Bodhi Tree Language Center
5403 SE Center Street, Portland, OR 97206
503-788-0336 · http://www.BodhiTreeLanguageCenter.org

Japanese After School Program for Children

Registration Form

Child(ren)'s Information

Name	Gender *Male or Female*	Birth Date	Start Date	Program Days & Times *E.g. Thursdays, 4:30-6:30 pm*

Mother's Information (or Primary Legal Guardian)

Name	
Address	
Telephone at Home	
Telephone at Work	
Telephone (Other)	
Email address:	

Father's Information (or Secondary Legal Guardian)

Name	
Address	
Telephone at Home	
Telephone at Work	
Telephone (Other)	
Email address:	

Consent for Emergency Medical Treatment and Program Participation

I hereby authorize the Bodhi Tree Center (the “CENTER”) to procure proper medical, dental, and hospital care for my CHILD, _____, in the event of injury or illness while my child is in the care of the CENTER. I understand and agree that I am financially responsible for any care or services provided. I hereby waive all liability of the CENTER and its staff and from any and all accidents, mishaps, or other injuries not covered by the insurance in force. Also, I hereby grant permission for my child to participate in all activities of the CENTER. I agree to bring and call for my child promptly on the days and times that he/she is scheduled for. I understand that the CENTER cannot assume responsibility for children left at CENTER facilities before and after program hours. In case my child is ill or cannot attend, I agree to notify the school with as much advance notice as possible.

Signature of Parent of Legal Guardian _____

Name of Above Signed (Please Print) _____

Date _____

Medical, Dental, and Emergency Contact Information

Family Physician

Address _____

Telephone _____

_____

Family Dentist

_____

Address _____

Telephone _____

_____

Insurance Carrier/Provider

_____

Policy Number and Group Number _____

_____

Emergency Contact #1

_____

Relationship to child _____

Address _____

Telephone (Home) _____

Telephone (Work) _____

Telephone (Other) _____

_____

Emergency Contact #2

_____

Relationship to child _____

Address _____

Telephone (Home) _____

Telephone (Work) _____

Telephone (Other) _____

_____

Health History

Does your child have any of the following health concerns or conditions? Please check all that apply:

___ Allergies
___ Bowel/Bladder problems
___ Diabetes (attach diet)
___ Emotional/behavioral problems or learning concerns
___ Handicapping conditions
___ Hay fever
___ Heart problems
___ Physical injuries (recent)
___ Seizure disorders
___ Skin problems
___ Vision/Hearing problems
___ Other chronic or recent illness or surgical procedure

Please provide specific information about any above identified health concern, including indications about treatment needed while your child is participating at the CENTER:

_____

_____

_____

_____

Date of child's last **tetanus booster**: _____

Does your child have any activity restrictions? If so, please specify:

_____

_____

Does your child have any dietary restrictions or needs (e.g. cannot eat eggs or nuts, is vegetarian, etc.)? If so, please specify:

_____

_____

Please list any and all other pertinent health information that we should know about:

_____

_____

Authorization for Administration of Over the Counter Medication

For the relief of minor health problems that might temporarily affect your child's comfort at the CENTER, a small supply of over the counter medication may be available. These medications are administered as needed. Your physician does not need to sign for the medications listed below. **The Health History is checked for Allergies and other Health Concerns before any medication is given.** Medications available for use may include the following:

- Asprin pain/fever relievers
- Non-aspirin pain/fever relievers such as Tylenol or Advil
- Throat lozenges
- Cough syrup
- Cough drops
- Antiseptic (Bactine)
- Sunscreen
- Other: _____
- Other: _____

If you want your child to receive over the counter medication, if needed, and at the discretion of CENTER staff, please sign below. If this list contains medication that you do NOT want your child to receive, please strike out that medication before signing.

I authorize the CENTER to administer over the counter medication (limited to those on the list above and not struck out) under direction of CENTER staff:

Signature of Parent of Legal Guardian _____

Name of Above Signed (Please Print) _____

Date _____