DELTA GAMMA CENTER FOR CHILDREN WITH VISUAL IMPAIRMENTS
1750 S. Big Bend Blvd. Richmond Heights, MO 63117
Phone (314) 776-1300 * Fax (314)776-7808 * E-Mail info@dgckids.org * www.dgckids.org

GENERAL ADMISSION FORM ALL SERVICES

CHILD'S INFORMATION

Child's Name ______________________________ **Date of Birth** ____________________

Address ____________________ Additional Address if applicable ____________________

City ______________ **County** __________ **State** ________ **ZIP** ________

School District/School ____________________ **Race** ______________ **Gender** M F

Visual Diagnosis, if known ______________________ Does child have health insurance coverage? Yes No

Other Medical Concerns/Diagnosis ______________________________

FAMILY INFORMATION

	MOTHER	FATHER	Guardian, if applicable
Name			
E-Mail			
Phone	Home ____________ Cell ____________	Home ____________ Cell ____________	Home ____________ Cell ____________
Employer			
Occupation			

Siblings (Name & DOB:) ______________________________

Emergency Contact Information Name ______________________________

Relationship ____________________ Phone ____________________

Family Financial Information (required by our funders)

____ $0 - $9,999
____ $10,000 - $14,999
____ $15,000 - $19,999
____ $20,000 - $29,999
____ $30,000 - $49,999
____ $50,000 - $99,999
____ $100,000 and greater

I/we understand that medical information will be obtained to determine eligibility for services or, for school age children, an IEP that indicates he or she receives vision services.

______________________________ ____________________
PARENT / GUARDIAN / RESPONSIBLE PARTY **DATE**

Revised 9/1/2015

DELTA GAMMA CENTER FOR CHILDREN WITH VISUAL IMPAIRMENTS
1750 S. Big Bend Blvd. Richmond Heights, MO 63117
Phone (314) 776-1300 * Fax (314) 776-7808 * E-mail info@dgckids.org * www.dgckids.org

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I understand that agencies and/or providers need specific information in order to provide services. By signing this form, I am allowing the named agencies/providers to exchange specific information to effectively provide or coordinate services for my child.

I, ____ give my informed consent for information regarding
Parent/Legal Guardian Name

____ / _____________________________ to be either
Child's Legal Name / Date of Birth

mutually exchanged or shared between the agencies / individuals listed below:

___________________________________ Pediatrician Name / Phone #	___________________________________ Ophthalmologist Name / Phone #
___________________________________ Neurologist Name / Phone #	___________________________________ School & School District Name / Phone #
___________________________________ Case Worker Name / Phone #	___________________________________ Service Coordinator Name / Phone #
___________________________________ First Steps (MO) Name / Service Coordinator / Phone #	___________________________________ CFC (IL) Name / Service Coordinator / Phone #
___________________________________ Regional Center Name / Phone #	___________________________________ PLB / Phone #
___________________________________ Name / Phone #	___________________________________ Name / Phone #
___________________________________ Name / Phone #	___________________________________ Name / Phone #
___________________________________ Name / Phone #	___________________________________ Name / Phone #

Permission to use photos of my child and media:

I hereby authorize and give my full consent to Delta Gamma Center for Children with Visual Impairments to take photographs, videotapes, and/or film of my child while receiving Delta Gamma Center services. I further agree these photographs, videotapes, or films can be used for any social media, public displays, publications, marketing and advertising purposes, without limitations or reservations.

I also have the option to limit photo use to: ____

____

Initial: **Yes, consent granted________** **No, I do not consent_______**

I give my permission to release my name and contact information to the Delta Gamma Center agency representative so that they can contact me with information about events and activities.

Check one: **Yes _____** **No, I do not wish to share this information _____**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, and it is not a requirement of service. I can inspect or request copies of the information to be disclosed.

I have a right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the Delta Gamma Center. Unless I indicate on this form that I wish to specific a different expiration date, this authorization will expire in one year. ___________________ **(expiration date)**
My signature below acknowledges that I have read, understand and authorize release of my child's records.

____ ________________________________
Signature of Parent / Guardian **Date**

DELTA GAMMA CENTER FOR CHILDREN WITH VISUAL IMPAIRMENTS

Additional permission/releases & information for GRADS enrollment. Please read carefully!

Registering For ___Explorers ages 3-5 ___Challengers I ages 5-8 ___Challengers II ages 9-12 ___Chat & Party ages 13+ ___Tandem Adventurers ages 10+ Other ___________________________ [Fee for each program is $30]

Insurance Waiver and Release of Liability **Initial____________ ←**

In consideration of being allowed to participate in any of the activities offered by the DELTA GAMMA CENTER FOR CHILDREN WITH VISUAL IMPAIRMENTS, I hereby give my permission for my minor child, listed below, to participate in all related events, activities, and the transportation needed to and from events as required. I fully acknowledge and understand that my child will be engaging in activities that involve risk of injury. This is to certify that I, as parent/guardian with legal responsibility for this child participant, do consent and agree to the following:

1. Acknowledge and fully understand that my child will be engaging in activities that involve risk of injury due to recreational activities engaged in, and further there may be other risks not reasonably foreseeable at this time.
2. Assume all the foregoing risks and accept personal responsibility for the cost of any emergency medical services secured as necessary by the Delta Gamma staff and volunteers.
3. I release and agree to indemnify and hold harmless the Delta Gamma Center, their administrators, directors, employees and volunteers as well as other participants or sponsoring agencies used to conduct events and activities, from any and all liabilities related to my minor child's involvement or participation in these programs as provided above.

Permission to Administer Emergency Medical Care **Initial ___________ ←**

I consent for an emergency medical care provider to administer any emergency medical care deemed necessary to the welfare of my child, while under the supervision of the Delta Gamma Center. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians' to hospitalize, secure appropriate consultation, and to administer appropriate medical care for my child. I hereby agree to pay for physicians' and/or hospital fees, charges, and related expenses for such emergency medical care.

Climbing Wall Waiver and Rules for Climbing (Applicable for children over 5 years) **Initial ___________ ←**

I agree to follow all the posted rules. I acknowledge the Inherent risks in rock climbing activities, including those that take place indoors. I realize those risks include falls, equipment failures, bad decision making, inattentive belayers, and holds that have become loose or damaged by other climbers. I understand that there are unforeseeable accidents, and I assume all risks associated with such accidents, even though I cannot foresee any of them.

About your Child: Parents please disclose ALL information that we need to provide a safe environment!

Do materials need to be in: _____Braille _____Large print ____Other ___________________________

Does your child use a cane or assistive device for mobility, vision or communication? _____Yes ____No

If yes, please specify: ____

Medical (mark yes/no):		**Support (mark yes/no)**		**Please explain all 'yes' answers**
Asthma	Y / N	Special Diet	Y / N	**Attach extra page if needed.**
Environmental/Food allergies	Y / N	Balance/Coordination	Y / N	________________________
Seizures	Y / N	Needs help with personal care	Y / N	________________________
Hearing Impairment	Y / N	Needs close supervision	Y / N	________________________
Emergency medication	Y / N	Communication Concerns	Y / N	________________________
Other health condition	Y / N	Behavior concerns	Y / N	________________________
Does your child have any restrictions	Y / N	Other support needs	Y / N	**T-Shirt Size**________________

Medications

Name	Dosage	Time Administered	Reason
Name	Dosage	Time Administered	Reason
Name	Dosage	Time Administered	Reason
Name	Dosage	Time Administered	Reason

Child's Name_______________________________________

Sign Here ←

Parent/Guardian Signature **Emergency Phone Number** **Date**

Revised 9/1/2015