OBSERVATION & GOALS

NAME _____

Observation: [Physical, mental, social, independence levels]

Goals

Observations/Goals performed by: _____ Date _____

THE CLUBHOUSE For Special Needs, Inc.

Member Application

Application Date _____

office

PLEASE PRINT

EMAIL: _____

NAME:	PHONE:	Date:
ADDRESS:		
CITY: STATE: ZIP CODE:		
AGE:_____ SEX: _____ DATE OF BIRTH:_____ SS #: __ __ __ - __ __ - __ __ __ __		

Diagnosis _____ MILD ___ MODERATE ___ SEVERE ___ PROFOUND ___

Allergies/Medications _____

MEDICATIONS TAKEN, WHEN and FOR WHAT: _____

Seizures ____YES ____ NO Need Assistance with: _____

Preferred doctor: Name _____ Phone _____

Hospital preferred _____ Location _____ Phone _____

Shot Records are up-to-date: ____ YES ____ NO

Comments: _____

NAME OF SCHOOL: CITY: Grade:

SERVICES REQUESTED:

_____ After-School Program _____ Spring/Winter Break _____ Summer Program
_____ All-Day Program _____ Other _____

PARENT/GUARDIAN NAME:

ADDRESS: CITY: ZIP:

PHONE:

NAME OF PERSONS TO CALL IN CASE YOU CANNOT BE REACHED IN AN EMERGENCY:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

THE CLUBHOUSE for Special Needs, Inc.

NAME _____

AUTHORIZATION FOR MEDICAL TREATMENT

Name of Student	DOB	Allergies/Special Conditions
_____	_____	_____
_____	_____	_____

I, being the parent or legal guardian of the above named student of The Clubhouse for Special Needs do hereby appoint the staff of The Clubhouse for Special Needs to act in my behalf in authorizing unexpected medical care and hospitalization for the above named student during the period of my absence.

This document shall be presented to the physician or appropriate hospital representative at such time as unexpected medical or surgical care or hospitalization may be required.

_____

Parent/Guardian Signature

HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED INSURED STUDENT:

_____ _____

INSURANCE COMPANY/ GOV'T PROGRAM I.D. OR CONTRACT #

_____ _____

FAMILY PHYSICIAN PHONE#

This document must be notarized

STATE OF TEXAS
COUNTY OF _____

SUBSCRIBED AND SWORN TO BEFORE ME, A NOTARY PUBLIC IN AND FOR TARRANT COUNTY, TEXAS, THIS THE _____ DAY OF _____ 20____.

MY COMMISSION EXPIRES

_____ _____

THE CLUBHOUSE For Special Needs, Inc.

AUTHORIZED TO PICK UP MEMBER

(Please Note: If the person is not on this list, the staff cannot release your member to them. This is for your member's protection)

Please note that if you do not pick your member up by the time allotted and we are unable to reach any of the three names below, our staff is instructed to call the local police department.

PLEASE PRINT

Name	Phone:	Driver's License #:
Name	Phone:	Driver's License #:

Name	Phone:	Driver's License #:
Name	Phone:	Driver's License #:

HEALTH HISTORY

HAS CHILD HAD:	YES	NO	DATE
Measles			
Mumps			
Chicken Pox			
Seizures			
Frequent bedwetting			
Urinary tract infections			
Rheumatic Fever			
Frequent Colds &/or earaches			
Hospitalizations			
Hepatitis			
Other			

All Shots are Current:

____ YES

____ NO

PHOTO/NAME PERMISSION SLIP

I, _____ give "**The Clubhouse for Special Needs, Inc.**" permission to use my student's name/photo in their brochure, mailings or other advertisements for The Clubhouse.

_____ _____ _____

Child's name Parent/Guardian signature Date

TRANSPORT PERMSISION SLIP

I, _____ give "**The Clubhouse for Special Needs, Inc.**" permission to transport my student on excursions, errands, or other planned field trips to off campus activities. I understand that precautions will be taken to ensure the safety and health of my child/adult.

_____ _____ _____

Student's name Parent/Guardian signature Date

The Clubhouse

Fun & Fellowship

For the mild to moderate mentally/ physically challenged teenagers and young

www.theclubhouse.org

Notice of HIPAA Privacy

By signing below I acknowledge that _____'s records are protected, whether oral or written – according to HIPPA Privacy rules. All information is private and confidential and The Clubhouse for Special Needs, Inc. is obligated to safeguard all consumer related information according to the Health Insurance Portability and Accountability Act of 1996.

_____ _____
Signature Date

_____ _____
Witness Date

LIABILITY DISCLAIMER

The Clubhouse for Special Needs, Inc. performs background checks on ALL staff and volunteers. While your young person is in our care, whether in our facility or on field trips, **The Clubhouse for Special Needs** is dedicated to provide a safe place. When the director is not present, there is always two staff assigned. This helps in eliminating any misconduct or abuse.

We realize that relationships are formed between staff, clients and families and often these relationships are not limited to within The Clubhouse and its activities.

By signing below I [parent/guardian] fully understand that:

1. The Clubhouse for Special Needs is NOT responsible or liable for any agreements between staff/child/parent, i.e. Picking up to bring to The Clubhouse or to take home. The only exception to this is if and only if it was made through the Director, Darlene Hollingsworth.
2. The Clubhouse for Special Needs is NOT responsible or liable for any agreements between staff/child/parent that is not a part of The Clubhouse activities.
3. When a parent is present, liability is upon that parent/guardian and not upon The Clubhouse.

Young Person's name _____

Parent/Guardian Signature Date

_____ _____
Witness Date