

# Cottage Cove Annual Registration and Medical Release

Child's Name \_\_\_\_\_ M F Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ School \_\_\_\_\_ Current Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Mom's Name \_\_\_\_\_ Employer \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Work Hours \_\_\_\_\_

Dad's Name \_\_\_\_\_ Employer \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Work Hours \_\_\_\_\_

Are both parents at the home address? Yes No If not, who has legal custody? \_\_\_\_\_

Can both parents pick up this child? Yes No Does this child have permission to walk home? Yes No

In case of emergency, if above cannot be reached, please provide an alternate contact person:

Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Who may pick up your child, besides those listed above?

Names \_\_\_\_\_

Does your child have any ALLERGIES or MEDICAL CONDITIONS that should be considered?

If yes, explain:

\_\_\_\_\_  
\_\_\_\_\_

My child's immunization records are on file at \_\_\_\_\_ school and are up to date: yes no

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

Do you have family medical/hospital insurance/TennCare? Yes No

If yes, indicate: Carrier/MCO \_\_\_\_\_ Policy or Group # \_\_\_\_\_

In the event that hospitalization is necessary, I prefer my child be sent to \_\_\_\_\_ hospital.

I hereby give my permission to the physician selected by Cottage Cove to order X-rays, routine tests, and treatment for the health of my child. In the event I cannot be reached in an emergency, I give permission to the physician selected by Cottage Cove to hospitalize, secure proper treatment for, and order injection and/or anesthesia and/or surgery for my child as named above. In the event it becomes necessary for the Cottage Cove staff to give consent for us, we agree to hold such person and Cottage Cove free and harmless of any claims, demands, or suits for damages arising from the giving of such consent, so long as the treatment is administered by or under the supervision of a licensed physician. I realize that Cottage Cove does not carry accident insurance on program participants. I also realize that I am responsible for all insurance and/or out of pocket expenses.

Wherein my child is permitted to attend Cottage Cove's program, I understand that I must sign additional releases and waivers covering image usage, transportation, and information transfer between your child's school and Cottage Cove. Also an annual written or verbal statement (recorded) may be required as to how this program is benefiting your child and/or family.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Child's Health History Checklist

The answers to these questions will help us to know if your child has any medical problems. We need this information in the event he/she should become ill and we are unable to reach you right away. Please circle the answers.

- Y    N    Has your child ever been in the hospital overnight, had surgery or a serious illness?
- Y    N    Is your child taking any medicine? If so, please list: \_\_\_\_\_
- Y    N    Any allergies or reactions to medicine, DPT, or other shots, or insects? \_\_\_\_\_
- Y    N    Has your child had asthma or wheezing?
- Y    N    Does your child have speech or hearing problems?    Speech \_\_\_\_\_    Hearing \_\_\_\_\_
- Y    N    Does your child have trouble with his/her eyes or seeing?
- Y    N    Has your child had a bladder or kidney infection?    Date \_\_\_\_\_
- Y    N    Does he/she have seizures, fits, or shaking spells?
- Y    N    Have you ever been told your child has a heart murmur, a heart defect, or heart disease?
- Y    N    Is your child able to play as hard as other children?
- Y    N    Has your child ever had a bumpy, swollen reaction to the TB skin test?
- Y    N    Has your child been with anyone having TB?
- Y    N    Is your child a hemophiliac (free bleeder)?
- Y    N    Does your child have Hepatitis?
- Y    N    Is your child HIV positive?
- Y    N    Does your child have tubes in his/her ears?
- Y    N    Does your child have a hernia?
- Y    N    Does your child have frequent ear infections?
- Y    N    Does your child have diabetes?
- Y    N    Does your child have high blood pressure?
- Y    N    Does your child have dizzy spells or headaches?
- Y    N    Does your child have skin problems?
- Y    N    Has your child ever had a broken bone(s), dislocated joints or serious sprains?    Date \_\_\_\_\_
- Y    N    Does your child have chronic or recurring illness?    Explain \_\_\_\_\_
- Y    N    Is your child in a special education class at school? \_\_\_\_\_
- Y    N    Does your child have any special problems not indicated above? \_\_\_\_\_

When did your child have:

\_\_\_\_\_ Chicken Pox    \_\_\_\_\_ Measles    \_\_\_\_\_ Mumps    \_\_\_\_\_ German Measles

Other children and adults in the Home	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_