fever-free without the use of medications such as Acetaminophen (Tylenol) or Ibuprofen (Advil, Motrin) for 24 hours.
2. Head lice that has been treated in less that 24 hours prior to event
3. Redness in eye with or without discharge
4. Any discharge from nose or eyes that is not clear in color
5. Any itchy, scaly or contagious rash
6. Cough that is productive (producing phlegm), chest or nasal congestion not associated with allergies
7. Vomiting
8. Diarrhea
9. Any condition that the event nurse or Unlimited Leadership Team feel is affecting the child's physical or mental state of being able to participate in planned activities or not able to enjoy themselves for an extended period of time.

Unlimited staff will contact parents/guardians to come get their child should they develop any of the symptoms/conditions listed above while in our care.

Child's Name: ____

By signing below, I am aware of the sick policy agreement.

____

Signature of Parent/Legal Guardian **Date**

This form must be signed in order for your child to attend respite events.