

Gateway Transition After School Program

Student's Information

Name: _____ Nickname: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Date of Birth: _____ Gender: _____

Parent/ Guardian Information

1. Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

2. Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Emergency Contacts if above listed cannot be reached:

1. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

2. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Gateway Transition After School Program

These individuals are the only ones authorized to pick up my child (include yourself):

1. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

2. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

3. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

4. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

5. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

6. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

7. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

8. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

9. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

If you need to add anyone to your list, please contact Sherri Fisher immediately at 738-5500. For your child's safety, ID may be required upon pick up.

Gateway Transition After School Program

AGREEMENT & UNDERSTANDING:

My signature below indicates that I have the legal authority to sign up the child named on this form and that to the best of my knowledge, the information on this registration form is complete and accurate.

I further understand that this is an application and that the named child's participation is contingent upon space being available in the camp session in which I want the child to participate. I also understand that this registration form must be completed in its entirety and full payment received prior to the child participating in the camp session. Failure to comply with the above could result in the loss of the program space.

Parent/ Guardian Signature: _____ **Date** _____

EMERGENCY AUTHORIZATION:

In the event I cannot be reached in an emergency, I hereby give permission to the physician/ medical facility selected by Gateway Services to hospitalize or secure proper emergency treatment for my child.

Parent/ Guardian Signature: _____ **Date** _____

TRANSPORTATION AUTHORIZATION:

I hereby give permission for my child to travel by van or light transit vehicle with the Gateway Summer Camp programs. I understand that only licensed qualified personnel will operate any vehicle to and from the Gateway program, and that there will be at least one Gateway staff member present at all times. I agree to release Gateway Summer Camp staff from any and all claims of damages, demands or liabilities which may arise as a result of my child's participation on these van or light transit field trips.

Parent/ Guardian Signature: _____ **Date** _____

SUNSCREEN WAIVER:

Gateway Services has my permission to administer sunscreen lotion to my child.

Yes _____ **No** _____ (please sign one)

PROMOTIONAL AGREEMENT:

Gateway Services has my permission to use photographs or films of my children in Gateway Summer Camp promotional material, and for marketing/ public relations with media and fundraisers.

Yes _____ **No** _____ (please sign one)

Gateway Transition After School Program

Read each section and check each box that applies to your child. Check “none” if this applies:

Communication	Does your child have difficulty expressing thoughts, wants or needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Verbal (able to speak and does so) <input type="checkbox"/> Nonverbal (does not speak or unable to do so) Does child use any of the following: <input type="checkbox"/> Communication device (type) _____ <input type="checkbox"/> Sign Language <input type="checkbox"/> Gesturing or Home Signs <input type="checkbox"/> Facilitated Communication <input type="checkbox"/> Other? (type) _____
Eating/ Swallowing/ Diet	Is your child diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Special diet (describe) _____ <input type="checkbox"/> No feeding assistance needed <input type="checkbox"/> Assistance needed (describe) _____ <input type="checkbox"/> Food allergies: _____ <input type="checkbox"/> Special drinking cup(describe) _____ <input type="checkbox"/> Feeding tube/ nothing by mouth
Toileting	<input type="checkbox"/> Needs no assistance or prompting <input type="checkbox"/> Wears diapers or pull-ups <input type="checkbox"/> Needs assistance on/off toilet <input type="checkbox"/> Needs other assistance Please describe: _____ <input type="checkbox"/> Other instructions or procedures are attached on a separate piece of paper <input type="checkbox"/> Is on a bathroom schedule Please describe: _____
Mobility	<input type="checkbox"/> Ambulatory (walks) <input type="checkbox"/> Needs Assistance (Describe) _____ <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Motorized Wheelchair <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Pushes self <input type="checkbox"/> Needs pushed
Assistive Devices	<input type="checkbox"/> Helmet <input type="checkbox"/> Braces <input type="checkbox"/> Prosthesis (describe) _____ <input type="checkbox"/> Glasses <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Oxygen <input type="checkbox"/> Other (describe) _____
Hearing & Vision	<input type="checkbox"/> Normal Hearing & Vision <input type="checkbox"/> Deaf or hard of hearing <input type="checkbox"/> Uses hearing aid? Which ear? _____ <input type="checkbox"/> Legally blind <input type="checkbox"/> Needs guided <input type="checkbox"/> has guide dog <input type="checkbox"/> has cane <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts
Disability	Does your child have a disability? Please list: _____ _____ Are there any accommodations or issues she/he will need not otherwise listed above? Describe: _____ _____ _____

Gateway is committed to serving all persons with disabilities. We will do our best to accommodate your child’s unique needs. However, in the interest of safety, we reserve the right to require that an attendant accompany the child if specialized medical care is necessary beyond normal program capabilities.

Gateway Transition After School Program

Pediatrician or Primary Care Physician: _____

Phone: _____ Date of last visit: _____

Current Medications: _____

Allergies-Food or Other: _____

Date of last Tetanus inoculation: _____ (if none given, one may be required in an emergency)

Has your child ever had a seizure or a seizure disorder? ___Yes ___No

Does your child have a strong sensitivity to sunlight or heat? ___Yes ___No

Please check any that apply to your child:

___Wanders/ Runs Away ___Withdrawn/ Shy ___Temper Tantrums ___Fears/
Phobias (type) _____

___ Behavioral Concerns (describe) _____

Is there anything else we should know about your child to make her camp experience more enjoyable?

Parent/ Guardian Signature

Date

.....
(for internal use only)

Student's information reviewed by program staff:

Staff Signature/ Title

Date

Staff Signature/ Title

Date

Staff Signature/ Title

Date

Staff Signature/ Title

Date

Staff Signature/ Title

Date