CARING FOR KIDS

REGISTRATION FORM

CHILD'S NAME: _____ **CHILD'S BIRTH DATE:** _____

CHILD'S DISABILITY: _____

CAUSE OF DISABILITY: (CHECK ONE) **CONGENITAL (PRESENT AT BIRTH)** **ACQUIRED**

IF ACQUIRED, DATE OF INJURY OR DIAGNOSIS: _____

CHILD PRIMARILY USES: (CHECK ONE) **MANUAL WHEELCHAIR** **POWER WHEELCHAIR**

WALKER **NONE** **OTHER:**_____

CHILD'S PRIMARY PHYSICIAN:_____ **PRIMARY PHYSICIAN'S PHONE NUMBER:**_____

DOES YOUR CHILD SEE A PHYSICIAN AT THE REHABILITATION INSTITUTE OF CHICAGO? **YES** **NO**

MOTHER'S NAME: _____ **FATHER'S NAME:** _____

MOTHER'S CELL PHONE: _____ **FAHTER'S CELL PHONE:** _____

MOTHER WORK PHONE: _____ **FATHER'S WORK PHONE:** _____

MOTHER'S HOME PHONE: _____ **FATHER'S HOME PHONE:** _____

MOTHER'S EMAIL: _____ **FATHER'S EMAIL:** _____

PRIMARY PARENT CONTACT: (CHECK ONE) **MOTHER** **FATHER**

CHILD'S ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____

WE WERE REFERRED TO CARING FOR KIDS BY OUR:

Doctor **Friend** **Physical Therapist** **Occupational Therapist**

Other: (PLEASE TELL US) _____

WILL YOUR CHILD NEED BUS TRANSPORTATION? **YES** **NO**
(PLEASE NOTE TRANSPORTATION IS NOT PROVIDED FOR WEEKEND PROGRAMS)

DOES YOUR CHILD PARTICIPATE IN THE REDUCED LUNCH PROGRAM AT SCHOOL? **YES** **NO**

DOES YOUR CHILD HAVE A SIBLING IN CARING FOR KIDS: **YES** **NO**

IF YES, PLEASE TELL US HIS/HER NAME: _____

CHILD'S ETHNICITY: **African American** **Asian** **Caucasian** **Hispanic** **Native American** **Other**

PLEASE SEND COMPLETED FORM TO

Shirley Ryan AbilityLab

Shirley Ryan AbilityLab
Caring For Kids
ATTN: Ashley Gruenwald
355 E. Erie Street, 18th Floor
Chicago, IL 60611
Fax
312-238-1025

Caring For Kids

Shirley Ryan AbilityLab Caring for Kids
Participant Medical Form

THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN

Child's First Name: _____**Last Name**: _____

Street Address: _____**City**: _____ **State**: _____ **Zip**: _____

Parent Primary Phone: (_____) _____ **Secondary Phone**: (_____) _____

Child's Date of Birth: _____/_____/_____ **Parent Email**: _____

Emergency Contact: _____ **Relationship**: _____ **Phone**: _____

Diagnosis:

_____ Amputation Cause: _____ Level: _____
_____ Cancer Type: _____
_____ Cerebral Palsy
_____ Head Injury Cause: _____
_____ Muscular Dystrophy
_____ Stroke
_____ Spinal Cord Injury Cause: _____ Level _____ Complete Incomplete
_____ Visual Impairment

_____ Other: (Explain disability & cause) _____

Is disability: Congenital (*present at birth*) Acquired or diagnosed on this date: ___/___/___

Child uses: (check one) Manual Wheelchair Power Wheelchair Walker None Other: _____

List surgeries and dates: _____

Medications (prescriptions and over-the-counter) _____

Allergies: _____

Please indicate if you have:

Seizures YES NO How many in the past 12 months: _____ Date of most recent seizure: ___/___/___

Diabetes	YES	NO	Use Insulin	YES	NO
Heart Disease	YES	NO	High Blood Pressure	YES	NO
Asthma	YES	NO	Heat Related Problems	YES	NO

Other: _____

I **am currently receiving outpatient physical therapy**: YES NO

If yes, is child receiving physical therapy at a Shirley Ryan AbilityLab location? YES NO

I give permission to the Shirley Ryan AbilityLab, Adaptive Sports and Fitness Program and or representatives from local competing organizing committees and /or local sport team representatives, to seek medical care on my behalf in the event of an emergency for the above person.

_____ Date: ____/____/____

Signature of participant, or parent/guardian if under 18 years of age

Shirley Ryan Abilitylab

Caring For Kids

THIS SIDE TO BE COMPLETED BY PHYSICIAN

Participant's Name: _____

Diagnosis: (List all) _____

List Impairments: (eg: Hemiparesis, etc…) _____

_____

Sex: M F Height: _____ Weight: _____ Pulse: _____ BP: _____

Physical Exam	**Normal**	**Abnormal**	**Explanation of abnormalities**
Head/Neck	_____	_____	_____
Eyes/Vision	_____	_____	_____
Ears/Hearing	_____	_____	_____
Heart/Lungs	_____	_____	_____
G.U.	_____	_____	_____
C.N.S.	_____	_____	_____
Skin	_____	_____	_____

Orthopedic Exam

ROM Loss/Contractures: _____

Joint Laxity/Instability: _____

Other: _____

Is patient weight bearing? YES NO

Dates of hospitalization in past two years with admitting diagnosis: _____

_____

Significant "ABNORMAL TEST" (EKG/X-Ray/Lab/DEXA): _____

APPROVAL FOR PARTICIPATION: YES NO

Comments/Restrictions: _____

_____

Physician Name: (Print) _____Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____/_____/_____

Mail Completed Form To:
Shirley Ryan AbilityLab Caring for Kids Program
ATTN Ashley Gruenwald, 18th Floor
355 East Erie St., Chicago, IL 60611

OR

Fax Completed Form to: 312-238-1025

Call 312-238-5005 with questions

Last revised 3-16-17

Seizure Information Sheet

Child's name: _____ Age: _____

Type of Seizure(s): _____

Typical Seizure looks like: _____
_____

Are there any conditions that seem to trigger a seizure? _____

Does your child have any warning signs? _____

Typical seizure lasts for: _____

Frequency of seizures: _____

Last known seizure: _____

How child acts after seizure ends: _____

Usual time before he or she is back to normal: _____

Does your child need to take any medication during a seizure (ex: rectal valium, VNS)?
_____

How to administer medication: _____

Anything child is not allowed to do after a seizure? _____
_____

If your child has a seizure, the following should be done: _____
_____

Parent(s) telephone number(s): _____

If parent(s) cannot be reached, call: _____

Do you have a specific hospital or rescue squad? _____

Doctor's name: _____ Phone number: _____

Other information RIC should know: _____
_____

Shirley Ryan Abilitylab

Caring For Kids

INSURANCE WAIVER AND RELEASE OF LIABILITY TO PARTICIPATE IN SHIRLEY RYAN ABILITYLAB CARING FOR KIDS PROGRAM

In consideration of being allowed to participate in any way in the Shirley Ryan AbilityLab programs, related events, and activities, including but not limited to Caring for Kids, I and/or the minor participant identified below and next of kin, as set forth below:

1. Agree that prior to participating, I will inspect, or if a parent and/or legal guardian, I will instruct the minor participant to inspect, the facilities and equipment to be used, and if I believe to the best of my ability that anything is unsafe, I and/or the minor participant will immediately advise the RIC of such condition(s) and refuse to participate.

2. Acknowledge and fully understand that I and/or the minor participant will be engaging in activities that involve risk of serious injury, including permanent disability and death, and severe social and economic losses which might result only from my own actions, inactions or negligence of others, the rules of play, the condition of the premises or any equipment used. Further, I acknowledge and fully understand that there may be other risks not known to me or not reasonably foreseeable at this time.

3. Assume all of the foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.

4. Release, waive, discharge and covenant not to sue the Shirley Ryan AbilityLab, its officers, directors, employees, agents, coaches, affiliated clubs, representative administrators, and other employees or agents of Shirley Ryan AbilityLab or affiliated organization, other participants, sponsoring agencies, sponsors, advertisers, heirs, and if applicable, owners and lessors of the premises used to conduct the event (all of which are hereinafter referred to as the "Released") from demands, losses or damages on account if injury, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of any of the Released used to conduct the event or otherwise.

I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND HAVE SIGNED THIS RELEASE VOLUNTARILY

_____	_____	_____
PARTICIPANT'S NAME (print)	SIGNATURE	DATE

FOR PARTICIPANTS OF MINORITY AGE

This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided above of the Released and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Released from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASED.

_____	_____	_____
1st PARENT/GUARDIAN NAME	SIGNATURE	DATE
_____	_____	_____
2ND PARENT/GUARDIAN NAME	SIGNATURE	DATE

Consent to Photograph/Record and Provide
Health and Treatment Information

Patient's First and Last Name ("Patient") Medical Record # (where applicable)

Phone Number E-mail Address

I permit the Shirley Ryan AbilityLab, its contractors, and agents ("Shirley Ryan AbilityLab") to take, use, and release photographs, video, other recordings of the Patient ("Images") named above. The Images may be taken, used, and released in the interest of medical science, research, education, donor relations or general public relations for the Shirley Ryan AbilityLab, or any such other related purposes as it decides is appropriate, without limitation as to the time or date of use. This includes, but is not limited to, making the Images available through broadcast programming, marketing materials and/or website postings, including postings to social media websites such as Facebook or Twitter.

In connection with the use of the Images, the Shirley Ryan AbilityLab may disclose the Patient's name or other identifying information, and also may disclose information about the Patient's health, such as the Patient's health information, medical condition, and medical or professional treatment, as it deems appropriate, in connection with the use of the Images. The disclosures may be in writing, by e-mail or other electronic method, or in another manner. I can ask to inspect a copy of the Patient health information released under this consent.

Additionally, the Shirley Ryan AbilityLab respects the privacy of its patients, visitors and staff. Patients, visitors, participants, or Shirley Ryan AbilityLab staff cannot be photographed or recorded without their consent.

By signing below, I understand that I am providing formal written consent to the Shirley Ryan AbilityLab as set out above. This consent lasts for 75 years, but I can take it back ("revoke it") in writing. I can ask the Shirley Ryan AbilityLab to stop taking Images, or I can revoke this consent, by requesting it within a reasonable amount of time prior to use of the Images. I will send any such request in writing to Privacy Officer, Shirley Ryan AbilityLab, 355 E. Erie Street, Chicago, Illinois 60611 or by e-mail to privacyofficer@ric.org.

I understand I am not required to sign this consent, and that the Shirley Ryan AbilityLab will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign it. I understand that health information disclosed under this consent may be re-disclosed by the recipient to others who may not be required to protect it under the Privacy Rule or other applicable law. I acknowledge receiving a copy of this form.

Signature of Patient or Legally Authorized Representative Date
(If legally authorized representative, also list relationship to Patient)

ORIGINAL *- to RIC File* ***COPY*** *– to Patient/Legally Authorized Representative*