

 **Project Sunshine**  
**SHSU Participation Application**

Child's First Name:	Child's Last Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Address:		
City:	State	ZIP:
Date of Birth:	Grade in School:	

**Parent/Guardian Information**

Mother's Name (First, Last):		
Cell Phone:	Home Phone:	Work Phone:
Father's Name (First, Last):		
Cell Phone:	Home Phone:	Work Phone:

**Emergency Contact Information**

Name (First, Last):		Relationship:
Cell Phone:	Home Phone:	Work Phone:
Name (First, Last):		Relationship:
Cell Phone:	Home Phone:	Work Phone:

**Medical Information**

Primary Care Physician Name:	Phone Number:
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Please list any allergies		
Foods:	Medications:	Other:

Is there anything that you feel is important for us to know about caring for your child? Please be specific.

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# **Project Sunshine** **SHSU Participation Application**

I understand and certify that my child's participation in Sam Houston State University's (SHSU) Project Sunshine and its programs/activities is completely voluntary. I have familiarized myself with SHSU's Project Sunshine programs/activities in which my child will be participating. I recognize that certain hazards and dangers are inherent in these programs/activities which may include, but not limited to, the activities of various sports. I acknowledge that although SHSU's Project Sunshine has taken safety measures to minimize the risk of injury to program/activity participants, and SHSU's Project Sunshine cannot ensure or guarantee that the participants, equipment, premises, or activities will be free of hazards, accidents, or injuries. I recognize the importance of knowing and abiding by the rules, regulations, and procedures for SHSU's Project Sunshine at any event in which my child is participating. Further, my child has received approval from a doctor authorizing my child to participate in SHSU's Project Sunshine program/activities. I also agree to inform SHSU's Project Sunshine of any programs and/or activities in which I may not participate. I acknowledge, understand, and agree that SHSU's Project Sunshine may use or disclose my child's personal health information, as disclosed in this application, in connection with certain situations and events without additional consent or authorization including, but not limited to, the disclosure of such personal health information to medical personnel in an emergency.

Child's Name (printed): \_\_\_\_\_

Parent's/Guardian's Name (printed): \_\_\_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please initial the following:

YES	NO	
		In the event that I or my child's primary care physician cannot be contacted in an emergency, I hereby grant SHSU Project Sunshine permission to bring my child to a hospital emergency room.
		I will remain financially responsible for any incurred expenses and shall indemnify fully SHSU Project Sunshine volunteers.
		Permission is hereby granted for Project Sunshine to take photographs, audio, or audiovisual recordings of my child to be used in promotional, educational, and fundraising materials including, but not limited to, Project Sunshine's website, videotapes, and brochures. I hereby irrevocably consent to and authorize the reproduction, publication, and/or sale by Project Sunshine of the photographs or artwork in any medium for lawful purposes including, but not limited to, illustration, promotion, or advertising without any further compensation to me. I waive any rights to notice the approval of any use of the photographs or artwork by Project Sunshine.

Parent's/Guardian's Name (printed): \_\_\_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

THIS FORM WILL BE PUT INTO YOUR CHILD'S PROJECT SUNSHINE FILE TO HELP US BETTER SERVE YOUR CHILD.  
 PLEASE COMPLETE **ENTIRELY** – CHECK ALL APPLICABLE BOXES AND WRITE "N/A" WHEN NOT APPLICABLE.  
 IT IS YOUR RESPONSIBILITY TO UPDATE THIS FORM AS NEEDED. THANK YOU!

**General Information**  
 Full Name \_\_\_\_\_  
 Chronological Age \_\_\_\_\_  
 My child acts like a/n \_\_\_\_\_ year old.  
 Approximate Weight \_\_\_\_\_ Approximate Height \_\_\_\_\_

**Allergies**  Yes (list below)  No  
 Foods: \_\_\_\_\_  
 Medications: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Ambulation**  Walks Assisted  Walks Unassisted  
 Walks Using:  Walker  Crutches  Braces  
 Wheelchair:  Manual  Electric  
 Transfers:  Alone  Needs assistance

**Communication**  
 No Problems  Non-Verbal  Sign Language  
 Limited abilities but can communicate daily needs  
 Communication Device: \_\_\_\_\_

**Vision**  
 Normal  Deaf  Hard of Hearing  Hearing Aids

**Toileting**  
 Toilet Trained  Training Pants  Wears Diapers  
 Bring to bathroom every \_\_\_\_\_ hours  
 Needs help with \_\_\_\_\_  
 Caths every \_\_\_\_\_ hours. Self-cath?  Yes  No

**Additional Equipment**  
 None  Nebulizer  Tracheotomy Tube  
 Monitors  Oxygen  Ventilator  
 Other: \_\_\_\_\_

**Seizures**  
 None  One or two as a small child  
 Type: \_\_\_\_\_  
 Last one: \_\_\_\_\_  
 Usual Frequency: \_\_\_\_\_  
 Usual Duration: \_\_\_\_\_  
 Pre-Seizure Activity: \_\_\_\_\_  
 Triggered by: \_\_\_\_\_  
 \_\_\_\_\_

**Chief Diagnosis** (List all – e.g. Seizures, Asthma, MR, CP, ADHD)  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_  
 5. \_\_\_\_\_

**Behavior**  
 No Problems  
 Problems Triggered by: \_\_\_\_\_  
 \_\_\_\_\_  
 Positive Reinforces: \_\_\_\_\_  
 Discipline:  Withhold Privileges  
 Time Out ( \_\_\_\_\_ minutes)  
 Other: \_\_\_\_\_

**Eating/Diet**  
 Regular Diet  No Help Needed  
 Food must be:  Cut  Chopped  Mashed  Pureed  
 Child must be totally fed.  
 Special Utensils: \_\_\_\_\_  
 G-tube  Dentures  Tongue Thrust  
 Special Diet: \_\_\_\_\_  
 Needs Help Only With: \_\_\_\_\_  
 Favorite Foods: \_\_\_\_\_

**Activities**  
 Does child have PE tubes in ears?  Yes  No  
 Heat Tolerance:  Good  Fair  Poor  
 Wanders?  Yes  No  
 Restrictions: \_\_\_\_\_  
 \_\_\_\_\_

**Additional Instructions/Precautions/Explanations**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I, \_\_\_\_\_, understand that my child, \_\_\_\_\_, may not participate in Project Sunshine events until his/her application is completely filled out. I understand that it is my responsibility as the parent/guardian to update my child's application as needed. All information submitted to Project Sunshine will be kept confidential among Project Sunshine staff.

Parent/Guardian Printed Name \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL INFORMATION & RELEASE FORM

\_\_\_\_\_  
 Child's Name (Print full name)

In reference to the above individual participating in Project Sunshine programs/activities, I grant permission to the staff of Project Sunshine, Sam Houston State University, to exercise the following:

To administer any therapy that would be indicated and available for prevention and/or treatment of any medical problems including, but not limited to, necessary steps for prevention and/or cessation of seizures, depending on each case as indicated by the child's guardian (as indicated and signed below).

In cases of emergency, to perform and provide access to medical and surgical emergency services, that may include transport to a medical facility off the premises of the current program/activity, as determined by the staff of Project Sunshine.

I understand that my child's participation in Project Sunshine programs/activities is voluntary. I also agree that in the event of any injuries to my child from his/her participation in any Project Sunshine activities, I will not hold responsible Project Sunshine, Sam Houston State University, any Project Sunshine agents (including, but not limited to, owners of property upon which events take place) and/or any volunteer, Project Sunshine or otherwise, who participates as staff for these injuries. My signature below acknowledges my voluntary authorization for my child's participation in any and all programs/activities of Project Sunshine. By signing this form, I understand and consent to all of the above.

\_\_\_\_\_  
 Initials

\_\_\_\_\_  
 Child's Name, printed

\_\_\_\_\_  
 Parent/Guardian Name, printed

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent/Guardian Signature

**Please provide the following medical information. All information will be treated confidentially.**

Current diagnoses and/or problems:

Current medications (prescription and over-the-counter):

History of any allergies and/or adverse reactions?

	Cause	Response
Medication		
Food		
Environment		

Date of last negative PPD (skin test for TB): \_\_\_\_\_ or Date of last negative chest x-ray: \_\_\_\_\_

History of varicella (chicken pox)?  yes  no      Date of last tetanus booster: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

# AUTHORIZATION TO BE PHOTOGRAPHED

## Full Consent

I do \_\_\_/ do not \_\_ give Project Sunshine the right to take photographs, audio or audiovisual recordings of my child to be used in promotional, educational, or fundraising materials including, but not limited to videotapes, pamphlets and brochures. I understand my child's name may be used in connection with these materials. By signing this media release, I intend to legally bind my child. Project Sunshine shall have the right to use photographs and other images of my child in promotion, educational or fund-raising materials. I acknowledge that Project Sunshine shall have rights of copyright in and to such photographs and videotapes and may use such copyright fully. I also hereby release Project Sunshine and its officers, agents, and volunteers from all liability connected with the taking and use of these materials as is authorized by Project Sunshine. In addition, I waive all rights, interest or claims for payment in connection with any exhibition or release of this material. This consent is voluntary, and I give it in the interest of public information, education, the furtherance of the goals of these institutions, or other lawful purposes. I acknowledge that I have legal authority to sign this form on behalf of the name mentioned above.

Initials\_\_\_\_\_

\_\_\_\_\_  
Child's Name, printed

\_\_\_\_\_  
Parent's/Guardian's Name, printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's/Guardian's Signature

## PARTICIPATION CONSENT

I understand and certify that my child's participation in Project Sunshine and its programs/activities is completely voluntary. I have familiarized myself with Project Sunshine programs/activities' in which my child will be participating. I recognize that certain hazards and dangers are inherent in these programs/activities, which may include, but not limited to, the activities of various sports. I acknowledge that although Project Sunshine has taken safety measures to minimize the risk of injury to program/activity participants, and Project Sunshine cannot insure or guarantee that the participants, equipment, premises or activities will be free of hazards, accidents or injuries. I recognize the importance of knowing and abiding by the rules, regulations, and procedures for Project Sunshine programs/activities at any event in which my child is participating. Further, my child has received approval from a doctor authorizing me to participate in the Project Sunshine programs/activities. I also agree to inform Project Sunshine officers and/or volunteers of any programs and/or activities in which I may not participate.

Initials\_\_\_\_\_

\_\_\_\_\_  
Child's Name, printed

\_\_\_\_\_  
Parent's/Guardian's Name, printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's/Guardian's Signature