ENROLLMENT FORM

CHILD'S INFORMATION:

Child's Name: _____

Child's Nickname that he/she is called by: _____

Date of Birth: _____ Female: _____ Male: _____

Address: _____

City: _____ State: _____ Zip: _____

FAMILY INFORMATION:

Parent/Guardian Name: _____ Relationship to child: _____

Address (if different than child): _____

City: _____ State: _____ Zip: _____

Occupation: _____ Place of Employment: _____

Work Phone: _____ Cell Phone: _____ Home: _____

PHYSICIAN INFORMATION:

Pediatrician's Name: _____ Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Psychiatrist/Psychologist Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Preferred Hospital: _____

MEDICAL AND EMERGENCY CARE: (Please Initial)

_____ In an emergency, I authorize the staff of Pediatric Haven to provide any first aid care deemed necessary for my child.

_____ In an emergency in which I cannot be reached, the physicians listed below, or a local hospital are authorized to provide any emergency care deemed necessary for my child.

_____ In an emergency, I authorize the transfer of my child's health records to the appropriate medical team.

_____ I authorize the treatment of my child as defined in the developed Protocol of Care verified and signed by the prescribed physician. Pediatric Haven has my consent to provide medical care, therapy and nutritional services as defined in the Protocol of Care.

PICKUP AUTHORIZATION:

Please list all persons authorized to pick up your child. Only those listed below will be able to check your child out of Pediatric Haven.

Name: _____ Relationship to child: _____ Phone: _____

Name: _____ Relationship to child: _____ Phone: _____

Name: _____ Relationship to child: _____ Phone: _____

Authorized Adults:

Please indicate the names and contact information for adults who can be reached and make decisions for your child in case of an emergency.

Name: _____ Relationship to child: _____ Phone: _____

Name: _____ Relationship to child: _____ Phone: _____

Please Initial:

_____ I authorize for the persons above to be allowed to pick up my child.

Parent/ Guardian Signature: _____

Date: _____

Allergies (food, medication, latex):

_____

_____

Medications (list any taken on a regular basis):

_____ _____

_____ _____

_____ _____

Please describe any medical issues, previous illnesses or surgeries:

_____ _____

_____ _____

_____ _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

ID No: _____ Group No: _____

Member: _____

Secondary Insurance Company: _____

ID No: _____ Group No: _____

Member: _____

COMMUNICATION:

Pediatric Haven may send email notices or send emergency notifications through text messaging. Please list contact information for these services. Your mobile phone's service provider is required for text messaging service.

Email: _____ Phone No: _____

Service Provider: _____

CHILD'S NAME: _____

EMERGENCY DISPOSITION PLAN: (Please Initial)

_____ I am aware that Pediatric Haven conducts quarterly fire drills to familiarize children and staff with proper procedures. I understand that in the event of severe weather, it is safer for my child and myself to remain where we are at the time of the alert. Pediatric Haven has established safe places within buildings for all children in the event of such emergency.

LIABILITY RELEASE: (Please Initial)

_____ By enrolling in Pediatric Haven, I hereby release Pediatric Haven, its owners, successors, affiliates, administrators, agents and assigns, including and its employees, agents, administrators, and assigns, from any and all liability from any and all claims, demands, damages, actions, causes of action or suits of any kind or nature whatsoever, including but not limited to, personal injuries, including death, property losses and damage, in any way arising out of or connected with my child's attendance at Pediatric Haven and any services, activities, care or treatment provided.

PHOTOGRAPHY RELEASE: (Please Initial)

_____ Yes, I hereby grant Pediatric Haven the absolute and irrevocable right and unrestricted permission in respect of photographic images and audio/video recording of my child, or in which he/she may be included with others, to copyright the same; to use, reuse, publish and republish the same in whole or in part, individually or in any and all media now or hereafter known, and for any purpose whatsoever without restriction as to alteration; and to use for libel or invasion of privacy. This authorization and release shall also insure to the benefit of the heirs, legal representatives, licenses, and assigns of Pediatric Haven and its agents. I am of full age and have the right to contract in my own name. I have read the foregoing and fully understand to contents thereof. This release shall be binding upon me and my heirs, legal representatives, and assigns.

_____ No, I do not grant Pediatric Haven the right to make photographic images or audio/video recordings of my child.

Parent/Guardian Signature: _____

Date: _____

Authorization to Release Patient Information

Patient Name: _____

Patient DOB: _____

Pediatric Haven is committed to providing privacy while working in partnership with your child's therapists, physicians, and other agencies. Permission to release certain information is required to assist with this partnership.

INFORMATION RELEASE AUTHORIZATION (Please initial)

_____ I give permission for information regarding my child to be released to and from Kids' Kastle by the following agencies and personnel. This authorization to release information is regarding educational, psychological, and medical records that may be deemed confidential under existing laws to and from the listed agencies, physicians or professionals. I understand that the above- delineated information will be sent and discussed and used for medical care, therapy assessment, program planning, and/or report documentation. It is understood that Kids' Kastle will not share information but will maintain confidentiality with this information in accordance to federal law. No further disclosure of this information will be made without written consent of the child's parent or legal guardian. This authorization expires one year from the date of signature.

Parent/ Guardian Signature: _____

Date: _____