



300 E. Main St. | Siloam Springs, Ar 72761 | 1-855-373-6033 | abilitytree.org

REGISTRATION AND CHILD PROFILE FORM

CHILD INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name (Nickname): _____ Age: _____ DOB: _____

Diagnosis: _____

FAMILY INFORMATION

MOTHER (OR FEMALE GUARDIAN):

First Name: _____ Middle Initial: _____

Last Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

E-mail: _____

Home Phone: () _____ - _____

Work Phone: () _____ - _____

Cell Phone: () _____ - _____

FATHER (OR MALE GUARDIAN):

First Name: _____ Middle Initial: _____

Last Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

E-mail: _____

Home Phone: () _____ - _____

Work Phone: () _____ - _____

Cell Phone: () _____ - _____

EMERGENCY PICK-UP

DESIGNATED PRIMARY EMERGENCY PICK-UP CONTACT

(must provide positive identification at pick-up):

Name: _____ Primary Phone: () _____ - _____ Relationship: _____

EMERGENCY CONTACTS

1. Name: _____ Primary Phone: () _____ - _____ Relationship: _____

2. Name: _____ Primary Phone: () _____ - _____ Relationship: _____

I, (print name) _____, certify that the above individuals are approved to pick up my child in the event that I or my child's designated primary emergency pick-up contact are unable to be reached or located in an emergency. I furthermore understand that positive identification must be provided before my child will be released into their custody.

Signature of Legal Parent/Guardian: _____ Date: _____

EMERGENCY INFORMATION

In the event of an emergency, I give the Ability Tree staff or any emergency medical personnel permission to transport my child to the nearest hospital/clinic for medical treatment in the event that I cannot be located. I consent for necessary emergency treatment by the medical staff for my child in the event that I cannot be reached to make arrangements at the time of illness or accident.

Child Name: _____ Child's Social Security Number: _____ - _____ - _____

Mother's Name: _____ Father's Name: _____

Address*: _____

City: _____ State: _____ ZIP: _____

Phone Number: () _____ - _____ Place of Birth: _____

Date of last Tetanus booster: _____ Known Drug Allergies: _____

Please list all Medications that your child is taking: _____

INSURANCE INFORMATION

Insurance Carrier: _____ Policy Number: _____

Group Number: _____ Insurance Company Phone Number: () _____ - _____

Insured's Name: _____ Insured's Social Security Number: _____ - _____ - _____

Insured's Relationship to Child: _____

(cont'd next page)

* Fill out only if different from address of parents or legal guardians.

INSURANCE INFORMATION CONT'D

Primary Physician: _____ Physician Phone Number: () _____ - _____

City: _____ State: _____ ZIP: _____

Preferred Hospital: _____

City: _____ State: _____ ZIP: _____

PARTY RESPONSIBLE FOR MEDICAL PAYMENT

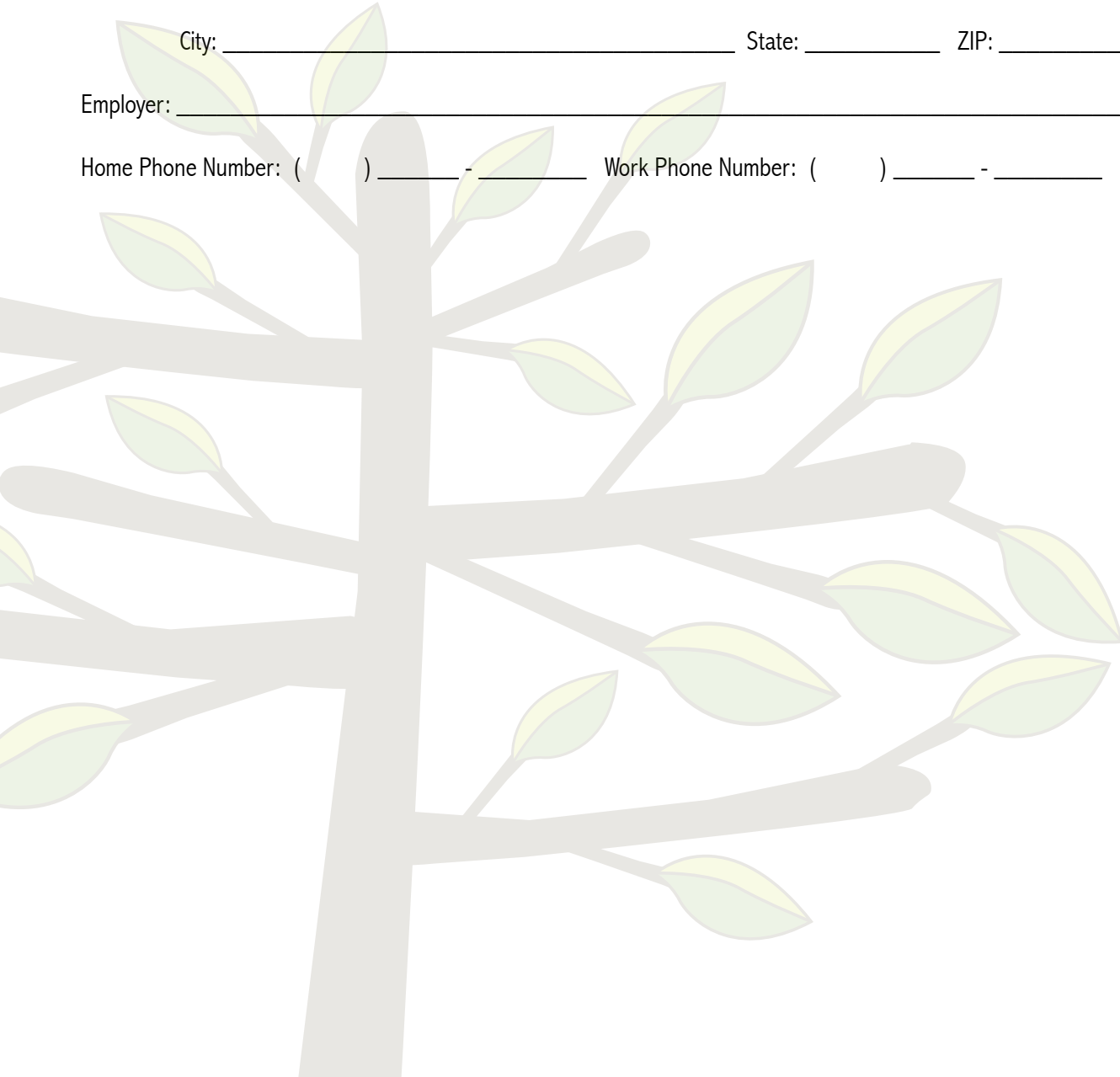
Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____

Home Phone Number: () _____ - _____ Work Phone Number: () _____ - _____



DECLARATION OF CONSENT & WAIVER OF LIABILITY

Families with children with special needs face challenges above and beyond what typical families face on a daily basis. According to the 2000 Census, there are 54 million Americans living with a disability and close to 9 million are under the age of 15! Ultimately, living with a child with a disability can have profound effects on the entire family - parents, siblings, and extended family members.

This is why we started **Ability Tree Inc.** To help grow able families and accessible churches by providing **R.E.S.T.** (recreation, education, support and training). But the greatest source of rest is found in God. The Word of God says, "Come to me, all of you who are weary and carry heavy burdens, and I will give you rest" (Matthew 11:28). We hope that you find this rest today.

In consideration for the services provided by Ability Tree through its programs, I agree to the following terms and conditions of my child's participation.

AGREEMENT TO PARTICIPATE AND WAIVER OF LIABILITY

To assist **Ability Tree** in providing the best care for my child, I agree to provide them with accurate and complete medical information about my child, including all special medical, physical, mental, and emotional need or disabilities that my child may have, on the "**Child Profile Form**", and to immediately update such information as developments occur from time to time.

I understand the risk of injury to my child inherent in a program whose participants consist of individuals with physical, intellectual, or emotional disabilities, who may exhibit violent or impulsive behavior or suffer from epileptic seizures. During any of the **Ability Tree** programs and activities, including but not limited to after school programs, respite nights and family events, my child may engage in activities such as music, art, sports activities utilizing balls or other game equipment, contact with animals, and playground equipment.

To the extent permitted by law, I (we) assume all risks of injury to my (our) child, including those caused by accidents or by the acts of other participants. To the extent permitted by law, I (we) further agree to release **Ability Tree** as well as ANY ADDITIONAL CHURCH, ORGANIZATION OR BUSINESS THAT ASSISTS WITH PUTTING ON ABILITY TREE PROGRAMS OR HOLDS ABILITY TREE ACTIVITIES IN THEIR FACILITIES - their staff, volunteers, directors, and agents - of all liability for injury or illness to my (our) child or for damage to my (our) child's property arising during any Ability Tree program or event due to any case except the gross negligence or willful misconduct of Ability Tree staff, volunteers, or agents.

PLEASE USE ONE FORM FOR EACH CHILD ENROLLING.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

MUST BE SIGNED BY BOTH PARENTS OR GUARDIANS.

CHILD PROFILE FORM

PHYSICAL NEEDS

VISION:

- Typical
- Impaired
- Blind

HEARING:

- Typical
- Impaired
- Deaf
- Hearing Aid

MOTOR FUNCTION:

- Head Control
- Walks
- Rolls Over
- Walker
- Sits
- Crutches
- Crawls
- Braces
- Cruises
- Wheelchair

TOILETING SKILLS:

- Toilets independently
- Needs help
- Potty trained, needs assistance
- Wears a diaper
- Being potty trained

EATING HABITS

- No restrictions
- Can take nothing by mouth
- Soft foods only
- Bottle

Please list all food allergies: _____

Staff can help by: _____

COMMUNICATION WITH OTHERS

COMMUNICATES WITH:

- Words
- Babbles
- Other (please describe): _____
- Phrases
- Gestures
- Sentences
- Sign Language

CAN UNDERSTAND WHAT OTHERS SAY:

- All of the time
- Most of the time
- Some of the time

BEHAVIOR (CHECK ALL THAT APPLY):

- outgoing
- adapts to new situations with difficulty
- sometimes threatens others
- shy
- responds to corrections well
- sometimes hits, bites, or hurts self/others
- plays in groups
- responds to corrections with difficulty
- sometimes attempts to run away
- adapts to new situations well
- is sometimes destructive
- Hyperactive and/or ADD

COMMUNICATION

MY CHILD RESPONDS TO SEPARATION FROM HIS/HER PARENTS BY:

COMMUNICATION CONT'D.

MY CHILD IS BEST COMFORTED BY:

MY CHILD LETS SOMEONE KNOW WHAT HE/SHE WANTS OR NEEDS BY:

ACTIVITIES

ACTIVITIES MY CHILD LIKES (EX. MUSIC, COLORING, INDEPENDENT PLAY, ETC.):

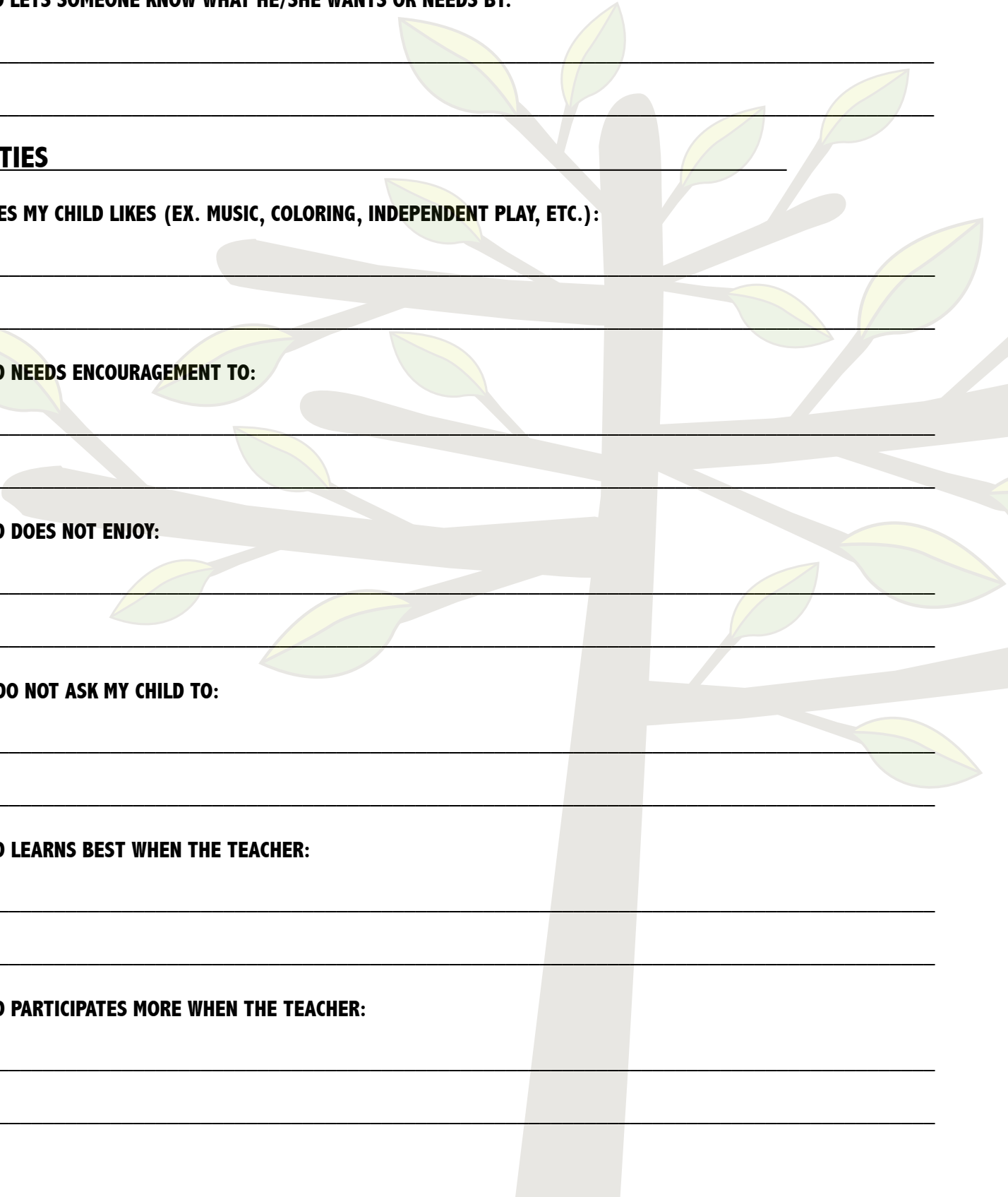
MY CHILD NEEDS ENCOURAGEMENT TO:

MY CHILD DOES NOT ENJOY:

PLEASE DO NOT ASK MY CHILD TO:

MY CHILD LEARNS BEST WHEN THE TEACHER:

MY CHILD PARTICIPATES MORE WHEN THE TEACHER:



OTHER THINGS TO KNOW ABOUT MY CHILD

My pet's name is: _____ Favorite Toy: _____

Favorite stuffed animal: _____ Favorite Color: _____

Fears or dislikes (ex. dogs, loud noises, balloons): _____

SIBLINGS AT ABILITY TREE

1. Name: _____ Age: _____ Date of Birth: _____

2. Name: _____ Age: _____ Date of Birth: _____

3. Name: _____ Age: _____ Date of Birth: _____

Parent Signature: _____ Date: _____

Staff Review: _____ Date: _____

PERMISSION/AUTHORIZATION AGREEMENT

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INITIAL IN THE DESIGNATED SPACE INDICATING THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS.

Initial: _____ I have fully disclosed to Ability Tree all pertinent facts about my child's special needs and accept full responsibility for failure to do so.

Initial: _____ I will supply all necessary food, drink, snacks, and diapers/wipes for my child.

Initial: _____ In case of an emergency or accident, I understand that EMS (911) will be called. I authorize EMS to administer any medical treatment, medication, or appliance deemed necessary by EMS. I also authorize transportation by EMS to the nearest appropriate medical facility, as determined by EMS. I understand that I will be responsible for the payment of all EMS, hospital, and physician charges for emergency services to my child.

Parent/Guardian Signature: _____ Date: _____

PUBLICITY RELEASE

Ability Tree is an organization seeking to reach out to families impacted by special needs. Because we will want to reach as many families as possible, we may publicize the program through television, radio, newspaper, or internet advertising. The use of your name and your child's name or picture is strictly voluntary. If you want to participate in our effort to help other families learn about **Ability Tree** in the future, complete this form and return it to us.

I CONSENT FOR MY CHILD TO BE PHOTOGRAPHED. THE PICTURE MAY BE USED FOR PRESS RELEASES, JOURNAL ARTICLES, OR OTHER POSITIVE PUBLICITY RELATED TO RESPITE PROGRAMS AND ABILITY TREE.

Parent/Guardian Signature: _____ Date: _____