



A program of UCP Huntsville

2075 Max Luther Drive
Huntsville, AL 35810
CENTER: 256-852-5600
ADMIN: 256-859-4900
FAX: 256-852-6722
www.ucphuntsville.org

Fun Fridays
UCP and Children's Therapy Services
Registration and Emergency Medical Treatment Form

Today's Date: _____ Where did you hear about Fun Fridays? _____

Child's Name: _____ DOB: _____ Race: _____

Home Address: _____

City, Zip : _____

Preferred Phone: _____ Alt Phone: _____

Child's School: _____ Last grade completed: _____

Please list any therapy services provided at school: _____

Previous/current client of UCP? _____ Services received: _____

Therapy services outside of UCP? _____ Services received: _____

Parent/Guardian Information

Mother's Name: _____ Email: _____

Father's Name: _____ Email: _____

Emergency Contact

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

Authorized to Pick-Up Child

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

| Name | Relationship to child |
|-------|-----------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please provide the following information about your child so UCP can meet his/her needs and preferences:

Nature of Disability: (check all that apply)

- ADD/ADHD Autism/ASD Cerebral Palsy Muscular Dystrophy
 Spina Bifida Seizure Disorder Intellectually Disabled
 Other _____

Communication: My child makes wants and needs known by

- Speaking Gestures Sign Language
 Picture Symbols AAC/Communication Device _____

Motor Skills:

- Independent in both fine and gross motor skills
 Difficulty with fine motor skills (cutting, drawing, etc.)
 Uses switches/adaptive equipment for fine motor activities: _____
 Difficulty with gross motor skills (walking, jumping)
 Uses adaptive equipment for gross motor activities:
 Electric Wheelchair Manual Wheelchair Crutches Cane
 Stander AFOs/Braces/Inserts Other _____

Vision:

- No Concerns Sensitive to Light Glasses CVI Blind

Hearing:

- No Concerns Sensitive to Loud Noises Hearing Aids Hard of Hearing
 Deaf Cochlear Implant

Computer Skills:

- Independent Computer Users Needs assistance Touchscreen Special Mouse/Keyboard

Behavior:

What may cause your child to become upset? _____

What comforts and calms your child? _____

Activities of Daily Living:

Outside: Does your child have any outdoor limitations?

- Hat Sunglasses Overheats quickly Other: _____

Toileting:

- Independent (will be reminded)
 Some assistance needed
 Needs full assistance in changing (diapers)

How does your child communicate toileting needs _____

Eating:

- Independent Needs assistance No food by mouth
 Special cup for drinking Thickened liquids
 Will need to be tube fed during camp
 Only soft foods like _____

Diet Restrictions/Food Allergies:

- Low Sugar/Diabetic Gluten Red Food Dye Dairy Peanut allergy

Please indicate any other diet restrictions: _____

Please indicate for each of the following food items:

| Food | YES Child will eat this food | OK May choose not to eat it because of taste/texture | CAN NOT EAT due to allergies, choking, or diet restrictions |
|-----------------------------|--|--|---|
| Artificial sweetner/Splenda | | | |
| Fresh Fruit | | | |
| Raw Vegetables | | | |
| Popsicles | | | |
| Pudding | | | |
| Jello | | | |
| Chips | | | |

Allergies: Does your child have any specific allergies:

- Allergic to Latex (Gloves, Balloons)
- Peanut Allergy
- Insect stings (wasps, bees, ants)
- Animals (farm, pets, birds)
- Sensitive Skin (We will be feeling lots of texture during camp including different foods and fabrics!)
- My child will have EPI Pen in their bag

Medical Needs:

- Seizures
- Diabetic (will need to check sugar levels)
- Feeding Tube
- Other: _____

In case of emergency, please list all medications child currently taking:

| MEDICATION | DOSAGE | PRESCRIBED FOR |
|------------|--------|----------------|
| | | |
| | | |
| | | |

Child's Primary Physician: _____

Date of last known tetanus antitoxin: _____ Booster: _____

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

By my signature below, I certify that this form is complete and accurate.

Name: _____ Date: _____

2018

UCP Fun Fridays Pre- Registration Checklist

I am registering my child, _____ for the following date/dates*:

- June 15th**
- June 29th**
- July 13th**
- July 27th**

I understand that registration is on a first-come, first served basis and class sizes are limited. I have returned the following completed information in this packet:

- Doctor's prescription for PT, OT, and Speech Therapy**
- Proof of immunization (“Blue Card”) or exemption
- Registration form
- Payment (\$25 per day)
- Photo release (voluntary)

* Registration form and payment required to hold your child’s spot

**Page 6 of this packet completed by physician’s office including doctor’s signature is considered an acceptable prescription for Fun Fridays

Prescription for Services/
Doctor's Orders



A program of UCP Huntsville

Provide Physical Therapy, Occupational Therapy, and Speech Therapy
for UCP's Fun Fridays

Date: _____

Patient Name: _____

Date of Birth: _____

Diagnosis: _____

Referring Physician's Name, Address, Phone:

Physician Signature: _____

UCP/Children's Therapy Services

2075 Max Luther Dr.
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RELEASE FORM



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

2075 Max Luther Drive
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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, once this information is released, UCP is not responsible for information released by others.

This release will expire five years from the date of signature. I understand that I can revoke this authorization in writing at any time. I further understand that UCP cannot deny treatment or services if I refuse to sign this authorization.

Signature of Parent/Legal Guardian: _____

My E-Mail Address: _____

Date of Signature: _____