Cypress School
Autism and Behavioral Services
Learning without limits for people with disabilities

UCP United Cerebral Palsy of the North Bay
Life without limits for people with disabilities

Cypress Summer Program
Registration & Information Form

Please return completed Registration & Information Form, Waiver Form and Cypress Medical Authorization Form(s) to:

United Cerebral Palsy of the North Bay
Attn: Jennifer Whalen
3835 Cypress Drive, Suite 103
Petaluma, CA 94954

PLEASE NOTE: *Space is limited.*
Session I Due Date: May 1, 2014; Session II Due Date: July 2, 2014

COST: $950.00
Make checks payable to: UCPNB (payable on or before the first day of program)

If you would like to set up a payment schedule or have any questions, please contact Jennifer Whalen: **jwhalen@ucpnb.org**; 707-338-2584

Check Session(s) the participant will be attending: ☐ Session I (June 9-20) ☐ Session II (August 4-15)

Parent(s): _____

Participant: _____ **Age:** _____

Address: _____

City: _____ **Zip:** _____

Email: _____

Evening Phone: _____

Day Phone: _____

Emergency Contact: _____ **Phone:** _____

Participant Physician: _____

Allergies: _____

Play without limits for people with disabilities

Name of Participant

The following questions will assist staff in accommodating the needs of your child during the program.

1. What is your son/daughter's disability and what do we need to know in order to safely and successfully work with him/her in an activity setting? Any activity limitations? ***Include a copy of school or home behavior support plans.***		
2. Does your son/daughter require 1:1 supervision? (i.e., constant supervision to assure safety of him/herself or others) ***We do not provide a 1:1 support aide. If it is required throughout the day, extra 1:1 funding is purchased through Regional Center.*** • If yes, please describe.	Yes ___	No___
3. Does he/she have equipment needs? (electric or manual wheelchair, braces, walker, crutches, helmet, other.	Yes ___	No___
4. Does he/she need help eating? (i.e. small bites, food cut into small pieces) • If yes, please describe.	Yes ___	No___
5. Does he/she have dietary needs? • If yes, please describe.	Yes ___	No___
6. Is he/she toilet trained? ***Parents must provide diapers, extra clothes, and swim diapers if needed by child.*** • What assistance is needed? (e.g., snaps, buttons, undressing/dressing, wiping, etc.)	Yes ___	No___
7. Has he/she ever been separated from the family before? • Please describe.	Yes ___	No___
8. Does he/she have seizures? • Please describe. Date of last seizure, frequency, usual duration, procedure for handling seizures.	Yes ___	No___
9. Does he/she have speech, hearing, or vision limitations? • If yes, please describe.	Yes ___	No___
10. Does he/she have behaviors that could result in harm to self or others? • If yes, please describe. (Please note: if these behaviors occur at program, he/she may be sent home.)	Yes ___	No___
11. What HEALTH PRECAUTIONS, ALLERGIES, SPECIAL INSTRUCTIONS, RESTRICTIONS, BEHAVIORS, OR MEDICATIONS, etc., do we need to know about? Any effective strategies or procedures would be helpful?		
12. What are his/her favorite activities? Hobbies? Interests?		

Use additional paper if more explanation is needed.

Cypress Summer Program
Waiver/Release Form

Child's Name: **DOB:**

Photographic Release

I/We hereby give consent to United Cerebral Palsy of the North Bay (UCPNB) to photograph our **child/self (_____)** to educate others about the programs and services offered by UCPNB.

YES, I give consent_____ (Initial) **NO, I do not give consent_____ (Initial)**

Among the uses contemplated are illustration of articles in newsletters, in profiles that contributors receive, in brochures, to illustrate services discussed on the web site, in displays at community fairs, to publicize local programs, to make professional presentations, to conduct research on teaching techniques and equipment used at the program, and to publicize the equipment and teaching methods used. In giving approval, I/we understand it is without consideration of compensation of any kind, and UCPNB is released from any claims or liability. If wider use is contemplated will get separate approval.

Medical Release

In the event that an emergency requiring medical or surgical care or treatment should arise while **(Child's Name),**

_____is attending the UCPNB program, and I /We ARE NOT PRESENT TO MAKE MEDICAL DECISIONS, **I/We** (Initial)_____, authorize/**do not** (Initial)_____authorize the said UCPNB to select and designate nurses, physicians, emergency medical staff (EMS) and surgeons to furnish such medical and/or surgical care as, in the judgment of a physician and/or surgeon holding a physician's certificate issued by the Board of Medical Examiners of the State of California may be needful and proper. I/We absolve UCPNB, and nurses, physicians, EMS personnel, and surgeons selected and designated by them, from any and all liability for their acts rendered in good faith.

Family Doctor: Phone:

Insurance Co. & Plan No.:

Personal Property

I/We (Initial) _____, recognize that UCPNB cannot accept responsibility for child's personal property. To help eliminate losses, please tag name inside equipment, clothes or other personal items.

Parents:
(Both parents required)

Mother Date

Father Date

Guardian(s):

Guardian Date

If Separated or Divorced:
(Signature of Party with Legal Custody)

Mother Date

Father Date

Child: If responsible for his/her own legal affairs

Child Date

Medical Authorization Form
Parent Request for Giving Medication or Treatment at Camp

*****One Medical Authorization Form Per Medication*****

My child, adult child, _____, a camper at Cypress Summer Intensive Camp requires medication and/or a medical procedure during the camp day as prescribed by his/her physician. I hereby authorize the designated staff person to administer the medication/procedure prescribed below according to the directions. In consideration of the service I (we) further agree that I (we) will not hold liable, and will otherwise hold harmless, the United Cerebral Palsy of the North Bay/Cypress Summer Intensive Camp and any such member of the camp staff thereof for any injury or death resulting from the administration or assistance of the medication/procedure described below.

Date: _____ Signature: _____ Print Name: _____
(Parent/Legal Guardian)

Physician's Statement

The above named child/adult, _____, requires medication during the camp day as follows:

Diagnosis:

Medication:	Dosage:
Time:	Frequency/Duration:

Possible side-effects, adverse reaction contraindications:

Identification of medication procedures (details):

Identification of medication procedures (details):

Date: _____ Signed: _____
Physician Telephone #: _____ Print Name: _____

All medications (over the counter and prescribed) must be placed in the original pharmacy labeled container and accompanied by this form.