

Cardinal Cushing Centers

Enrichment Program

Please complete this form and return with payment to: Cardinal Cushing Centers
405 Washington St.
Hanover, Ma 02339
Attn. Community Enrichment Program

General Information

Participant Name _____

Parent/Guardian _____

Address _____

City, State, Zip _____

Home Phone _____ Cell or Business Phone _____

Email Address _____

Date of Birth _____ Age _____ M ___ F ___

Hair color: _____ Eye color _____

School Attending _____

School Address _____

School City, State, Zip _____

Name of person responsible for transportation _____

Address if different than Parent/Guardian information listed above :

Phone number where this person can be reached during the time student is in program:

Health History:

Disability/Diagnosis: _____

Other Health conditions: _____

Allergies: Yes No

If yes, please describe: _____

Will child be carrying an Epi Pen: Yes No

Asthma: Yes No

If yes describe triggers: _____

Will child be carrying an inhaler: Yes No

Visually Impaired: Yes No

If yes, please describe: _____

Hearing Impaired: Yes No

Toilet trained? Yes No

Menstruating? Yes No

If yes, please describe assistance needed if any: _____

General and Behavioral Information

Please provide any behavioral problems your child has:

How does your child communicate his or her needs or wants?

Is your child able to follow multiple step directions?

What does the child like to do? What motivates the child?

What are your goals for your child while participating in the Cardinal Cushing Centers Community Enrichment Program?

What are your social goals for your child?

Please provide any additional information that would benefit our instructors on how to make this activity meaningful for your child:_____

Parent/Guardian Permission and Release

I hereby give my permission for _____ to participate in the Cardinal Cushing Centers Enrichment Program. In the event that my child should for any reason require any minor medical or emergency treatment and/or medication during the course of the activity, I authorize such physician or emergency care to carry out the necessary treatment or to take my child to the emergency room of the nearest hospital and I further authorize the hospital and its medical staff to provide the treatment deemed necessary.

I, the undersigned, am the parent/guardian of the above specified individual. I have read and fully understand the provision of the above releases. I hereby agree on behalf of my child to hold harmless Cardinal Cushing Centers, the attending physicians and any and all persons concerned in connection with any liabilities arising out of attending the said activity and any liabilities out of treatment rendered.

Parent/Guardian

date

Private Insurance or Medicaid: _____

Policy #: _____

Please note: All participants who have not attended a Cardinal Cushing Centers Enrichment program must attend an assessment appointment with the program coordinator. Please call for an appointment. Credits will not be issued for dismissal due to a child's uncontrollable behavior. Cardinal Cushing Centers reserves the right to terminate a child participation in any program due to behavior that becomes a threat to their health and safety of themselves or that of other children or staff.