

Joe's Movement Emporium

Youth Registration Form

Today's Date: _____

PARTICIPANTS'S INFORMATION (one form per child)

Child's Name: _____

Date of Birth (MM/DD/YYYY) ^{Last} ____ / ^{First} ____ / ^{Middle} ____ Age: ____ Sex: Male or Female Grade: ____

School Attending: _____ Teacher: _____

PARENT/GUARDIAN INFORMATION

Mother/Guardian 1 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Father/Guardian 2 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

In case of emergency and parent/guardian cannot be reached, please contact:

Name: _____ Phone: _____

List Programs you would like to enroll your child in:

Description	Cost	Dates/Days
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total Tuition Due \$ _____

For more information about any of our youth programs, please call 301.699.1819 or visit www.joesmovement.org

OFFICIAL USE ONLY

Deposit _____ Total Due _____ Payment Method _____ Date Rec'd _____ Staff Initial _____

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt.# City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt.# City State Zip Code

Mother's Name _____ Home Telephone _____
Last First

Mother's Employer/School _____
Name Address

Mother's Home Address (If different from above) _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Father's Name _____ Home Telephone _____
Last First

Father's Employer/School _____
Name Address

Father's Home Address (If different from above) _____
Street/Apt.# City State Zip Code

Work Telephone _____ Cellular Phone _____ Beeper _____

Name of Person Authorized to Pick Up Child (daily) _____
Last First Relationship to Child

Address _____
Street/Apt.# City State Zip Code

ANNUAL UPDATES _____
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

INSTRUCTIONS TO PARENT:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____)_____
Telephone Number

Arts Education
RELEASE FORM



I _____ am the parent/guardian of _____
a Joe's participant.

Print Parent Name

Print Child's Name

I understand that as part of the program my child attends, he/she may create or perform under the direction and control of Joe's staff. I do authorize the use of my child's voice, appearance and image in photographs and videos. _____ (initial)

I understand that Joe's may use my child's artwork, writings, and other materials within Joe's publications, handouts, website, presentations, in connections with the mission of the organization and educational activities. I authorize this activity. _____ (initial)

If you do not authorize the activities listed above, please check the box below.

I do not agree with use of my child's voice, appearance, image or materials being used for Arts Education purposes.



Signature

Date



3309 Bunker Hill Rd., Mt. Rainier, MD 20712 Tel: 301-699-1819, Fax: 301-699-1818 www.joesmovement.org

Permission Slip

To Whom it May Concern:

I _____, being the Legal
Print your full name

Guardian of _____ Date of Birth _____ Gender _____
Print full name of Child

_____ Date of Birth _____ Gender _____
Print full name of Child

_____ Date of Birth _____ Gender _____
Print full name of Child

_____ Date of Birth _____ Gender _____
Print full name of Child

_____ Date of Birth _____ Gender _____
Print full name of Child

Hereby, grant authority to the staff of Joe's Movement Emporium to escort child(ren) to offsite activities for artistic, creative, and physical enrichment. Activities will include but are not limited to P.G. Community Pool and open play at both parks located on the grounds of Mt. Rainier Elementary School. The Cities Mount Rainier and Hyattsville will provide transportation.

Name of Guardian (Printed)

Emergency Phone Number

Signature of Guardian

Date

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- **A physical examination** by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).
- **Evidence of immunizations.** A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf
- **Evidence of Blood-Lead Testing for children living in designated at risk areas.** The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: <http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf>

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://www.marylandpublicschools.org/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.pdf

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M F
 Last First Middle Mo / Day / Yr

Address: _____
 Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W: _____	C: _____	H: _____
		W: _____	C: _____	H: _____

Where do you usually take your child for routine medical care? Name: _____
Address: _____ **Phone Number:** _____

When was the last time your child had a physical exam? Month: _____ **Year:** _____

Where do you usually take your child for dental care? Name: _____
Address: _____ **Phone Number:** _____

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>	
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Bowels	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>	
Lead Poisoning/Exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>	
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Does your child take medication (prescription or non-prescription) at any time?
 No Yes, name(s) of medication(s): _____

Does your child receive any special treatments? (nebulizer, epi-pen, etc.)
 No Yes, type of treatment: _____

Does your child require any special procedures? (catheterization, G-Tube, etc.)
 No Yes, what procedure(s): _____

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Parent/Guardian _____ Date _____

PART II - CHILD HEALTH ASSESSMENT
To be completed ONLY by Physician/Nurse Practitioner

Child's Name: Last First Middle			Birth Date: Month / Day / Year			Sex M <input type="checkbox"/> F <input type="checkbox"/>	
1. Does the child named above have a diagnosed medical condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card. <input type="checkbox"/> No <input type="checkbox"/> Yes, describe:							
3. PE Findings							
Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lead Exposure/Elevated Lead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior/Adjustment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal/orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac/murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness/Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REMARKS: (Please explain any abnormal findings.)							
4. RECORD OF IMMUNIZATIONS – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider <u>or</u> a computer generated immunization record must be provided. (This form may be obtained from: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf)							
RELIGIOUS OBJECTION: I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease. Parent/Guardian Signature: _____ Date: _____							
5. Is the child on medication? <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate medication and diagnosis: (OCC 1216 Medication Authorization Form must be completed to administer medication in child care).							
6. Should there be any restriction of physical activity in child care? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify nature and duration of restriction:							
7. Test/Measurement		Results			Date Taken		
Tuberculin Test							
Blood Pressure							
Height							
Weight							
BMI %tile							
Lead Test Indicated: <input type="checkbox"/> Yes <input type="checkbox"/> No							

(Child's Name) **has had a complete physical examination and any concerns have been noted above.**

Additional Comments:

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date: