



Calvary Church of Los Gatos
SHINING STAR RESPITE – First Time Registration

www.calvarylg.com/youth/specialneeds.html

Please register by email or phone before submitting this application
Phone (408)307-4348 / Fax: (408) 559-1953 / E-mail: joyceconnection@aol.com

One form for EACH attendee with Special Needs	Date Form Completed:
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Name of Attendee:	Last Name	First Name
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Age:		Birthday:		Grade:		Male :		Female:
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Address:	Street	City	State	Zip
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Parent/Guardian:	Home Phone :
E-Mail:	Work:
	Cell:

Parent/Guardian:	Home Phone :
E-Mail:	Work:
	Cell:

Address:	Street	City	Zip
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(If different than above)

Siblings who will attend:

Name	Age	Birth date	Brother	Sister

Additional comments to any question can be added on last page of Registration Form

Attendee's primary diagnosis:

Attendee's secondary diagnosis:
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Any recent surgeries or procedures? (Please help us better serve your child by providing as much information as possible.)

Has your child had any health condition related to the following? (Please Check)

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Skin Sensitivity	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Hearing
<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	Kidney/Bladder	<input type="checkbox"/>	Vision	<input type="checkbox"/>	Balance

If YES, please describe below:

Special Diet:	Yes ___ No ___	Please Specify:
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Allergies:	Yes ___ No ___	Please Specify:
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Any Medication to be given during Shining Stars Respite Care?	Yes _____ No _____	Please specify below:
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MEDICATION	DOSE	TIME TO BE GIVEN	MEDICATION	DOSE	TIME TO BE GIVEN

Any Emergency Medication to be given ?	Yes ___ No ___	Please specify below:
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Epi Pen Yes <input type="checkbox"/> No <input type="checkbox"/>	Benadryl Yes <input type="checkbox"/> No <input type="checkbox"/>	Albuterol Inhaler Yes <input type="checkbox"/> No <input type="checkbox"/>	Glucagon Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Yes <input type="checkbox"/> No <input type="checkbox"/> Please specify:			

Name of Attendee:	
Physician:	Phone:
Dentist:	Phone:
Medical Insurance:	Policy :

Please Note: Whenever the health and safety of your child is in question, 911 will be called.

Further Information

Communication: Please describe such as: talks in sentences, few words, babbles, gestures, etc.

Can attendee understand what others say, please describe:

Personal Care / Bathroom:

Independent	Minimal Supervision	Needs Complete Care	Diapers	Depends / Training Pants	Other-Please specify
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Behavior: Check all that apply and if necessary please give more details in the space provided below.

Shy	Outgoing	Plays Alone	Plays in Group	Adapts Well to New Situations	Adapts to New Situations with Difficulty	Responds well to correction
Responds to correction w/ difficulty	Sometimes destructive	Sometimes threatens others	Sometimes hits, bites, hurts others/self	Sometimes runs away	Hyperactive or ADD	Likes to "Help" Others

Attendee responds to separation from his / her parents by
Attendee is best comforted by
Attendee indicates wants / needs by
Activities attendee especially enjoys and participates in are

If you need more room to answer any questions on page 1 or 2, or if you wish to write any comments, a blank page at the end of this questionnaire is included.

Emergency Contacts (Other than doctor)

In case of emergency, and if parents cannot be contacted, the following persons may be called and are authorized to pick up my child. (At least one contact must be provided. Identification must be shown before attendee will be released.)

Name:	Phone:	Cell:
Address:		
Relationship:		

Name:	Phone:	Cell:
Address:		
Relationship:		

Permission/Authorization Agreement:

Please read the following statements carefully and initial in the designated spaces indicating that you have read and agree to the provisions:

	I have fully disclosed to Calvary Church-Shining Stars Respite all pertinent facts about attendee's special needs and accept full responsibility for failure to do so.
	If my child is enrolled in Shining Stars Respite program, I authorize the staff to provide any required special treatment or procedures to attendee while in respite care. I will provide written instructions and all necessary supplies for these procedures.
	I will supply necessary foods, drinks, snacks and diapers / wipes for attendee.
	In case of emergency or accident, I understand that 911-EMS 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 I will be responsible for payment of all EMS, hospital and physician charges for emergency services to attendee.

Handwritten Signature - I have read and initialed the above permission/authorization statements and agree to the terms designated in each.

Signed	Date

Electronic signature if e-mailed back. **Type name, put in date and put X in box** Date

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Electronic Signature - I have read the above Permission/Authorization Agreement and agree to the terms. I understand and intend that by putting an X in the box, I have consented to submit my authority and signature electronically ..

Publicity Release and other information:

Please tell us how you found out about Shining Stars Respite:

I do ____	do not ____	Give permission for attendee to be photographed for use in publicity related to Shining Stars Respite.
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Food choices for the evening: PIZZA – PLEASE LET US KNOW IF YOU ARE BRINGING FOOD FOR YOUR CHILD.

Additional information I wish to share