Heart Reach Neighborhood Ministries
2019 Program Application
Ages 5 – 18
Registration Required

Please choose a center:

☐ **Heart Reach @ Redondo**
211 Redondo Rd.
Youngstown, OH 44504
Phone: 330-744-2000
Fax: 330-744-8116

☐ **Rockford Village Community Center**
1402B Dogwood Lane
Youngstown, OH 44505
Phone: 330-744-1446
Fax: 330-744-1456

☐ **Kirwan Homes Community Center**
75 Jackson St.
Campbell, OH 44405
Phone: 330-755-8696
Fax: 330-755-8699

Child's Name:_____ Date of Birth:_____ First Day at Center:_____

Age:_____ Current Grade:_____ Gender: (Circle one) Male Female T-shirt Size _____

Ethnicity: (Circle all that apply) African American Caucasian Hispanic Native American Asian

Home Address:_____ City:_____

State:_____ Zip Code:_____ Home Telephone Number:_____

Parent/Guardian Name:_____ Relationship to Child:_____

Home Address:_____ City:_____

State:_____ Zip Code:_____ Home Telephone Number:_____

Email Address:_____ Cell Phone:_____

Parent's Work/School Telephone Number:_____ Parent's Work/School Name:_____

Parent's Work/School Address:_____ City:_____

Preferred phone # to reach you while your child is in this program?_____

Please indicate if your name should be released if a parent/guardian, of a child attending the center, requests contact information for other parents/guardians. **Yes** **No**
If you answered yes, please indicate which number(s) above to include on the list. __ Work# __ Cell # __Home # __ Email

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Parent/Guardian Name:_____ Relationship to Child:_____

Home Address:_____ City:_____

State:_____ Zip Code:_____ Home Telephone Number:_____

Email Address:_____ Cell Phone:_____

Parent's Work/School Telephone Number:_____ Parent's Work/School Name:_____

Parent's Work/School Address:_____ City:_____

Preferred phone # to reach you while your child is in this program?_____

Please indicate if your name should be released if a parent/guardian, of a child attending the center, requests contact information for other parents/guardians. **Yes** **No**
If you answered yes, please indicate which number(s) above to include on the list. __ Work# __ Cell # __Home # __ Email

Child's Name:_____

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness **if you cannot be reached.** Any person listed should be able to assist in contacting you. **At least one person listed should be within one hour of the center, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.**

1. Name:_____ City: _____ State:_____

Cell Phone _____ Home Phone_____ Relationship to Child:_____

2. Name:_____ City: _____ State:_____

Cell Phone _____ Home Phone_____ Relationship to Child:_____

Physician or Clinic/Hospital:_____ **Dentist**_____

Street Address:_____ Street Address _____

City: _____ State: ___ Phone:_____ City:_____ State: ___ Phone:_____

Allergies, Special Health or Medical Conditions and Food Supplements (WE ONLY ADMINISTSER EMERGENCY MEDICATIONS -Inhaler and Epi-pen)
Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring staff to perform child specific care, such as: to monitor the condition, provide treatment, care or to give medication it must be clearly written and approved by the director.

Does your child have any food, medication or environmental allergies? (Check all that apply)
__ No
__ Yes – check all that apply __ Food __ Medication __ Environmental Please list and explain:

Does your child's allergy/allergies require staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (Check one)
__ No
__ Yes; complete details in "Child Medical/Physical Care Plan" section

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__ **Does your child have a special health or medical condition? (Check one)**
__ No
__ Yes

Does this special health or medical condition require staff to perform a procedure, or perform specific care such as: to monitor your child for symptoms or administer medication during child care hours? (Check One)
__ No
__ Yes – complete details "Child Medical/Physical Care Plan" section

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (Check one)
__ No
__ Yes
If yes, does this medication, food supplement, or medical food need to be administered at the child care center?
__ No
__ Yes - complete "Child Medical/Physical Care Plan" section
__ N/A – program does not administer any medications

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (Check one)
__ No
__ Yes – please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?
__ No
__ Yes – complete "Child Medical/Physical Care Plan" section.

Child's Name: _____

CHILD MEDICAL/PHYSICAL CARE PLAN

Special Health Conditions:
Symptoms to watch for and emergency action to be taken if the following symptoms occur:
Activities/foods/environmental conditions to avoid, if applicable
Medical procedures to be followed and expected benefit of treatment, if applicable
Are medications required? We only administer emergency medications (inhaler and epi-pen). What medications are required? **All meds must be in their original container with prescribed dosage.**
In an emergency does your child require additional assistance (more than other children the same age or in the same group) to evacuate? If yes, explain.
Parent or Guardian: I verify that I have trained the program director/staff in administering my child's medication and give permission for them to follow instructions and emergency medications. Parent/Guardian Signature_____ Director_____ Other Trained or informed Staff or Volunteers of the condition and treatment: Signature _____ Date_____ Trained_____ Informed_____ Signature _____ Date_____ Trained_____ Informed_____ Signature _____ Date_____ Trained_____ Informed_____ Signature _____ Date_____ Trained_____ Informed_____

List any history of hospitalization, outpatient surgery or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.

List any additional information about your child that would be useful for the staff to know, such as fears, eating or sleeping habits or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Emergency Transportation Authorization

Center Name: Heart Reach Neighborhood Ministries
Has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.

Parent's Signature:_____ Date:_____

I give permission for my child to attend Heart Reach Neighborhood Ministries programming. I understand that reasonable care will be given for my child by Heart Reach Neighborhood Ministries staff and volunteer workers and I give permission for emergency medical treatment in case of accident of illness if I cannot be reached by telephone first. I agree to hold Heart Reach Neighborhood Ministries and its workers harmless for accident, injury, theft or counseling which may occur as part of this program**. I give permission for photographs or videos of my child to be used without charge for publication, promotion or advertising purposes if such occasion should arise.** This application will be good for one year.

Parent's Signature: _____ Date: _____