SOS
HEALTH CARE, INC.

Summer Program Registration

Child's Name: _____ Birth Date: _____ Age: _____

Address: _____

_____

Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact Person: _____

Relationship to Child: _____ Home Phone: _____

Cell Phone: _____

Medical Information:

Medical Diagnosis_____

Is there a current condition or medical history of:

A). Seizures_____

B). Visual/Hearing Impairment_____

C). Allergies_____

D). Infections_____

E). Other_____

Medications_____

Will your child/children need medications while attending program?

_____ YES _____ NO

If you checked YES please complete the following section.

Name of Medication:_____ Purpose:_____

Dosage and time given:_____ How given:_____

Side Effects:_____

Prescribed by Dr.:_____ Phone:_____

Name of Medication:_____ Purpose:_____

Dosage and time given:_____ How given:_____

Side Effects:_____

Prescribed by Dr.:_____ Phone:_____

Please attach additional pages if necessary.
I authorize administering the described prescription medications:

Parent/Caregiver Signature_____ Date_____

Diet:

Food allergies: _____

Specific diet: _____

Choking/swallowing risks: _____

Supervision: please place an 'X' by the level of supervision your child requires.

_____ Level 1 (Will stay with group with minimal supervision)

_____ Level 2 (Will stay with group with supervision in close proximity)

_____ Level 3 (Will wonder from group, must have one-to-one supervision)

Assistance: please place an 'X' on the line if your child requires assistance with the following

_____ Toileting _____ Eating ____Communication

Behavior:
Please describe any behavior problems such as hitting, screaming, refusing to follow directions, self-abuse, etc, and how you would like the Program Staff to respond to such behaviors:

_____

_____