

Santa's Sitters

Respite Morning Registration and Emergency Medical Treatment Form (December 8, 2017, 9 a.m. - noon)

Today's Date: _____
Child's Name: _____ Date of Birth: _____
Home Address: _____
Home Phone: _____ Cell: _____ Alt Phone: _____ Primary: _____
Parent/Guardian Name: _____ Email: _____
Parent/Guardian Name: _____ Email: _____

Emergency/Alternate reference if parent/guardian can't be reached: _____
Relationship to child: _____ Phone: _____
Has this individual agreed to be listed as an emergency/alternate reference? Yes No
May we use your e-mail address as the primary way to contact you regarding this event? Yes No

Child's Medical Diagnosis/needs: _____
List any known allergies: _____
Any behaviors/other information you feel we should know: _____

Does your child use special seating or mobility equipment? If yes, please list _____

What are your child's toileting needs (check all that apply)
 Reminder Will let us know Diaper or pull ups

What helps to calm your child (singing, rocking, special toy, etc): _____

The following people are hereby authorized to escort my child to and from the UCP Center:

Name	Relationship to child
_____	_____
_____	_____
_____	_____

I hereby give permission for provision of emergency medical treatment of my child named above as follows:

1. Staff members of United Cerebral Palsy of Huntsville and Tennessee Valley may arrange for transporting my child to the emergency room by calling 911 and following emergency procedures as outlined by 911 personnel.
2. Records pertinent to emergency treatment may be released to hospital personnel.
3. Physicians and hospital personnel have permission to provide emergency medical treatment to the above named child.

Parent/Guardian Signature Date



Santa's Sitters Parent Information

1. **Registration:** Your child's spot is not reserved until this registration form is returned to the UCP Therapy Center. You must complete a form for each child. Registration is due no later than November 30th; however, space is limited and is provided on a first come, first served basis.
2. **Illness:** Please do not bring your child if within the last 24 hours they have had fever, vomiting, diarrhea, infectious virus, contagious disease, or runny nose with yellow/green discharge. If you have any questions regarding whether you should bring your child or not, please call the Therapy Center (852-5600). We do not want to spread any illnesses to the other children or staff members. If your child is sick, and the staff feels this will place other children at risk, you will be contacted to pick your child up.
3. **Drop-Off:** Please enter the building through the main lobby. UCP staff will escort your child to the classroom.
4. **Timeliness:** To lessen distractions, your child **must** arrive no later than 9:15 a.m.
5. **Sign-in:** Please be sure to sign-in with the staff or volunteer before you leave. You must leave a cell number (be sure to have your cell phone with you and turned on) or emergency contact name with phone number and relationship to child.
6. **Diaper bag:** Please be sure to bring anything we may need during the morning (diapers, wipes, change of clothes, shoes, jacket, etc.) in your child's bag. The bag should be labeled with their name. Snack and drinks will be provided.
7. **Diapering/Potty Training:** Please attempt to bring your child with a dry diaper on. We have a restroom available with a changing area if you need to use it when you arrive for drop-off. If your child is working on potty training, please let us know! We will gladly offer potty opportunities.
8. **Special dietary restrictions:** UCP will provide snacks during group time. However, if your child has an allergy to any foods, you must notify us in writing as well as verbally. You may provide your child's snack if you prefer. Please discuss this with a staff member.
9. **Special equipment:** If your child requires any mobility or positioning devices or any other equipment, this must be brought with your child, unless previous arrangements have been made.
10. **Picking up your child:** Children must be picked up, under the portico, on the left side of the building by (or before) noon. Please press the intercom button beside the side entry door to notify staff of your arrival if you wish to pick up your child prior to noon. Staff and volunteers will bring your child to your car. For your child's safety, please help buckle them up correctly.



RELEASE FORM

Authorization to Release Protected Health Information by United Cerebral Palsy of Huntsville and Tennessee Valley, Inc. (UCP)

Client (Child) Name: _____

Parent/Legal Guardian Name: _____

Relationship to Client: _____

I hereby authorize UCP to use and disclose the following protected health information:

Photographs of client and/or family	Videotape of client and/or family
Client's name	Client's age
Client's diagnosis	Shared personal story
Types and frequency of treatment received at UCP	

The above information may be used for the following events from the date of signature at the bottom of this release until the expiration date at the bottom of this release:

- Print media, including regional newspapers
- Electronic media, including radio, TV and internet websites
- Special events and promotion thereof
- Community fundraising events for UCP and promotion thereof
- Irish Evening and promotion thereof
- UCP web page
- Information fairs / displays in the UCP Center and off-site
- UCP family newsletter
- Proposals and thank you items for corporate sponsors / donors
- Seasonal parties
- Tour groups

UCP of Huntsville and Tennessee Valley has my permission to use my or my child's photograph, likeness, artwork, profile and/or story in all forms of media and all manners, including publications, web pages, and other promotional materials. I understand the circulation of the materials could be worldwide and that there will be no compensation to me for this use. I waive any right to inspect or approve the finished product, including written copy that may be created in connection therewith.

I understand that I can revoke this authorization in writing at any time. I further understand that UCP can not deny treatment or services if I refuse to sign this authorization. I understand that, once this information is released, UCP is not responsible for information released by others.

Signature of Parent/Legal Guardian: _____

My E-Mail Address: _____

Date of Signature: _____

Expiration Date: _____