



Providing Smiles and Understanding Needs (PSUN) Family Application

*PLEASE ATTACH PHOTO(S) OF YOUR CHILD(REN) TO THIS APPLICATION WITH THEIR NAMES WRITTEN ON THE BACK OF THE PHOTO(S)

CHILD INFORMATION

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Date of Birth _____

Sex Assigned at Birth (please circle) Male/Female Grade _____ Age _____

T-Shirt Size (please circle one):

Youth Small/Youth Medium/Youth Large

Adult Small/Adult Medium/Adult Large/Adult XL/Adult 2XL/Adult 3XL/Other: _____

Pant Size (please circle one):

Youth Small/Youth Medium/Youth Large

Adult Small/Adult Medium/Adult Large/Adult XL/Adult 2XL/Adult 3XL/Other: _____

SIBLING INFORMATION *IF THERE ARE MORE THAN TWO SIBLINGS, PLEASE REQUEST ADDITIONAL

SIBLING FORM

1. Name _____

Date of Birth _____ Age _____ Grade _____

Sex Assigned at Birth (please circle) Male/Female

T-Shirt Size (please circle one):

Youth Small/Youth Medium/Youth Large

Adult Small/Adult Medium/Adult Large/Adult XL/Adult 2XL/Adult 3XL/Other: _____

2. Name _____

Date of Birth _____ Age _____ Grade _____

Sex Assigned at Birth (please circle) Male/Female

T-Shirt Size (please circle one):

Youth Small/Youth Medium/Youth Large

Adult Small/Adult Medium/Adult Large/Adult XL/Adult 2XL/Adult 3XL/Other: _____

PETS OWNED IN HOME

Please list: _____

CONTACTS

PARENT GUARDIAN INFORMATION

1. Name _____ Relationship _____
Home Phone _____ Work Phone _____
Cell Phone _____
Email _____
2. Name _____ Relationship _____
Home Phone _____ Work Phone _____
Cell Phone _____
Email _____

Please List People Who May Serve as Guardians in Your Absence

1. Name _____ Relationship _____
Home Phone _____ Work Phone _____
Cell Phone _____
Email _____
2. Name _____ Relationship _____
Home Phone _____ Work Phone _____
Cell Phone _____
Email _____
3. Name _____ Relationship _____
Home Phone _____ Work Phone _____
Cell Phone _____
Email _____

Medical Information/Contact

Regular Physician _____ Contact Number _____
Health Insurance Company _____
Policy/Group Number _____

If physician is different for a sibling, please indicate the child and physician information here:

PLEASE INITIAL THE FOLLOWING

_____ I give permission for a PSUN staff member to transport and consent for my child(ren) for medical, dental, psychological, and surgical treatment if necessary.

_____ In case of emergency, time permitting, I would prefer that my child(ren) be taken by ambulance to the following hospital:

_____ I give permission for basic first aid trained PSUN members or a present EMT to provide basic first aid if necessary.

_____ I will remain financially responsible for any incurred expenses and shall indemnify fully PSUN staff members acting on behalf of my child(ren).

Parent/Guardian Printed Name _____

Date _____

Parent/Guardian Signature _____

Date _____

MEDICAL INFORMATION AND RELEASE FORM FOR CHILD APPLICANT

(PLEASE COMPLETE AN ADDITIONAL MEDICAL FOR EACH SIBLING)

Child's Full Name Printed _____

In reference to the above individual participating in PSUN programs/activities, I grant permission to the staff of PSUN at 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 PSUN.

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

Child's Name Printed _____

Sibling's Name(s) Printed _____

Parent/Guardian Printed Name _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

MEDICAL INFORMATION

(PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION. ALL INFORMATION WILL BE TREATED CONFIDENTIALLY)

THIS FORM WILL BE PUT INTO YOUR CHILD'S PSUN 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!

Current Diagnoses and/or Problems (ex. Seizures, Asthma, MR, CP, A, ADHD): _____

Current Medication (prescription and over the counter): _____

Allergies (food, medication, environmental, etc.): _____

Date of Last Negative PPD (skin test for TB): _____ OR Date of Last Negative Chest X-Ray: _____

History of Varicella (chicken pox) (please circle): YES/NO

Date of Last Tetanus Booster: _____

General Information

Child Name: _____

Age: _____ My Child Acts Like A: (Age) _____

Approximate Weight: _____ Approximate Height: _____

Behavior

Behavior We Should Know About: _____

Behavior Triggered By: _____

Ambulation

Walks Assisted Walks Unassisted

Walks Using: Alone/Needs Assistance/Transfers

Wheelchair Manual Walker Crutches Electric Wheelchair Braces

Discipline

Positive Reinforcers: _____

Withhold Privileges Time Out (_____ minutes) Other: _____

Communication

No Problems Non-Verbal ASL Limited abilities, but can communicate daily needs

Communication Device: _____

Eating/Diet

Regular Diet No Help Needed Tongue Thrust G-Tube Dentures

Child Must Be Totally Fed Special Utensils:

Special Diet: _____

Favorite Food: _____

Food Must Be: Cut Chop Mashed Pureed

Vision

Normal Limited Blind Glasses

Hearing

Normal Deaf Hard of Hearing Hearing Aids

Specific Ear? LEFT/RIGHT

Toileting

Toilet Trained Training Pants Wears Diapers Bring to bathroom every _____ hours

Caths Every _____ hours. Self-Cath? YES/NO Needs Help With: _____

Activities

Does Child Have PE Tubes in Ears? YES/NO

Heat Tolerance: Good Fair Poor

Wanders? YES/NO

Additional Equipment

Nebulizer Tracheostomy Tube Oxygen Monitors

Ventilator Restrictions: _____

Other: _____

Other:

Seizure Additional Instructions/Precautions/Explanations

None One or two as a small child

Type: _____

Last One: _____

Usual Frequency: _____

Usual Duration: _____

Pre-Seizure Activity: _____

Triggered By: _____

I, _____, understand that my child, _____,
may not participate in PSUN 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
will be kept confidential among PSUN staff. I certify the information in this form is true and correct to the
best of my ability.

Child's Name Printed _____

Parent/Guardian Printed Name _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

AUTHORIZATION TO BE PHOTOGRAPHED

I give PSUN the right to take photographs, audio-visual recording of my child(ren) to be used in promotional, educational, or fundraising materials including, but not limited to videotapes, pamphlets, and brochures. I understand my child(ren)'s name may be used in connection with these materials. By signing this media release, I intend to legally bind my child(ren). PSUN has the right to use photographs and other images of my child(ren) in promotion, educational, or fund-raising materials. I acknowledge that PSUN shall have rights of copyright in and to such photographs and videotapes and may use such copyright fully. I also hereby release PSUN and its officers, agents, and volunteers from all liability connected with the taking and use of these materials as it is authorized by PSUN. In addition, I waive all rights, interests, 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(s) mentioned below.

Child's Name Printed _____

Sibling's Name(s) Printed _____

Parent/Guardian Printed Name _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

PARTICIPATION CONSENT

I understand and certify that my child(ren)'s participation in PSUN and its programs/activities is completely voluntary. I have familiarized myself with PSUN programs/activities in which my child(ren) 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 PSUN has taken safety measures to minimize the risk of injury to program/activity participants, and PSUN 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 PSUN programs/activities at any event in which my child(ren) is participating in the PSUN programs/activities.

Child's Name Printed _____

Sibling's Name(s) Printed _____

Parent/Guardian Printed Name _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____