

Shimek BASP Child Registration

Child's First Name	Last Name	Date of Birth	Sex
Address		City, State, Zip	

Parent/Guardian	Home Phone ()	Cell Phone ()
Workplace	Work Phone ()	Cell Phone Provider
Address, City, State, Zip (if different from child)		Email

Cell provider allows us to send text alerts in the event of an emergency.

Parent/Guardian	Home Phone ()	Cell Phone ()
Workplace	Work Phone ()	Cell Phone Provider
Address, City, State, Zip if different from child)		Email

Physician	Address, City State, Zip	Phone ()
Dentist	Address, City State, Zip	Phone ()
Hospital	Address, City State, Zip	Phone ()

Unless indicated above E.A.S.Y will use the following providers: The College of Dentistry, 801 Newton Rd, Iowa City, IA 52242, (319) 335-7499 Iowa City, IA 52245

The University of Iowa 200 Hawkins Dr, Iowa City, IA 52242, (319) 356-2233

Pediatric Associates of Iowa City 1360 N Dodge St #1500, Iowa City, IA 52245, (319) 351-1448

Name of Insurance	Subscriber's Name	Plan ID #
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Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations

Name any concern that might require special care. Expect and give permission for the center to post the name, photo, and type of health concern the child has that might require an emergency response, eg, food allergy, severe reaction to insect stings, asthma, blood sugar condition, medication problem.

I give consent for my child to participate on group walks. Fieldtrips in a car, van, or public transportation will require a separate permission statement.

Parent/Guardian	Date
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Usual Schedule	Tues	Wed	Thur	Fri
Mon				

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Emergency Contacts (a minimum of 2 required)

(Individuals to whom a child may be released if parent/legal guardian is unavailable or who may be contacted in an emergency)

Emergency Contact 1	Home Phone ()	Cell Phone ()
Workplace	Work Phone ()	Relationship to child
Emergency Contact 2	Home Phone ()	Cell Phone ()
Workplace	Work Phone ()	Relationship to child
Emergency Contact 3	Home Phone ()	Cell Phone ()
Workplace	Work Phone ()	Relationship to child
Emergency Contact 4	Home Phone ()	Cell Phone ()
Workplace	Work Phone ()	Relationship to child

Parent/Legal Guardian Consent

As parent/legal guardian, I give consent for my child to receive first aid from facility staff and, if necessary, to be transported to receive medical/surgical/dental care in an emergency. I understand that I will be responsible for all charges not covered by insurance. The information on this form may be shared with staff members who are responsible for supervision of my child. I understand that I will be asked to sign separate consent forms for medication administration, release of confidential information, field trips, and special program activities.

For child pickup and emergencies: If I am unavailable for a routine or emergency pickup of a child, I give consent for the emergency contact person listed previously **to act on my behalf** until I am available. I understand that a photo ID will be requested by staff members to be sure that the person picking up my child is a person who is listed on this form as a person who is authorized to do so. I agree to review and update this information whenever a change occurs and at least annually.

Parent/Guardian	Date
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Photography Release

E.A.S.Y may take photographs/video tapings of our child for use in classroom projects, portfolios, and displays within the center.

Parent/Guardian	Date
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I/We do do not **(circle)** give consent that E.A.S.Y/Shimek BASP may take photographs/video tapings of our child and I/We consent that the program may use the photographs/video tapes of our child in promoting the purpose of the Center. We recognize E.A.S.Y/Shimek BASP **will not** identify our child by name in the photographs used. We understand that no financial benefits from the use of the photographs/video tapes are obligated to be paid by us.

Parent/Guardian	Date
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