Church of Saint Dominic

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JuniorHighYouthGroup

Strengthening
Growing
Serving
Participating

Registration 2011-12

Household Family

Name:____

Mother's Name: _______________________ **Father's Name:** _______________________

To whom should correspondence be sent? (circle one): Mr. Mrs. Mr. and Mrs. Other ____________

Address: _________________________________ **Phone:** _______________________

____

____

Valid E-mail: ______________________________________ **(Russ's preferred method of communication is email. It's quicker, cheaper and better for the environment)**

Please check here ______ if you'd like to receive communication ONLY through US Mail. Otherwise most communication will be sent via email.)

Student Name(s)

____**grade**______

____**grade**______

____**grade**______

☐ I have enclosed the $40.00/per student registration fee (make checks payable to St. Dominic Church)

☐ I have completed and enclosed the Medical History Form, Emergency Medical Authorization, and Special Needs Form

This Box For Office Use Only

St. Dominic JHYG
Confidential Health Form 2010-2011

Please fill out 1 form for each child you are registering.
(print additional forms at http://www.stdominicchurch.net/groups/yhyg/)
Additional information may be added on the back.

Child's Full Name : ____

Date of Birth: ______________________ Grade: __________

Address: ______________________________ Home Phone: ______________

Current Medications: (name, dosage, reason) ______________________________
____
Allergies (food, medicines, etc.) ______________________________________
____
____

Medical History: Has this child had any of the following? Check all that apply. Provide details in spaces below.

_____________ Chicken Pox
_____________ Frequent Ear Infections
_____________ Hearing difficulty
_____________ Asthma
_____________ Eczema, hives or other skin conditions
_____________ Diabetes
_____________ Vision problems
_____________ Severe headaches or migraines
_____________ Hay fever
_____________ Recurrent strep throat
_____________ Seizure or convulsions
_____________ Heart problems
_____________ Learning Disability*
_____________ Developmental Delay*
_____________ ADD/AHD*
_____________ Others

*Please see reverse side of this form to complete more information regarding your child's specific needs.

____
____
____
____

Hospitalizations—reason and approximate date ______________________________
____
Operations—please specify ____
____
Serious Illness or Injury—please specify ______________________________
____
Any other issues affecting this child's attendance/performance in school that the teacher should know? ____
____
____
____
____

____
Parent Signature

Learning Differences Inquiry

Child Name:____ Age: _______ Grade:_______

Parent Names: ____

Learning Difference/Special Need____

Day school he/she attends during the week: ____

Please check all that apply:

My child…

- ☐ has a documented IEP.
- ☐ is in a specialized classroom.
- ☐ attends therapy sessions regularly.
- ☐ works with an aide.
- ☐ receives tutoring for areas of difficulty.

Please provide us with detailed information about your child's specific need in the spaces below.

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Please check below if you would be interested in meeting with Christina Emerson, DRE to further discuss your child's participation in JHYG programming.

☐ Yes, I would like to receive a phone call or set up a meeting to discuss my child's specific needs and their involvement in JHYG programming.

Phone:________________________ Email_______________________________

Child's Full Name: ____

Home Phone #:____

EMERGENCY MEDICAL AUTHORIZATION

Purpose—To enable parents and guardians to organize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Please indicate who should be called first:

Mother's Name:______________________________ Father's Name :______________________________

Pager #:______________________________ Pager #:______________________________

Cell Phone :______________________________ Cell Phone :______________________________

Emergency Contact if unable to reach parent:

Name:____

Relationship: ____

Phone #: home_________________________ cell:______________________________________

Family Physician Name:____

Phone Number:____

Family Dentist Name:____

Phone Number:____

Preferred Hospital :____

PART I: TO GRANT CONSENT

I hereby give consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications taken, and any physical impairments to which a physician should be alerted:

____

____

____

____ ______________________________

Parent Signature Date

PART II—TO REFUSE CONSENT:

I **DO NOT** give consent for the emergency medical treatment of my child. In the event of illness or emergency treatment being required, I wish the school authorities to take no action or to: ____________________

____

____ ______________________________

Parent Signature Date