



Weekend "Circle of Games" Program 2011-Registration Form

Child's Name: _____ Age: _____

Child's address: _____ City: _____ State: _____ Zip: _____

Child's Phone: _____

Mother's Name/Legal Guardian:

Name: _____ Email: _____

Home address: _____

Daytime phone number: _____ Cell phone number: _____

Father's Name/Legal Guardian:

Name: _____ Email: _____

Home address: _____

Daytime phone number: _____ Cell phone number: _____

Person(s) with whom your child may be released:

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Emergency Contact Information (Person other than parent/guardian)

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Child's Physician/Medical Care Provider:

Dr's Name: _____ Phone number: _____

Child's Health Insurance/Medical Assistance Benefits: _____ Policy #: _____

Medication:, Special Conditions: _____

Allergies (including medication reaction): _____

Emergency Medical/Dietary Information: _____

Additional information on special care needs of child: _____

Check box if a severe allergy action plan is required. If box is checked, please provide a copy with your registration form. Attach additional medical information as needed.

Authorization for emergency hospital or medical treatment

In the case of an emergency due to illness or accident, when it is thought advisable to have immediate medical attention for my child, I hereby authorize Teamwork Wins Ltd. to send my child to the nearest hospital. I agree to meet the staff at the hospital as soon as possible after being notified. I understand that I must bear all expenses involved, including those incurred to transport my child to the hospital. In the event of a minor injury, I authorize Teamwork Wins Ltd. to administer minor First Aid to my child.

Parent/Guardian Signature: _____ Date: _____ Relationship to child: _____

I authorize TWW to use photographs of the weekend program in which my child may appear for publicity or promotions:

Parent/Guardian Signature: _____

Date: _____

Diagnosis/Symptomatic Behaviors

Please list your child's diagnosis: _____

Is he/she aware of diagnosis? _____ How do you refer or talk about your child's diagnosis/behaviors? _____

Please list current support services in place for your child, e.g. Wraparound, Speech and Language, ABA, etc.:

Please help us understand your child by describing his/her behaviors, triggers and suggestions on how you handle the symptomatic behaviors:

Price Packages, please check:

_____ Saturday\$100 per session

_____ Monthly - (Two Saturdays).....\$200 per month

Payment Options:

Check: Please make check payable to Teamwork Wins Ltd. and bring it with you Saturday or mail it to:

Teamwork Wins LTD.
c/o Mary Herald
PO Box 42
New Hope, PA 18938-0042

Or

Please charge my: Mastercard _____ Visa _____ Amount: _____

Account #: _____ Exp. Date: _____ Security Code _____

Signature: _____