



The Relief Zone

Community Youth Center

2019-2020 TRZ CARDINAL CARE REGISTRATION FORM (One child per form/ new form each year)

The Relief Zone Inc.
5 Frew Run St. Box 334
Frewsburg, NY 14738
716-569-2614
trz@thereliefzone.org
www.thereliefzone.org

Name of Child: _____

Gender: _____ Male _____ Female

Grade: _____ Age: _____ Date of Birth: / / _____

Teacher: _____

Family Mailing Address: _____

Ethnicity (Please check those that apply): _____ Native American

_____ Zip: _____

_____ Caucasian _____ African American/Black _____ Asian

_____ Hispanic/Latino _____ Prefer not to answer

Parent or Guardian: _____

Relationship to child: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Work phone: _____

Email Address: _____

Does this person reside with the child? YES NO

Parent or Guardian: _____

Relationship to child: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Work Phone: _____

Email Address: _____

Does this person reside with the child? YES NO

Authorized Person for Pick Up/Emergency

Name: _____

Address: _____

Name: _____

Address: _____

Name: _____

Address: _____

Relationship _____

Phone #s: _____

Relationship _____

Phone #s: _____

Relationship _____

Phone #s: _____

DAYS ATTENDING: (please mark in bubbles which days your child will attend)

MONDAYS, TUESDAYS, WEDNESDAYS, THURSDAYS, FRIDAYS, ONLY WITH NOTE

Payments are due at the beginning of each week and can be made by check, cash, venmo, or paypal. (www.thereliefzone.org)

I give The Relief Zone and RCS Staff permission to share information regarding my child, so that the staff may better understand any needs my child may have.

Signature _____ DATE _____

Important – This Box Must Be Completed For TRZ Program Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities except as noted.

Publicity photos may be taken throughout the program duration. I allow my child to be included in photos.

Report card data and NWEA-MAP scores results are needed for program data collection; names of individual students are not disclosed, but needed for TRZ to apply for funding. I allow my child's data to be collected.

Authorization for Treatment:

I give my child permission to attend TRZ Cardinal Care After School Program held at Gail N. Chapman Elementary School, 22 Main Street, Randolph, NY 14772. I understand the program rules. I hereby give permission to staff to assist in the application of sunscreen to my child if necessary. By signature below, I hereby release TRZ from all responsibility and liability for any injury or illness my child may sustain. In the event of a medical emergency, I give an adult leader of this program consent to any medical treatment my child may require.

I give permission to the medical personnel selected by the director to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to secure and administer treatment, including hospitalization, for the person named above.

The completed forms may be photocopied.

Signature of Parent or Guardian _____ Date _____

A COPY OF YOUR CHILDS IMMUNIZATION RECORDS MUST ACCOMPANY THIS REGISTRATION FORM

Please Complete the following questions. Be sure to provide an explanation where needed.			
1.	Is your child physically, mentally, and behaviorally able to participate in TRZ's School Age Child Care Program?	YES	NO
	If NO, please explain?		
2.	Does your child have any condition requiring special attention?	YES	NO
	If YES, please explain?		
3.	Does your child have an Individual Education Plan (IEP) or is being evaluated for one? (If YES, provide a copy of IEP)	YES	NO
4.	Has your child had an illness/injury within the last year or an on-going condition which we should be aware of?	YES	NO
	If YES, please explain?		
5.	Is your child allergic to bee stings? (If YES, Medication Consent is needed)	UNKNOWN	YES NO
6.	Is your child allergic to any food?	YES	NO
	If YES, Please Explain?		
7.	Is your child allergic to any medications?	YES	NO
	If YES, Please Explain?		
8.	Does your child have any other allergies (i.e. seasonal, etc.) ?	YES	NO
	If YES, Please Explain?		
9.	Does your child have asthma? (If YES, Medication Consent is Needed)	YES	NO
10.	Is your child on any medication?	YES	NO
	If YES, Please Explain?		
11.	Does your child have any eye problems and/or wears glasses/contacts?	YES	NO
	If YES, Please Explain?		
12.	Does your child have any hearing problem?	YES	NO
	If YES, Please explain?		
13.	Does your child have any speech problems?	YES	NO
	If YES, Please explain?		
11.	Special needs or "triggers" we might need to know to help with your child's success:		

Family Physician: _____

Phone: _____

Insurance Carrier: _____

Policy #: _____