Client Name: _____ Loving Hands Children's Home Registration Form Age: ____

Loving Hands Children's Home
P.O Box 48004
Los Angeles, CA 91401
(424) 781-8194
www.lovinghandschildrenshome@yahoo.com

Program of Interest ☐ **Mentor Program** ☐ **Farm Intro Field Trip**

Client

First_____ Middle _____ Last _____ Gender: Male __ Female__
School Name _____ Grade _____ Birth date _____/_____/_____ Age _____
Street Address _____
Town/City _____ State _____ Zip code _____ Child's Home Phone _____

Emergency Contact Information
Emergency Contact #1
First Name _____ Last Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ Email _____ Relation to child _____

Emergency Contact #2
First Name _____ Last Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ Email _____ Relation to child _____

Medical Release Information
Insurance Information
Policy Number_____ Name of Health Insurance Provider_____
Primary Physician_____
Address_____
Phone_____ Hospital Preference_____

Please list any medical problems, including any requiring maintenance medication (i.e. Diabetic, Asthma, Seizures).

Medical Problem	Required treatment	Should paramedic by called?
_____	_____	Yes/No
_____	_____	Yes/No
_____	_____	Yes/No

Are you presently being treated for an injury or sickness, or taking any form of medication for any reason?
Yes__ No__ If yes, explain:_____

Are you allergic to any type of food or medication?
Yes__ No__ If yes, explain:_____

Do you require a special diet?
Yes__ No__ If yes, explain:_____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

In case of medical emergency:

I understand that my emergency contact listed will be notified in the case of a medical emergency. In the event that they cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event I am injured or become ill.

Initials _____

I understand that Loving Hands Children's Home will not be responsible for the medical expenses incurred, but that such expenses will be my responsibility.

Initials _____

Please circle how you heard about Loving Hands Children's Home Programs .

After School Program Website School_____ Referral_____ Flyer Other_____

Terms of Agreement

Photo Release

I hereby give my permission to be photographed during **Loving Hands Children's Home Programs**. I understand the photos will be used to keep a journal of activities, to share during power point presentations and/or reports to our donors and for promotional purposes including flyers, brochures, newspaper and on the internet. I understand that although my photograph may be used for advertising, my identity will not be disclosed, I do not expect compensation and that all photos are the property of Loving Hands Children's Home and its affiliates.

Initials _____

Transportation Release

I hereby give permission for the transportation to official **Loving Hands Children's Home** activities by modes of transportation agreed to by the program organizers when available.

Initials _____

Loving Hands Children's Home and its co-organizers are not responsible for lost or damaged personal property. All scheduled events are subject to change. I understand that no fees will be refunded or transferred unless I am unable to participate due to an accident or illness per physician orders. Photos and quotes may be used for publicity purposes. In case of an emergency, and if a family physician cannot be reached, I hereby authorize to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, and/or Physician).

Upon the conclusion of the program. I MUST be picked up/ vacate promptly. Release form,
Termination Policy-

Client Signature: _____ Date: _____

Printed Name : _____