

REGISTRATION AND EMERGENCY INFORMATION

SIDE 1

Child's Name

D.O.B.

Age

Grade

Parent's / Guardian's Name

Parent's / Guardian's Name

Address

Address

City, Zip code

City, Zip code

Home Phone

Cell Phone

Home Phone

Cell Phone

Email

Email

MEDICAL INFORMATION

Pediatrician Name

Phone

Dentist Name

Phone

Preferred Hospital

Insurance Company

Policy number

Diagnosis

Allergies / Special Health Considerations

PLEASE COMPLETE BOTH SIDES OF INFORMATION

Child's Name: _____ D.O.B. _____ Age: _____

Sibling's names _____

Child's likes: _____

Child's dislikes: _____

Child's strengths: _____

Concerns: _____

Child's reinforcement: _____

Level of supervision needed: **High** **Medium** **Low**

Child's safety awareness: **Good** **Fair** **Poor**

PROGRAM SELECTION AND WAIVER INFORMATION

_____ Program selection _____ Day/ Time Session _____

_____ Program selection _____ Day / Time Session _____

_____ Program selection _____ Day / Time Session _____

Amount Enclosed \$ _____

I hereby certify the minor is my son/daughter and that his/her date of birth is noted above and I do hereby certify that to the best of my knowledge and belief said minor is in good health. I understand the policies as stated on this form/registration. I understand the risks to my child in participating in activities, particularly physical activity. I take responsibility for these risks and agree to indemnify and hold harmless TPH and its officers, the Town of Fairfield, and the staff in the event my child sustains an injury. Program fees are **non-refundable**. I agree to photos be taken during programs for use of scrapbooks, social story books and grant applications. In the event that you **do not** want photos to be taken, please initial _____.

In case of illness or accident, permission is granted for emergency treatment to be administered. It is further understood that the undersigned will assume full responsibility for any such action, including payment of costs. I hereby advise that the above named minor has had the following allergies, medicine reactions or unusual physical conditions which should be made known to a treating physician.

Name of Parent / Guardian (**Please Print**) _____

Signature _____ Date: _____

Please send and make checks payable to: The Pilot House
P.O. Box 1553
Fairfield, CT 06825

