SENSATIONS THERAFUN PROGRAM PARTICPATENT

REGISTRASTION, INFORMATION & MEDICAL CONSENT FORM

Participant's Name ____________________ Nickname ____________________

Address ____

City ____________________ State ____________ Zip ____________

Gender: M____ F____ Date of Birth ____________ Age as of June ____________

Check all the boxes that apply to your program choice:

☐ Wonder League (Saturday mornings) Session Dates: August 23-October 16 Cost: $ 250

☐ 9 am-9:45 am (4 to 6 yrs) ☐ 10 am-10:45 am (7 to 9 yrs) ☐ 11 am-11:45 am (10+)

☐ Ninja Therapy (Monday evenings????? Session Dates: Cost: $

☐ Experiential Social Skills (Thursday Evenings) Session Dates: Cost: $

☐ Improv/Music Therapy (Tuesday Evenings) Session Dates: Cost: $

Family Information:

Guardian's Name ____________________ Email ____________________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

2nd Parent's Name ____________________ Email ____________________

Home Phone ____________ Cell Phone ____________ Work Phone ____________

Authorized Pick up ☐ Parent's and emergency contacts listed may pick up my child

Additional people who can pick up ____________________ ____________________

Unauthorized to pick up ____________________ ____________________

Emergency Information

Emergency Contact #1 ____________________ Emergency Contact #2 ____________________

Relationship ____________ Phone: ____________ Relationship ____________ Phone: ____________

Check all the boxes that apply to your camper's special needs:

☐ Allergies ☐ Physical Limitations ☐ PRN RX or TX ☐ Asthma ☐ Diabetes ☐ Autism ☐ Turrets
☐ ADD/ADHD ☐ Seizures Disorder ☐ Food Sensitivities ☐ Surgery History ☐ Other ☐ Other
____________________ and ____________________

Provide information about supportive healthcare needed for each checked item (staple additional pages as needed):

____

____

CONFIDENTIAL

Check all the boxes that apply to your camper's behaviors:

☐ Physical Aggression ☐ Emotional Aggression ☐ Elopement ☐ Sexually Active ☐ Sexual Acts Out
☐ Physical Restraint ☐ Non-Verbal ☐ Other ____________________

Provide information about each item checked, such as date of last incident, frequency, intensity and duration we can expect an episode to last and helpful hints of how we can be supportive for each checked item (staple additional pages as needed): ____

____

____

(Please provide any other pertinent information about your child on the back of the page or attach a sheet to explain.)

Are there any activities that should be restricted or encouraged? ____

Physician Name ____________________________________ Physicians Phone ______________________________

In an emergency, hospital preference ____

Emergency Medical and Liability Release Form

I, the undersigned, am the parent/legal guardian of____, who is enrolled in Sensations TheraFun Programs. By initially each item and signing this document, I confirm that:

__I wish to have my child registered and participate in Sensations TheraFun program described above.
__I release the Sensations TheraFun staff, partners, its directors, counselors, volunteers, and owner of the property, from the liability in connection with my child's participation in any activities of the camp which includes, without limitation, any liability related to an accident, injury or illness suffered by my child;
__If I am not available immediately, I authorize the Sensations TheraFun and their staff to consent medical treatment for my child, to select the medical personnel, hospitals, and/or clinics to treat my child in case of an accident, injury or illness that may occur;
__I am to notify the Executive Director in writing if I do not want my child to be photographed for Facebook, brochures, etc.
__In the event of an emergency, I authorize the Sensations TheraFun to contact my child's doctor, to administer first aid, to take my child to a clinic or emergency room or to take any other action deemed necessary by the Sensations TheraFun partners or its employees.
__ I understand that is my responsibility to carry health insurance on my child.
Health Insurance Provider ______________________________ Policy number ______________________________
__ I understand if I cancel my registration I will lose 50% of paid fees.
__I understand the sessions cannot be prorated without a written doctor's excuse.

Parent/Guardian Signature____ Date ______________________

ANY OTHER IMPORTANT INFORMATION FOR SENSATIONS THERAFUN STAFF AND IT'S PROGRAM PARTNERS TO KNOW PLEASE USE THE BACKSIDE IF NECESSARY. Thank you!

Total Paid: **Date Paid:** **Cash** **Check** **Credit Card** **Other**

CONFIDENTIAL