



Calvary Church of Los Gatos SHINNING STAR RESPITE – Repeat Registration

(when we have First Time Registration on File) 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:

Name of Attendee: | |

Last Name

First Name

Age: | Birthday: | Grade: | Male : | Female

Address: | | | |

Street

City

State

Zip

Parent/Guardian: | Home Phone :

E-Mail: | Work: | Cell:

Parent/Guardian: | Home Phone :

E-Mail: | Work: | Cell:

Address: | | |

(If different than above)

Street

City

Zip

Siblings who will attend:

Name	Age	Birthdate	Brother	Sister

Attendee's primary and secondary diagnosis. Any recent surgeries or procedures? (Please help us better serve your child by providing as much information as possible) *Additional comments to any question can be added on last page of Registration Form*

Has your child had any new 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"/>	Kidney/Bladder	<input type="checkbox"/>	Vision
<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"/>	Joint Pain	<input type="checkbox"/>	Hearing

If **YES**, please describe:

Special Diet: Yes ___ No ___ Please Specify:
Allergies: Yes ___ No ___ Please Specify:

Any Medication to be given during Shinning Stars Respite Care? Yes ___ No ___ Please specify below:

MEDICATION	DOSE	TIME TO BE GIVEN	MEDICATION	DOSE	TIME TO BE GIVEN

Any **Emergency Medication** to be given? Yes ___ No ___ Please specify below:

Epi Pen Yes No Benadryl Yes No Albuterol Inhaler Yes No Glucagon Yes No
Other Yes No 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.

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Signature of Parent/Legal Guardian

Date

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.

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

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Signed

Date

Publicity Release and other information:

We encourage you to participate in our effort to help other families learn about Shining Stars Respite. Feel free to forward flyers and any other information including our website to others.

I do ___ do not ___	Give permission for attendee to be photographed for use in publicity related to Shining Stars Respite.
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How did you hear about Shining Stars respite?

Food choices for the evening:

Please use the space below If you need more room to answer any questions on page 1 or 2, or if you wish to write any comments.