

 **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:	E-mail:	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.

Project Sunshine

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!

<p>General Information Full Name _____ Chronological Age _____ My child acts like a/n _____ year old. Approximate Weight _____ Approximate Height _____</p> <p>Allergies <input type="checkbox"/> Yes (list below) <input type="checkbox"/> No Foods: _____ Medications: _____ Other: _____</p> <p>Ambulation <input type="checkbox"/> Walks Assisted <input type="checkbox"/> Walks Unassisted <input type="checkbox"/> Walks Using: <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Braces <input type="checkbox"/> Wheelchair: <input type="checkbox"/> Manual <input type="checkbox"/> Electric <input type="checkbox"/> Transfers: <input type="checkbox"/> Alone <input type="checkbox"/> Needs assistance</p> <p>Communication <input type="checkbox"/> No Problems <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Sign Language <input type="checkbox"/> Limited abilities but can communicate daily needs <input type="checkbox"/> Communication Device: _____</p> <p>Hearing <input type="checkbox"/> Normal <input type="checkbox"/> Deaf <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Hearing Aids</p> <p>Vision <input type="checkbox"/> Normal <input type="checkbox"/> Partial Vision <input type="checkbox"/> Blind <input type="checkbox"/> Glasses</p> <p>Toileting <input type="checkbox"/> Toilet Trained <input type="checkbox"/> Training Pants <input type="checkbox"/> Wears Diapers <input type="checkbox"/> Bring to bathroom every _____ hours <input type="checkbox"/> Needs help with _____ <input type="checkbox"/> Caths every _____ hours. Self-cath? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Additional Equipment <input type="checkbox"/> None <input type="checkbox"/> Nebulizer <input type="checkbox"/> Tracheotomy Tube <input type="checkbox"/> Monitors <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> Other: _____</p> <p>Seizures <input type="checkbox"/> None <input type="checkbox"/> One or two as a small child Type: _____ Last one: _____ Usual Frequency: _____ Usual Duration: _____ Pre-Seizure Activity: _____ Triggered by: _____ _____</p>	<p>Chief Diagnosis (List all – e.g. Seizures, Asthma, MR, CP, ADHD) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____</p> <p>Behavior <input type="checkbox"/> No Problems <input type="checkbox"/> Problems Triggered by: _____ _____ <input type="checkbox"/> Positive Reinforces: _____ <input type="checkbox"/> Discipline: <input type="checkbox"/> Withhold Privileges <input type="checkbox"/> Time Out (_____ minutes) <input type="checkbox"/> Other: _____</p> <p>Eating/Diet <input type="checkbox"/> Regular Diet <input type="checkbox"/> No Help Needed <input type="checkbox"/> Food must be: <input type="checkbox"/> Cut <input type="checkbox"/> Chopped <input type="checkbox"/> Mashed <input type="checkbox"/> Pureed <input type="checkbox"/> Child must be totally fed. <input type="checkbox"/> Special Utensils: _____ <input type="checkbox"/> G-tube <input type="checkbox"/> Dentures <input type="checkbox"/> Tongue Thrust <input type="checkbox"/> Special Diet: _____ <input type="checkbox"/> Needs Help Only With: _____ <input type="checkbox"/> Favorite Foods: _____</p> <p>Activities Does child have PE tubes in ears? <input type="checkbox"/> Yes <input type="checkbox"/> No Heat Tolerance: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Wanders? <input type="checkbox"/> Yes <input type="checkbox"/> No Restrictions: _____ _____</p> <p>Additional Instructions/Precautions/Explanations _____ _____ _____ _____ _____ _____ _____</p>
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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 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