Bethel Neighborhood Center

Here to offer a renewed sense of hope

Community Partner

Bethel Program Registration

Year: 20____ Semester: Fall/Spring/Summer Form Date: _____

Student Name: _____

Gender: Female Male

Will you need transportation? _____

Home Address: _____

Parent/Guardian Names: _____

Cell Phone: _____ Home/Work Phone: _____

School: _____ Grade (in Fall): _____

Does the student receive free or reduced school lunches? Yes No

Does the student have any relatives (brothers, sisters, cousins) that currently attend Bethel programming?
Yes No

If yes, please write their names and what programs they attend:

_____

_____

T-Shirt Size: (Adult) S M L XL

Emergency Contact #1

Name: _____ Relationship to Student: _____

Home Address: _____

Cell Phone: _____ Home/Work Phone: _____

Emergency Contact #2

Name: _____ Relationship to Student: _____

Home Address: _____

Cell Phone: _____ Home/Work Phone: _____

Medical Information

Is your child up to date on all immunization requirements? Yes _____ No _____

Insurance

Is your child covered by family medical/hospital insurance? Yes _____ No ____

Carrier or Plan Name: _____ Group #: _____

Carrier Address: _____

Name of Insured: _____ Relationship to Student: _____

Allergies

Please list all known allergies:

Medication Allergies: _____

_____

Food Allergies: _____

_____

Other Allergies: _____

Medication

Please list ALL medications including over-the-counter or non-prescription drugs taken routinely. Bring enough medication to last during the trip. Keep it in the original packaging that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration.

Bethel staff/volunteers cannot administer Tylenol, Benadryl, antacids, etc. without written permission from parent or guardian. If your child needs these items, please send them with the student.

Med #1: _____ Specific Time Taken: _____

Med #2: _____ Specific Time Taken: _____

Med #3: _____ Specific Time Taken: _____

Restrictions or Health Needs

Please list any restrictions that may apply to the student or any additional information about the student's behavior and physical, emotional, or mental health about which Bethel staff/volunteers should be made aware:

_____

_____

Signatures: Required for Attendance!

Parent/Guardian Authorizations: This health history is correct and complete, as far as I know, and the person herein described has permission to engage in all activities except as noted. I hereby give permission to Bethel Neighborhood Center to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for Bethel Neighborhood Center to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. It is my intention that Bethel Neighborhood Center be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of Bethel Neighborhood Center be treated as "personal representatives"

for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree, pursuant to the HIPAA Act, to the disclosure to Bethel representatives of the protected health information of the person herein described as necessary: (i) to provide relevant information to Bethel Neighborhood Center representatives related to the person's ability to participate in planned activities; and (ii) in the case of minors, to provide relevant information to the representatives to keep me informed of my child's health status. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Bethel Neighborhood Center to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian: _____

(If you are 18 years old or over, please sign the above line for yourself.)

Printed Name: _____ Date: _____

Waiver Consent, Waiver and Release of Liability, Photo and Video Release

On behalf of my minor child, _____, I hereby give permission for her/him to participate in Bethel's High School Program. I hereby warrant that both I and my child are familiar with the risks associated with participation in Bethel activities. I acknowledge that my child's participation in this program is wholly voluntary and is not part of the regular school curricular program.

I do hereby agree and consent to my child's participation in Bethel programming during summer and the following school year and do assume all risks and hazards which are conducted as part of the associated activities. I hereby release, absolve, indemnify, and hold blameless Bethel Neighborhood Center, its staff members and volunteers of any and all liability for damage, injury, or expense of any kind arising out of or connected with my child's participation in Bethel programming. I understand that in case of a medical emergency, my own personal medical plan will be used. As a condition of participation in the Bethel program by the student named in this application, I acknowledge that I have read this consent form, and knowingly, on behalf of my child, assume all of the risks associated with participating in any way in the Bethel program.

I understand that as part of my child's participation in Bethel, photos, videos, electronic images, audio recordings and quotations of my daughter/son may be taken for use in publications and reports about the program. I grant permission for Bethel to use such materials as described.

Printed Name_____ Signature_____

Date _____

FOR STAFF ONLY

Date Received: _____/_____/_____ Staff Initials: _____

Completed:

- € Bethel Registration Form
- € Authorization for Emergency Medical Care
- € Bethel Health Form
- € Health History

CCL 010-SPA
Rev. 9/2003

Kansas Department of Health and Environment
Departamento de Salud y Medio Ambiente de Kansas

Bureau of Child Care and Health Facilities
Oficina de Cuidado de Niños e Instituciones de Salud

1000 SW Jackson, Suite 200
Topeka, KS 66612-1274

Day Care Unit: (785) 296-1270 Fax: 785- 296-0803
Unidad de Guardería de Niños: (785) 296-1270 Fax: 785- 296-0803

Foster Care Unit Phone : (785) 368-7015 Fax: 785- 296-7025
Unidad de Cuidado Sustituto: (785) 368-7015 Fax: 785- 296-7025

Website: www.kdhe.state.ks.us/kidsnet/
Sitio Web: www.kdhe.state.ks.us/kidsnet/

AUTHORIZATION FOR EMERGENCY MEDICAL CARE
AUTORIZACIÓN PARA CUIDADO MÉDICO DE EMERGENCIA

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

Es obligatorio mantener en los archivos de la institución un permiso escrito para recibir tratamiento médico de emergencia. Consulte a la institución local médica de emergencia para confirmar si este formulario es aceptable. Haga referencia al K.A.R. 28-4-127(b)(1)(A) excepto para Programas de Guardería para niños de Edad Escolar , para los cuales aplica la referencia K.A.R. 28-4-582(e)(2)(B).

Name of facility exactly as stated on the license/certificate Nombre de la institución exactamente como aparece en la Licencia/ el Certificado.	License or Certificate # Licencia ó Certificado #
Bethel Neighborhood Center	14538-006

I hereby authorize Paul Rollet, Maug Sonra, Tim Schwartz, Manuala Arambula, Cing Zo, Binod Gurung Rosa Macias (Name of individual/staff member) and/or (Name of individual/staff member) who is(are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth _____ (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of 6-01-15 (MM/DD/YYYY) and 5-31-2016 (MM/DD/YYYY).

Por la presente autorizo a _____ (Nombre de la persona/empleado) y/o a _____ (Nombre de la persona/ empleado) que representa(n) a la institución arriba estipulada, para dar su consentimiento para suministrar cualquier y todo el cuidado médico de emergencia que sea necesario a mi hijo(a) o joven _____ (Nombre y Apellido del Niño(a) o Joven) mientras dicho niño(a) o joven permanezca bajo la custodia de la institución entre _____ y _____. (Mes/Día/Año) (Mes/Día/Año).

Signature of Parent or Guardian Firma del Padre/Madre o Tutor	Date Signed Fecha de Firma

Witness to Parent's or Guardian's Signature only if required by the local hospital or clinic. Testigo de la Firma del Padre/Madre o Tutor, únicamente si es requerido por el hospital o la clínica local.	Date Signed Fecha de Firma

Notarization of Parent's or Guardian's signature, only if required by local hospital or clinic.
Certificación por Notario de la Firma del Padre/Madre o Tutor, únicamente si es requerida por el hospital o la clínica local.

State of Kansas
Estado de Kansas

County of
Condado de _____

Signed or attested before me on _____ by
Firmada o Atestiguada ante mí en _____ por _____
(MM/DD/YYYY) Name of Person
(Seal, if any) (Mes/Día/Año) Nombre de la Persona
(Sello, si existe)

_____
Signature of Notarial Officer
Firma del Funcionario Notarial

_____
Title (and Rank)
Título (y Rango)

My appointment expires:
Mi nombramiento vence:
_____

Complete information regarding health care insurance, if applicable.
Llene información sobre el seguro de cuidado de salud, si aplica.

Health Insurance Policy Name — Policy Number
Nombre de la Póliza de Seguro de Salud: _____ Número de la Póliza: _____

Medical Assistance Program — Card Number
Programa de Asistencia Médica: _____ Número de Tarjeta _____

Military Medical Care I.D. Number
Número de Identificación del Cuidado Médico Militar: _____

If known, date of last Tetanus inoculation:
Si la conoce, fecha de la última vacunación contra el Tétano: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:
Enumere cualquier alergia u otra información que conozca sobre el estado médico de este niño(a) o joven que pueda ser pertinente en caso de emergencia:

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.

EL FORMULARIO DE REGISTRO/EVALUACIÓN MÉDICA (O EL FORMULARIO DE LA HISTORIA MÉDICA QUE APLICA A LOS PROGRAMAS PARA NIÑOS DE EDAD ESCOLAR) JUNTO CON LA AUTORIZACIÓN PARA CUIDADO MÉDICO DE EMERGENCIA DEBEN SER LLEVADOS A LA SALA DE EMERGENCIAS. AMBOS FORMULARIOS DEBEN TAMBIÉN LLEVARSE EN EL VEHÍCULO CUANDO UN NIÑO(A) O JOVEN ESTÉ SIENDO TRANSPORTADO(A) POR LA INSTITUCIÓN.

CCL. 358
Rev. 1/2014

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 296-0803
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed