SANDCASTLE Clinical & Educational Services

LA HEARING CENTER

EDUCATION DEMOGRAPHIC

CLIENT NAME: _____ DATE OF BIRTH:_____
First Name *Middle Initial* *Last Name*

Date to begin services: _____

Parent/Guardian Contact Information:

Parent/Guardian Name #1:_____

Parent/guardian #1 Home address: _____

Parent/guardian #1 cell phone: _____ home phone:_____

Parent/guardian #1 work address: _____ Work Phone:_____

Parent/Guardian Name #2: _____

Parent/guardian # 2 Home address (if different) _____

Parent/guardian #2 cell phone: _____ home phone: _____

Parent/guardian # 2 work address:_____ Work Phone: _____

EMERGENCY CONTACT(S) and PERMISSIONS to Release:

Please list whom the child may be released to for an emergency or daily departure if a legal guardian is unavailable, able to include home health and DHHS case managers if necessary:

Name #1 _____ Relationship: _____

Home address: _____ Home phone: _____

Cell phone:_____Work phone:_____

Name #2 _____ Relationship: _____

Home address: _____ Home phone:_____

Cell phone:_____Work phone:_____

Name #3 _____ Relationship: _____

Home address: _____ Home phone: _____

Cell phone:_____Work phone:_____

If my child needs to be sent to a nearby hospital for care, I prefer to utilize the services listed below:

Ambulance/ Air Service: _____

Hospital: _____

Child's Dentist's Name: _____ Office Phone: _____

Child's Primary Care Physician: _____ Office Phone: _____

EMERGENCY PERMISSION STATEMENT:

As a parent/legal guardian, I give consent to have my child receive first aid and/or CPR by trained Sandcastle staff and if necessary, be transported to receive emergency care using the preferred methods/locations above. I understand that I will be responsible for all charges not covered by insurance. I give consent for anyone named above under the "Permission to release" section to act on my behalf until I am available. I agree to review and update this information whenever a change occurs and every year in September or at the beginning of the academic school year.

Parent/legal guardian signature: _____ Date: _____

PERMISSIONS cont'd

While in our program, your child may be photographed. Pictures are used for a variety of educational and marketing purposes.

_____ Yes, it is OK for my child to be photographed for **marketing (Facebook, website, videos, posters etc.)**

_____ No, I do not give permission for my child to be photographed for marketing.

_____ Yes, it is OK for my child to be photographed for **educational use** (remains inside the building)

_____ No, I do not give permission for my child to be photographed for educational use.

Sunscreen is used to protect from harmful exposure to the sun. Please refer to your Family Handbook and choose one of the following:

_____ I will supply sunscreen (SPF 15 or greater) to be applied and give permission for Sandcastle staff to apply the sunscreen prior to outdoor activity. (Please clearly label with child's name. The sunscreen will remain at Sandcastle.)

_____ I give permission for Sandcastle staff to apply sunscreen belonging to Sandcastle (SPF 15 or greater) to my child prior to outdoor activity.

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Greater Androscoggin Humane Society:

_____ I understand that on occasion, weather permitting, my child and his or her class will walk to the Greater Androscoggin Humane Society on Strawberry Avenue for a field trip. I give permission for my child to participate with his or her class.

FAMILY INFORMATION:

Does your child have any disabilities or special needs? (Ex: Medications, allergies, food intolerance, behaviors, cultural food not allowed, etc.)

_____ Yes _____ No

If yes, please list: _____

_____

Do any disabilities or special conditions exist in other relatives? (Ex: Speech problems, hearing problems, mental illness, physical disabilities, etc.)

_____ Yes _____ No

If yes, please list: _____

_____

_____

_____

Please list and describe any cultural habits/ languages spoken in the home that may affect your child's behavior: _____

_____

_____

The above information is accurate and true to the best of my knowledge. I understand that I will be asked to update this form on a yearly basis or upon a change of address, contact information, emergency contact information, or health information.

Parent/legal guardian signature: _____ **Date:** _____

SANDCASTLE
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LA HEARING CENTER

Immunization and Physical Request

Re: Client's name: _____ Date of Birth: _____

Primary Physician name/office: _____

Parent/Guardian signature: _____ Date: _____

Date:

OFFICE USE ONLY

Dear Physician,

The client listed above has enrolled in our program(s). We are in need of the documents checked off below. Please fax the Following information to (207) 517-6163.

☐ I request to have Immunization records sent to Sandcastle Clinical and Educational Services

Immunization Record

☐ I request to have the current Physical exam sent to Sandcastle Clinical and Educational Services

Current/ most recent physical examination

Comments: _____

_____

_____

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RELEASE OF INFORMATION

This release refers to health information as it pertains to the following service(s):

☐ Speech Language ☐ Occupational Therapy ☐ Mental Health ☐ Audiology ☐ Education

Patient name: _____ Date of Birth: _____

Name of Guardian (if applicable): _____

I hereby authorize use of protected health information about me as described below:

☐ The following person/ facility is authorized to share information about me:

☐ The following person/ facility is authorized to receive information about me:

Name: _____

Relationship to patient: _____ Phone #: _____

Address: _____

For the purpose of quality treatment, various documents regarding your care may be forwarded to the above named person/provider as they are completed. Documents may include Evaluations, Progress Reports, Plans of Care, etc.

☐ I grant permission for documents referring to the items stated above to be disclosed.

Unless the box below is checked, no information regarding alcohol/substance abuse, HIV/AIDS, or Mental Health will be disclosed.

☐ YES, I disclose this information. ☐ Not applicable

☐ NO, I DO NOT disclose this information.

This authorization expires on _____, 20 _____ OR upon the patient's/guardian's request that the authorization be revoked.

Signature of Individual: _____ Date: _____

Signature of Parent and/or Guardian: _____ Date: _____

Office use only - Data has been entered in Raintree ☐