Unlimited Kids SIBLING Packet

Today's Date: __________ New Family: _____ Updated Family: ________

Participant's Full Name: _______________________________ Nickname: ____________________

Gender: ☐ M ☐ F Date of Birth: _________________ Age: ____ Weight: ______ lbs Height: ______

Name of School: ____ Grade/Year: _______________________

Home Address: ____ Apt. #: ___________________

City: ____ State: ______ Zip Code: ________________

Participant Lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Guardian ☐ Foster family

Do you have a church you attend regularly? __________ If so, where?__________________________________

If Applicable For Participant:

Name of Employer: ____ Employed Since: _________________

Phone: ________________ Cell: ____________________ Email: ____

Is the participant his/her own guardian? ☐ Yes ☐ No

Family Information

Custodial Parent/Guardian:____

Street Address: ____ Apt. #: ____________________

City: ____ State: ______ Zip Code: _________________

Phone: _______________________ Cell: _________________ E-mail: _____________________________

Second Custodial Parent/Guardian: ____

Street Address: ____ Apt. #: ____________________

City: ____ State: ______ Zip Code: _________________

Phone: _______________________ Cell: ______________ E-mail: _________________________________

Marriage Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Siblings Living at Home:

#1 - Last Name: _____________________ First Name: ________________________ Nickname: ___________

Gender: M ☐ F ☐ Age: _________________

#2 - Last Name: ______________________ First Name: _________________________ Nickname: ____________

Gender: M ☐ F ☐ Age: _________________

#3 - Last Name: ______________________ First Name: _________________________ Nickname: ____________

Gender: M ☐ F ☐ Age: _________________

#4 - Last Name: ______________________ First Name: _________________________ Nickname: ____________

Gender: M ☐ F ☐ Age: _________________

Social & Behavioral Information

Please list things/activities the participant enjoys:

Please list activities or things the participant is afraid of or any activities they may not participate in:

Activity:	Reason/Explanation (if needed):

Does the participant have any behavioral issues? (biting, scratching, aggressive behavior, etc) ☐ Yes ☐ No

If yes, please describe the behavior & effective behavior management strategies (our goal is to be consistent with other environments):

Medical Information

Participant's Primary Care Physician: _________________________________ Phone Number: _______________

Address: ____ City, State, ZIP: _____________________

Medications **(please be specific as to the name of med, what it is for, dosage and time given):**

Medication	Dosage	Frequency	Purpose
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Allergies: ☐ None ☐ Lotions ☐ Penicillin ☐ Asthma ☐ Insect Stings

☐ Food: ____________________________ ☐ Other: ____________________________

☐ Epi Pen (*Guardian must provide Epi Pen)

Please describe allergic reactions: ____

____

Describe steps to be taken: ____

____

Alternate Emergency Contacts:

Contact #1: ______________________________________ Relationship to Participant: ____________________

Phone: (___) _______________________________ Cell: (___)____

Contact #2: ______________________________________ Relationship to Participant: ____________________

Phone: (___) _______________________________ Cell: (___)____

Hospital Preference (If applicable at the time): ☐ Yes ☐ No If Yes, Please list:_________________________

Emergency Medical Transport & Treatment Consent

Do we have permission to allow your child/adult to be transported by EMS to medical facility if we are unable to reach parent/guardian or emergency contact? ☐ Yes ☐ No

I hereby give consent for any necessary medical treatment that may be given by medical personnel in case of an accident or illness. By my signature below, I understand that expenses for medical care will be my responsibility. I agree not to hold Fellowship Community Church, their staff, Unlimited Ministry, or its volunteers responsible or liable for any injury or accident that may occur while participating in any event or activities sponsored by FCC or Unlimited Ministry.

____________________________ ______________________________ __________________

Printed Parent or Guardian Signed Parent or Guardian Date

How did you hear about Unlimited? ☐ FCC ☐ Flyer/Ad ☐ Website ☐ Friend ☐ Other: ________________

What area(s) of Unlimited Ministry are you interested in learning more about or participating in?

❒ Unlimited Buddy: ❒ North Campus ❒ Salem Campus ❒ Southwest Campus

❒ Unlimited Kids (Monthly respite for children & siblings)

❒ Unlimited Kids Camp (annual respite weekend for children & siblings)

Unlimited Contact Information:

1226 Red Lane Ext ● Salem, VA 24153 ● www.fcclife.org

Salem Campus	North Campus	Southwest Campus
540-387-3200	540-986-1117	540-685-2994

Fellowship Community Church
Unlimited & Kid's Life Ministry

Authorization to Reproduce Physical Likeness

I grant Fellowship Community Church the right to photograph my child and use his/her picture, silhouette, or other reproductions of my child's physical likeness in connection with advertisements, publications, and/or videos of Fellowship Community Church. These reproductions may include an exhibition, Internet webpage, incorporation into a publication, church advertisement or promotion, or any other use of videos.

My signature below indicates that I have read and understand the meaning and effect of this release form.

_________________________________ _________________________________

Child's Name (please print) Relationship to child

Agreed and Accepted: (See below if you do not agree)

_________________________________ _________________________________

Signature of Parent/Guardian Date

I **DO NOT WISH** to have my child's, ___________________________________, physical likeness used in connection with advertisements, publications, and/or videos of Fellowship Community Church. These reproductions may include an exhibition, Internet webpage, incorporation into a publication, church advertisement or promotion, or any other use of videos.

**Note: This information will be in force until such time as the parent notifies the church in writing that they want the information to be changed.

_________________________________ _________________________________

Child's Name (please print) Relationship to child

_________________________________ _________________________________

Signature of Parent/Guardian Date

Parent/Legal Guardian Sick Policy Agreement

Sick Policy Agreement-

If your child is experiencing any of the following conditions or illnesses listed below 24 hours prior to arrival, he or she **cannot** attend In His Image respite events:

1. Fever equal to or greater than 100 degrees. He or she must be fever-free without the use of medications such as Acetaminophen (Tylenol) or Ibuprofen (Advil, Motrin) for 24 hours.
2. Head lice that has been treated in less that 24 hours prior to event
3. Redness in eye with or without discharge
4. Any discharge from nose or eyes that is not clear in color
5. Any itchy, scaly or contagious rash
6. Cough that is productive (producing phlegm), chest or nasal congestion not associated with allergies
7. Vomiting
8. Diarrhea
9. Any condition that the event nurse or Unlimited Leadership Team feel is affecting the child's physical or mental state of being able to participate in planned activities or not able to enjoy themselves for an extended period of time.

Unlimited staff will contact parents/guardians to come get their child should they develop any of the symptoms/conditions listed above while in our care.

Child's Name: ____

By signing below, I am aware of the sick policy agreement.

____

Signature of Parent/Legal Guardian **Date**

This form must be signed in order for your child to attend respite events.