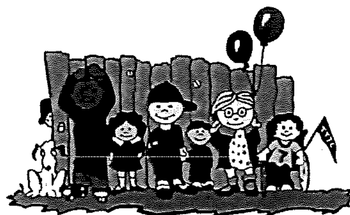

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Personal Record

Child's Name: ____

Nickname ____________________ DOB ____________ M _____ F _____

Parent(s)/ Guardian ____

Names of others living in household (siblings, grandparents, stepparents, pets, etc.)

Name	Relationship	Name	Relationship

Child's previous preschool or childcare experience ______________________________

Name of Preschool ____________________________ Date: ____________________

How did you hear about us? ____

Has your child ever received therapeutic services? OT___ ST___ PT___ BIT___ Counseling ____

If so, what services? ____________________ Where? ____________________

Does s/he have a diagnosis? If so, what? ____________________________________

What are your child's favorite activities? ______________________________

How do you comfort your child? ____

Your child communicates his/her needs by: Check all that apply

_____ Uses speech _____ uses gestures _____ uses body language

_____ other (please specify) ____________________________________

Does your child have any issues with the following? Please check all that apply

Eating behaviors Food restrictions Sleep Toileting Fears Security items Behavior

Allergies Sensitivities to light Sensitivities to sound Sensitivities to texture/touch

Please explain: ____

Does your child have any special health issues that the staff needs to be aware of _____Y ____N

Please list issues? Please list: ____

Does your child require a health care plan? _____ Y _______ N

Are there any topics you are interested in learning about for our parent education night? Do you prefer daytime or evening? ____

______________________________ ______________________

Parent/Guardian Signature Date

Please feel free to share any additional information on the back of this page.

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Statement of Responsibility

Name of Child_________________________________ DOB __________________

Please initial your acceptance of each statement.

_____1. I agree to have my child examined annually by a properly registered physician or as recommended by TLC Learning Center and provide to the TLC the proper documentation of the examination.

_____2. I agree to provide TLC with a copy of my child's current immunizations.

_____3. Parents/Guardians are requested to keep their child home when ill. When, in the opinion of TLC staff, the child is too ill to benefit from programming, the parents/guardians will be contacted. I agree to make arrangements for my child to be taken home.

_____4. It is frequently desirable to take the students to see interesting neighborhood events or to observe seasonal changes. I am willing to allow my child to join his/her class for these excursions that are within walking distance of the school.

_____5. I give permission for TLC Learning Center (and any person or company authorized by the Center) to use and copyright all photographs, film, video, and/or recordings taken by this student by the TLC staff (or their representatives) and understand that TLC Learning Center may use reproductions, alterations or additions to them.

_______ **I authorize my child's photo/video to possibly be used in the following external publications: marketing materials, newsletters, website, Facebook, event invites/posters.**

_______ **I authorize my child's photo/video to only be used in TLC event publications including slide shows at the annual fundraising events.**

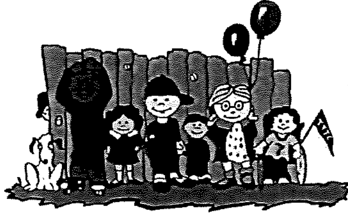
_______ **I authorize my child's photo/video to only be used internally at TLC including graduation and holiday slideshows and information TV in office.**

_____6. I give permission for my child's photo/video to be kept on file at TLC Learning Center and used for public awareness and fundraising needs after my child is no longer enrolled in the TLC Learning Center program.

Upon signing the statement of responsibility form, I have agreed to the above statements as indicated and can, at any time, question and rescind my permission should I feel in any way that TLC personnel have not complied completely in the most professional and discreet manner.

____ ____________________

Parent/Guardian Signature Date



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Release of Liability

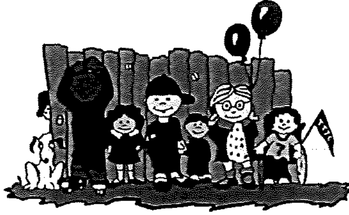
Name of child ___________________________________

DOB ____

It is understood that due care and concern to the welfare of my child will be provided by the director and staff of TLC Learning Center. It is agreed, however, that in any case of accident, injury or illness of my child, the officers, director, employees and volunteer staff of TLC Learning Center will not be held responsible. It is agreed that the officers, director, employees and volunteers shall not be held liable for any injury to my child during the periods in which he or she is under the care of TLC Learning Center staff or volunteers.

This agreement will expire one year from the date of my signature.

______________________________	________________________	____________
Parent/Guardian Signature	Relationship to Client	Date



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School Directory

Dear Parents,

Information used on this form will be published in a school directory. Please fill out and return to the office. If you do not wish to have your information in the directory please indicate that preference, and return to the form to the office.

Child's name:____

Child's address:____

Home phone:____

Parent Name (#1): ____

Cell phone:____

Address:____

Parent Name (#2): ____

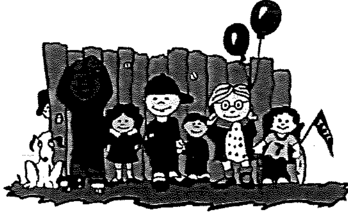
Cell phone:____

Address:____

_____ I/we do not wish to have my/our information included in the school directory.

______________________________ Parent signature

______________ Date



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Emergency Contact Form

Child's name______________________________ Date of Birth________________

Parent's name:____________________ Primary phone number:________________

Cell phone number:______________________ Other number:________________
Address:_________________________City:_____________ State, Zip__________

Parent's name:____________________ Primary phone number:________________
Cell phone number:______________________ Other number:________________
Address:_________________________City:_____________ State, Zip:__________

Emergency contacts/ Persons child may be released to:
Name:______________________________ Primary number:______________
Address:_________________________City:_____________State, Zip:__________

Name:______________________________ Primary number:______________
Address:_________________________City:_____________State, Zip:__________

Name:______________________________ Primary number:______________
Address:_________________________City:_____________State, Zip:__________

Physician's name:________________________ Phone number:______________
Physician's address:______________________City:_____________State, Zip:______
Preferred hospital in case of emergency:_________________________________

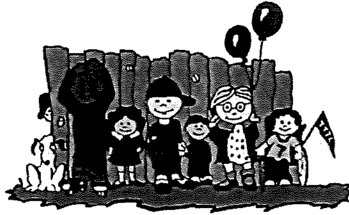
Dentist's name:_________________________ Phone number:______________
Dentist's address:_______________________ City:__________ State, Zip:________

Medical concerns: Allergies Seizures Asthma Diabetes Other

Please explain:____
____
____
____

I authorize any staff member at TLC Learning Center to administer emergency medical care, including first aid or CPR. I authorize TLC Learning Center to call 911 if deemed necessary by a TLC Learning Center staff member. I authorize TLC Learning Center staff members, as well as medical personnel, to transport my child to the nearest hospital. I release TLC Learning Center of all liability regarding these decisions.

______________________________________ ________________
Parent Signature Date



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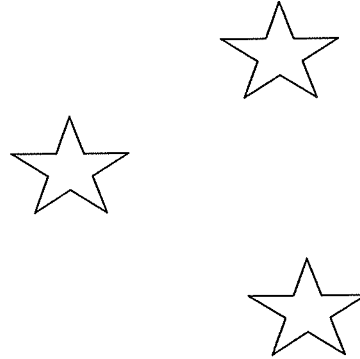
What To Bring to School

All Preschool Classrooms:

Water bottle
Extra set of clothes
Outside shoes
Seasonal hat
Sun block
Outdoor wear as appropriate for the weather daily
Diapers and baby wipes (if applicable)
Family photo(s)



Full Day Preschool Only

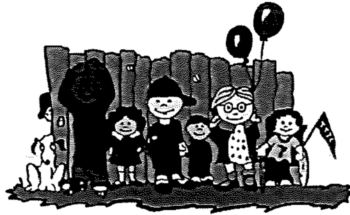
Crib sheet and nap blanket (Please wash 1x/week)
Canvas bag for naptime belongings
Packed lunch with ice pack and utensils if necessary (for information about preschool lunches, see http://www.choosemyplate.gov/preschoolers/HealthyEatingForPreschoolers-MiniPoster.pdf

Infant & Toddler Program:

Water bottle
2-3 extra sets of clothes
Seasonal hat
Sun block
Outdoor wear as appropriate for the weather daily
Bottles and formula/ breast milk daily, as appropriate (3 bottles per day)
Breakfast and/or lunch, as appropriate
Diapers and wipes (Please refill as needed.)

Please be sure to label ALL of your child's belongings! Please leave toys, candy, soda, plastic bags, and small items (choking hazards) at home. *Thank you.*

**** We are a nut-free facility!**
Please read all labels and make sure item was not made in a facility with nuts. **



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EARLY CHILDHOOD SERVICES

PERMISSION FORM

In its desire to provide high quality care for children, your preschool partners with Kid Connects, a program of the Early Childhood Services team at the Mental Health Center Serving Boulder and Broomfield Counties. Kid Connects provides early childhood consultation and health screenings to children in child care and preschools in Boulder and Broomfield Counties.

Our goals are to promote children's development, to support quality early care experiences, and to enhance relationships among children, parents and staff. The Kid Connects consultant provides support to staff as well as to the parents of young children. In addition, direct intervention services with families can be requested.

In our continuing efforts to improve our program and to renew our funding, we document the kinds of issues being addressed in each setting, such as child behavioral concerns. The consultant will ask parents and center staff to provide feedback on the consultation services on an annual basis.

Anything discussed between you, your child, the consultant, and staff is confidential, as protected by law. State and Federal laws indicate the following exceptions to the confidentiality policy: suspected child abuse and neglect, harm to self, or imminent harm to others.

By signing this form, I am informed that a consultant from the Early Childhood Services Team will be observing and interacting with my child in his/her preschool program. I also understand that the consultant and staff may exchange information about my child as outlined above. I acknowledge that the consultant will work with the staff in their efforts to understand and address my child's needs in the preschool program and that I can request consultation if I desire.

______________________ Name of Child	______________________ Child's Date of Birth
______________________ Parent/Guardian Signature	______________________ Parent/Guardian Phone #
______________________ Name of Child Care Center	______________________ Today's Date

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Certificate of Health

Child's name:____________________ Address:____

Phone:__________________________ Child's date of birth:___________________________________

Parent/Guardian name(s):____

Physician's name:_______________________ Physician's address:______________________________

Physician's phone:_____________________________

Hospital of choice:_____________________________ Hospital address:___________________________

Hospital phone:______________________________________

To be completed by Physician:

History: *Asthma* ___Yes ___No
*Diabetes*___Yes ___No
Seizures ___Yes ___No
Heart/ Respiratory: ___Yes ___No
*Allergies*___Yes ___ No Explain:____

If a health care plan for school is required for any of the above, please explain:__________________

____

Disease history:
Whooping cough (date):____________________
Rubella (date):___________________________
Mumps (date):____________________________
Measles (date): ___________________________
Other:___________________________________

Surgical history:
Tonsillectomy (date):________________
Adenoidectomy (date):________________
Appendectomy (date):________________
Mastoidectomy (date):________________
Tubes in ears (date):________________
Other: ______________________________

Height:________ Weight:_________

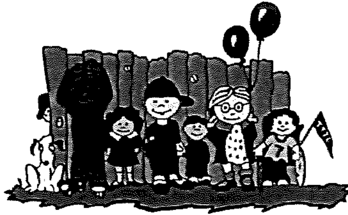
Are there any *restrictions* on normal physical activities indicated? ____ Yes ____ No
If yes, please specify:____

____

Does this child have any *chronic medical condition* necessitating dietary supplements, or restriction, medication, or avoidance of allergies? ___ Yes ____No
If yes, please specify:____

Are there any *handicapping conditions*? ___Yes ___No
If yes, please specify and indicate diagnosis if applicable:____

____



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Known *allergies or drug reactions*:______________________________
Special attention required for allergies/ reactions:__________________________

History of *seizures*? ___Yes ___No If yes, please describe:____________________

Is child *currently on medications*? ___ Yes ___ No
If yes, please list medication and its purpose:____________________________

*Hearing screening results:*______________________________________
*Vision screening results:*_______________________________________

The above named child is currently free of any infectious or contagious disease, and has my permission to attend school. This child is ___ up to date; ___ not up to date with immunizations. If not up to date, immunization can be made up in ____ months.

Physician comments:

Physician's name (print)	**Physician's signature**	**Date**

To be reviewed and signed by Parent/ Guardian:

1.A child who appears ill upon arrival shall not be permitted to stay at school.

2.When a child becomes ill at school, the parent/guardian shall be contacted and arrangements made for the child to be picked up as soon as possible. TLC Learning Center staff shall make this determination.

3. TLC Learning Center may require a physician's statement prior to readmitting your child to school following an illness.

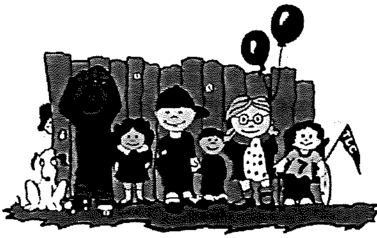
4. At the time of registration, the parent/ guardian shall authorize the child's physician to accept all calls from the Executive Director for emergency medical care.

5. I understand that, in the event of an emergency, it will be up to the emergency personnel to determine which hospital my child will be taken to (typically the nearest emergency room). If this is not my hospital of choice, the receiving hospital will be informed and will contact me for further instructions.

6. I understand that it is my responsibility, as parent/ guardian, to ensure that my child receives an updated physical appraisal from a physician, every twelve months.

____

Parent/ Guardian signature Date



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Volunteer Information Form

TLC Learning Center and the children benefit from parent volunteers. It is mandatory that each family volunteer 25 hours a year. Below is a list of volunteer opportunities that will be available.

Name: ______________________ Phone: ____________________

Email: ______________________

Address: ____

Child/ren Name(s): ____

Volunteer Opportunities

- Classroom help
- Fundraising (Christmas tree Festival etc.)
- Field Trip Assistance (Driving etc.)
- Snack Donations (String cheese, crackers, pretzels, popcorn, applesauce, canned fruit with pop top, chips & salsa)
- Outside Maintenance (Mowing, weeding, grooming etc.)
- TLC sign (Changing letters)
- Translating bilingual materials
- Small Building repairs
- Writing Thank you notes
- Recycling
- Onsite Fundraising (Bake sale, milk caps, boxtops etc.)
- Inside Maintenance (Laundry, sewing, organizing library)
- Organize Conference Meals
- Teacher Appreciation Week

Parent Signature: __________________________ Date: ____________

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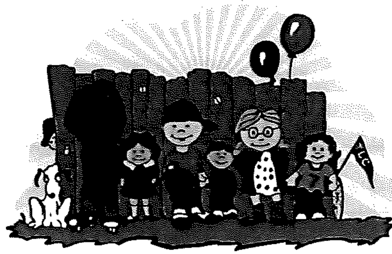
United Way
Foothills United Way

Office use: ES / TS



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Child Demographic Information

Please Complete One Form for Each Child & Return to TLC. Thank you!

TLC is a private 501c3 non-profit that serves children. We offer two key programs: an inclusive preschool and pediatric therapy. A necessary part of our fundraising activities is to gather demographic information that is anonymously reported to foundations that fund our programs. Funding from foundations is critical to TLC's ability to maintain high-quality programming for all children. We may need this information updated each year to have an accurate picture of our center's demographics. ***Information provided is kept entirely confidential.***

1. **Date of Form Completion:** _____/_____/_____

2. **Child's First Initial:** ________ **Child's Last Name:** ______________________ *(for tracking)*

3. **County of Residence** *(please circle one)*: Boulder Unincorporated Boulder County Broomfield

   Adams Gilpin Jefferson Larimer Weld Other____________________

4. **City of Residence:** ____________________________________

5. **Enrolled in** *(please mark all that apply)*: Preschool Half-Day _____ Preschool Full-Day _____
   Infant _____ Toddler _____ Occupational Therapy ____ Physical Therapy ____
   Speech Therapy____ Brain Integration Therapy _____

6. **Child's Therapy Need/s** *(please circle)*: Hearing impaired Visual impaired Motor Delay

   Mental/Cognitive Delay Physical Development Speech & Language Delay

   Sensory Integration Does not apply Other ____________________

7. **Pediatric Therapy Clients Appointments Held** *(please circle)*: Home (Early Intervention)

   Home (not EI) Hospital TLC (private) TLC (preschool)

8. **Gender:** Male ____ Female_____ **Child's Date of Birth:** _____/_____/_____ **Age:** _______

Please Continue on Other Side

Tiny Tim Learning Center is now TLC.

United Way
Foothills United Way

9. **Ethnicity** *(please circle one)*: Black/African American Asian/Pacific Islander White/Caucasian

Hispanic/Latino Native American/Alaska Native Mixed Race Unknown Other____________

10. **Language Spoken at home** ________________________________

11. **Number of persons living in your household** *(please include yourself, all children, and adults)*: _____

12. **Single parent home:** Yes ______ No _______

13. **Welfare:** Yes _____ No ______ **Workfare client:** Yes _____ No _____

14. **Immigrant/refugee/foreign born**: Yes ____ No_____

15. **Household Income:** *Please find the number of people in your household in the first column, and then **circle** the gross annual income that most closely fits your family in the appropriate column to the right. All information provided is kept confidential.*

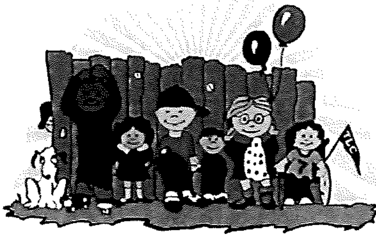
Size of Family	Annual income is equal to or less than:	Annual income falls between:	Annual income falls between:	Annual income falls between:	Annual income is equal to or greater than:
2	$23,100	$23,101 – $38,450	$38,451-$51,150	$51,151-$76,900	$76,901
3	$26,000	$26,001 - $43,250	$43,251-$57,550	$57,551-$86,500	$86,501
4	$28,850	$28,851-$48,050	$48,051-63,900	$63,901-$96,100	$96,101
5	$32,200	$31,201-$51,900	$51,901-69,050	$69,051-$103,800	$103,800
6	$33,500	$33,501-$55,720	$59,721-$74,150	$74,151-$111,500	$111,501
7	$35,800	$35,801-$59,600	$55,601-$79,250	$79,251-$119,200	$119,201
8 or more	$38,100	$38,101-$63,450	$63,451-$84,350	$84,351-$126,900	$126,901

16. **How did you hear about TLC Learning Center** *(please circle)*: Newspaper Facebook

Open House Google Ads Open House TLC Website Boulder County Kids

Referred by ________________________ Other ________________________

Authorization for Automated Payment



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Child's Name:___________________

I (we) hereby authorize The Tiny Tim Center (DBA TLC), to initiate debit Entries to my (our) ____Checking Account/_____Savings Account (select one) indicated below at the depository financial institution named below, hereafter called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Depository Bank Name:___________________ Branch:___________________

City:___________________ State:__________ Zip:___________

Routing Number:___________________

Account Number:___________________

This authorization is to remain in full force and effect until TLC Learning Center has received written notification from me (or either of us) of its termination in such time and in such manner as to afford TLC Learning Center and DEPOSITORY a reasonable opportunity to act on it.

Name:___________________ Name:___________________

Signature:________________ Signature:________________

Date:___________________ Date:___________________

Please indicate below the total amount to be debited to your account each month:

Item:	Amount:
☐ Current Monthly Tuition (See Parent agreement Form for any updated monthly tuition changes. Will include late Pick-up fees as incurred. See Parent Handbook)	___________________
☐ Monthly Giving Contribution to TLC	___________________
☐ Other	___________________
Total Amount to be billed monthly	___________________

Please attach a voided check with this authorization form.

Tiny Tim Learning Center is now TLC.

United Way
Foothills United Way

Authorization for Automated Payment

I authorize the Tiny Tim Center (DBA TLC) to charge my credit/debit card for the tuition and balance due payments as deemed to be parent responsibility by the Parent Handbook and Tuition Agreement.

I understand a tuition payment will be charged on the first of each month.

I understand that there is a processing fee of 2% for this method of payment and that this fee will be added to the tuition each month.

I understand that this authorization form is valid until I cancel the authorization through written notice to The Tiny Tim Center (DBA TLC).

I understand that it is my responsibility to notify The Tiny Tim Center (DBA TLC) of any credit card changes and/or expiration dates.

______________________________________ ____________________

Cardholder Signature Date

Child's Name:____

Email:____

Cardholder Name:____

Cardholder Address:____

City:______________________ State:__________ Zip Code:______________

Credit Card

Number:_______________________________________ Visa/MC/AMEX/DIS

Expiration Date:____________________ 3 Digit CVC code on back of card:________

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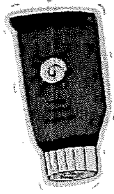


PARENT/GUARDIAN'S PERMISSION TO APPLY SUNSCREEN TO HIS/HER CHILD

Name of Child: ____

As the parent/guardian of the above child, I recognize that too much exposure to UV rays may increase my child's risk of getting skin cancer someday. We ask that all parents apply sunscreen to their child **before school every day**. I give permission for the staff at: **TLC Learning Center** to apply and re-apply a sunscreen product that is broad spectrum with SPF 15 or higher to my child, as specified below, when he/she will be playing outside.

I understand that sunscreen may be applied to exposed skin, including but not limited to the face (except eyelids), tops of ears, nose, bare shoulders, arms and legs.

I have *checked* and *initialed* below **all** applicable information regarding the child care program's choice in brand/type and use of sunscreen for my child:

____ **I agree to apply sunscreen to my child before school every day.**

____ I do not know of any allergies my child has to sunscreen.

____ My child is allergic to some sunscreens. Please use ONLY the following brand(s)/type(s) of sunscreen: ____

____ Staff may use the sunscreen of the program's choice following the directions and recommendations printed on the product container.

____ I have provided the following brand/type of sunscreen for use for my child: __________________

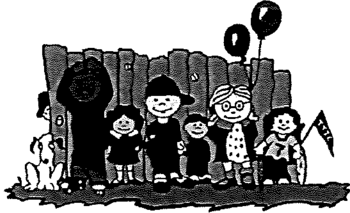
____

____ For medical or other reasons, please do NOT apply sunscreen to the following areas of my child's body: ____

Parent/Guardian's Name: ______________________________ **Date:** ____________

Parent/Guardian's Signature: ____

Health Care Provider's Signature (*optional*): ______________________________



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NOTE: DO NOT RELY ON SUNSCREEN ALONE TO PROTECT CHILDREN FROM SKIN CANCER!

Adapted from the *California Early Childhood Sun Protection Curriculum* (1998-Revised) from the Skin Cancer Protection Program, Cancer Prevention and Nutrition Section, California Department of Health Services.
• http://www.dhs.ca.gov/cpns/skin/skin_resources.html California Childcare Health Program (CCHP) 07/03 www.ucsfchildcarehealth.org

SUN-SMART POLICY FOR CHILD CARE PROGRAMS

Our Sun-Smart policy has been developed to ensure that all children and staff participating in this program are protected from skin damage caused by the harmful UVB and UVA rays of the sun. This policy will be implemented throughout the year, but with particular emphasis from March through October.

□**Sun-Smart strategies**:

1. Encourage staff & children to wear hats with wide brims that protect face, neck and ears when they are outside.
2. Encourage staff and children to wear sun-protective clothing (i.e., tightly woven, loose-fitting, full length, light colored and light-weight) when temperatures are reasonable.
3. Encourage staff to wear sunglasses that block 100% of UVA and UVB rays (broad spectrum) when outside.
4. Provide sufficient areas of shelter and/or trees providing shade on the play yard.
5. Encourage children to seek and use available areas of shade for outdoor play activities.
6. Schedule excursions and all outdoor activities *before* 10 a.m. and *after* 4 p.m. (10 a.m. to 3 p.m. during the winter months) whenever possible. The availability of shade will be considered when planning excursions and outdoor activities during these times.
7. Children will be hydrated and encouraged to drink water before and during prolonged physical outdoor activities in warm weather.
8. Staff and parents/guardians will model sun safety behaviors by:
    □□□□Wearing appropriate hats and clothing when outdoors.
    □□□□Using broad spectrum SPF 15 or higher sunscreen for skin protection.
    □□□Seeking shade whenever possible.
9. Provide broad spectrum SPF 15 or higher (and *paba* and *alcohol* free, if possible) sunscreen for staff and children to use on exposed skin, except eyelids, 30 minutes before exposure to the sun and every two hours while in the sun, unless parent/guardian provides their own sunscreen for their child.
10. Parents/guardians will complete and sign the *Parent/Guardian's Permission to Apply Sunscreen to His/Her Child* (see reverse) and it shall remain on file at the program.
11. Include learning about the skin and ways to protect the skin from the UV rays of the sun into the program's curriculum and daily routines.
12. The *Sun-Smart Policy* will be reinforced in positive ways through parent newsletters, staff memos, bulletin boards and meetings. Signage shall be posted that reminds staff, parents and children to practice sun safety.
13. Staff and parents will be provided with educational materials and resources on sun safety and protection.

When enrolling their child, parents/guardians will be:

1. Informed of the program's *Sun-Smart Policy*.
2. Asked to provide a suitable hat for their child's use when outdoors in the care setting.
3. Required to provide permission for staff to apply sunscreen (and *optional*: health care provider's signature included on consent form).
4. Asked to provide a broad spectrum SPF15 or higher sunscreen if child is allergic to the program's offered brand.
5. Encouraged to practice *Sun-Smart* behaviors themselves.

RECOMMENDED STANDARD/OPTIONAL: Every child should have on file a standing order from their health care provider for the use of sunscreen (nonprescription medication) in the care setting, in addition to the parental consent to have sunscreen applied[1].

California Childcare Health Program (CCHP) www.ucsfchildcarehealth.org 07/03

[1] American Academy of Pediatrics and American Public Health Association, (2002). *Caring for our children: National health and safety standards: Guidelines for out-of-home child care programs*, Second Edition. Elk Grove Village, IL.

TLC Learning Center

611 Korte Parkway • Longmont CO 80501 • Phone (303) 776-7417 • www.LearningWithTLC.org

Health Insurance Information

Child's Name:____

Date:____

Parent/Guardian Name(s):

____

____

______I/ we agree to provide health insurance information regarding our child
(Copy of insurance card is attached)

Insurance company:______________________________________

Group number:______________________________________

Policy/ID number:______________________________________

______I/we do not agree to provide health insurance information regarding our child.

____

Signature of parent or guardian Date

Registration Form

About the Young Athlete (Participating Child):

Athlete's Name ____
(Last/Family) (First/Given)

Address:___________________________________ **City:**____________________

State/Province:__________________ **Postal Code/Zip Code**_____________

Gender: ☐Male ☐Female **Birth Date:** Month_________ Day_________ Year_________

Ethnicity: ☐**Caucasian** ☐**Hispanic/Latino** ☐**African American** ☐**Asian** ☐**Other** ______________

My Young Athlete has special health information noted below: (Please check all that apply)

Heart Condition ☐ Yes ☐ No
Diabetic ☐ Yes ☐ No
Epileptic/Seizures ☐ Yes ☐ No
Down Syndrome ☐ Yes ☐ No If Yes ----------→ Clear AAI ☐ Yes ☐ No
Autism ☐ Yes ☐ No
Other: ______________________________

Visually Impaired ☐ Yes ☐ No
Hearing Impaired ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Developmental Delay ☐ Yes ☐ No
Allergies: ______________________________

About the Parents / Guardians:

Parent or Guardian Name: ______________________________________
(Last/Family) (First/Given)

Phone: _________________________ **Email :** _________________________

What is your relationship to the participant you are registering? ________________

Would you like to receive follow up information on how to get your child more involved in future Special Olympics Colorado youth programs? ☐ **YES** ☐ **NO**

MUST PROVIDE EMAIL ADDRESS FOR FOLLOW UP INFORMATION!!!

Program Information (To Be Completed By Site Coordinator/YAP Coach/Teacher)

A program may have multiple sites. Site is defined as the specific location of the Young Athletes™ activities. The Young Athletes™ site this child will attend is (Select one of the following).

☐ A preschool/kindergarten classroom site

(Please specify school name): TLC Learning Center

Does this Young Athlete receive or qualify for Special Education Services?

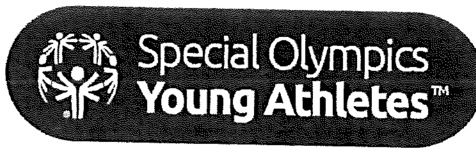
☐ Yes ☐ No

☐ A SOCO local program:
(Please specify local program): ______________________________

Date of Young Athletes™ Participant Release Form: Month _______ **Day** ________ **Year** _______
(Enter date of submission of the completed Participant Release Form which contains a release to be signed by a parent/guardian of a minor participant, medical matters and permissions for publicity).

Agency Site Coordinator/YAP Coach Signature: ______________________________

Please Turn Over for Page 2 →



Registration Form

Young Athletes Release Form

TO BE COMPLETED BY PARENT OR GUARDIAN OF MINOR ATHLETE

I am the parent/guardian of (child's name) ______________________________, the minor participant, on whose behalf I have submitted the attached application for participation in the Special Olympics Young Athlete™ Program. The participant has my permission to participate in Special Olympics activities. I further represent and warrant that to the best of my knowledge and belief, the participant is physically and mentally able to participate in Special Olympics.

If a medical emergency should arise during the participant's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the participant's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the participant is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the participant's health and well-being. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CONTACT SPECIAL OLYMPICS COLORADO - YOUNG ATHLETES™ PROGRAM MANAGER).**

In permitting my child to participate, I understand that group data collected from the Young Athletes™ Program will be used to plan, evaluate, and improve the program.

I specifically grant my permission to Special Olympics to use the participant's likeness, voice and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

❐ YES ❐ NO

I am the parent (guardian) of the participant named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the participant. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the participant named above. I hereby give my permission for the participant named above to participate in Special Olympics games, recreation programs, and physical activity programs.

____
Signature of Parent/Guardian

____
Date

____
Print Name

Original parent/guardian signature is required by the office of Special Olympics Colorado. Faxed signatures will not be accepted.

Special Olympics
Colorado

384 Inverness Parkway, Suite 100, Englewood, CO 80112 Tel 720 359 3100 Fax 303 592 1364
www.SpecialOlympicsCO.org
Created by the Joseph P. Kennedy Jr. Foundation for the benefit of persons with intellectual disabilities