



SPECTRUM PEDIATRICS GROUP PROGRAM REGISTRATION

Child's Name: _____ Date of Birth: _____

Gender (check one): Male Female

FAMILY INFORMATION

Parent/Guardian 1: _____ Relationship to Child: _____

Address: _____

Street

City

State

Zip

Phone: (____) ____-____ (____) ____-____ (____) ____-____ Email: _____
Home Cell Work

Parent/Guardian 2: _____ Relationship to Child: _____

Address: _____

Street

City

State

Zip

Phone: (____) ____-____ (____) ____-____ (____) ____-____ Email: _____
Home Cell Work

SESSION REGISTRATION

Each session will be 8 weeks long. Enrollment fee covers participation in one playgroup for the entire 8 week session. ENROLLMENT DEADLINE: May 6, 2011 (will accept on a rolling basis after deadline). Payment plan options are available. A non-refundable deposit of \$150 per playgroup will be due with enrollment application. (Deposit will be applied to the overall program fee.)

- _____ 1. HUNGRY HIPPOS: Fridays, May 13 - June 17, 2011 (10:30 a.m.—11:30 a.m.) \$450
Whether your child has aversions to certain foods, a limited diet or motor challenges that make feeding difficult, the Hungry Hippos can help.

Payment Options:

Pay in full, a check is enclosed for \$ _____

Pay for half, a check is enclosed for \$ _____ The remainder is due by June 3, 2011

MEDICAL INFORMATION

Physician's Name: _____ Phone: (____) ____-____

Address: _____

Street

City

State

Zip

Emergency Contact, if parent is not reachable: _____ Relationship to Child: _____

Phone: (____) ____-____ (____) ____-____ (____) ____-____

Home

Cell

Work

Does your child have any diagnosed medical conditions? Yes No

If Yes, Please describe: _____

Any previous medical conditions or surgeries? Yes No

If Yes, Please describe: _____

Is your child taking any medication? Yes No

Medication

Dosage

Frequency

Allergies (check all that apply): None Food Medicine Environment

Please describe the allergy and reaction seen: _____

Special Dietary Guidelines: _____

PARENT COMMENTS

Please describe any additional concerns/information you may have about your child at this time: _____

IMPORTANT—THIS BOX MUST BE COMPLETE FOR CHILD TO PARTICIPATE

Parent/Guardian Authorization: This health history is correct and accurately reflects the health status of the child to whom it pertains. The person described has permission to participate in all program activities. If I cannot be reached in an emergency, I give permission to a physician/hospital to order x-rays, tests, and provide treatment related to the health of my child. I understand the information on this form will be shared on a "need to know" basis with Spectrum Pediatrics staff. I give permission to photocopy this form. In case of chronic or serious conditions, Spectrum Pediatrics has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with Spectrum Pediatrics staff about my child's health status.

Parent/Guardian: _____ Relationship to child: _____

Signature: _____ Date: _____

SERVICE AGREEMENT

Enrollment deadline: May 6, 2011 (will accept on a rolling basis after deadline). A \$150 non-refundable deposit is required to reserve a spot for your child. Deposit will be applied towards the overall tuition cost.

I have enclosed a completed registration form for my child. I understand that all program activities are conducted by qualified personnel in a safe acceptable manner. I understand that I will receive a treatment note at the end of each session with the appropriate procedure and diagnosis codes. Please initial: _____

RELEASE OF LIABILITY CLAUSE

I hereby waive any claim of liability against Spectrum Pediatrics including its employees and representatives, and release them from all liability in connection with the program activities.

Parent/Guardian: _____ Relationship to child: _____

Signature: _____ Date: _____

PHOTO RELEASE

I give permission for Spectrum Pediatrics to use photographs of my child for any lawful purpose including treatment sessions, publicity, illustration, advertising and web content.

Photo Release (check one): Yes No Please initial: _____

ADDITIONAL INFORMATION:

Mail to:
Spectrum Pediatrics
2869 Duke St
Alexandria, VA 22314

