Vernon Memorial Healthcare
VMH Therapy Department
Physical • Occupational • Speech
407 South Main Street, Suite 302
Viroqua, WI 54665

FINE MOTOR FUN

OT Summer Camp

Name: _____ Sex: _____ Age: _____
Last First Middle

1. What grade will your child be attending in the fall? _____
2. What school does your child attend? _____
3. Is your child able to do the following: (y/n)

Write name	_____	Comments _____
Write letters	_____	_____
Write numbers	_____	_____
Draw shapes	_____	_____

4. Is your child having any difficulties in school or daycare/at home? If so, what?
   _____
   _____
   _____
5. Does your child have any diagnoses? If so, what? _____
6. Does your child have an IEP at school? _____
7. Does your child receive any services in school or outside of school? If so, what? _____
   _____
   _____
   _____
8. Does your child have any allergies? _____

The cost for this summer camp is _____. Payment in full and forms are due by _____.

If you need to cancel for any reason, please do so 2 weeks prior to start date for a full refund.

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FINE MOTOR FUN & MINDFUL BODIES

OT Summer Camp

PARTICIPANT INFORMATION

Name_____ Date of Birth_____

Grade Entering in Fall 2018 _____

Address_____ City/State/Zip_____

Phone_____ Email_____

Name of Primary Physician _____

Physician Phone Number _____

Clinic or Hospital _____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship_____

Address_____ Phone_____

Alternate Name_____ Relationship_____

Address_____ Phone_____

Please initial the following:

_____ In the event of an emergency, and in case the person named above cannot be reached, I authorize the bearer of the form to allow Vernon Memorial Healthcare emergency personnel to direct any and all necessary medical care for the above named participant.

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INFORMED CONSENT FOR PROGRAM PARTICIPANTS

I hereby consent for my child to engage in the OT summer camp offered through the therapy departments at Vernon Memorial Healthcare. I understand and I agree to provide information as needed relating to my child's medications, treatments, physical impediments, and medical conditions before participating. I certify that the information I provide to VMH therapy staff about my child's health and history is, to the best of my knowledge, complete and accurate. I agree to inform the therapy staff in the event of any change in my child's health or medical status.

I understand that the information obtained through program activities will be treated by the therapy staff as confidential, and will not be revealed or released to any other person, except authorized personnel in the therapy staff. I agree to allow the therapy staff to contact me on any of the numbers provided and leave a message in the event that they need to reach me for any reason including, but not limited to, cancellations or emergencies.

Signed_____ Date_____

Parent or Guardian (under 18 years)

WAIVER AND RELEASE OF LIABILITY

The VMH therapy department shall not be liable to the participant for any claims, demands, injuries, damages, or actions arising due to injury to participant's person or property arising out of or in connection with the use by participant of the services, facilities, and premises of the VMH therapy department, their representatives, successors, assignees, employees, and program sponsors harmless for all claims which may be brought against them by participant or on participant's behalf for any such injuries or claims.

Signed_____ Date_____

Participant

Signed_____ Date_____

Parent or Guardian (under 18 years)

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VMH Occupational Therapy Photo Release

I hereby authorize Vernon Memorial Healthcare (VMH) (or its designee) to photograph/video record _____ (patient's name) while under the care of VMH. I agree the recordings/films/other images may be used for purposes including, education for VMH employees, public education, and promotional purposes unless I specify otherwise.

I consent to have pictures taken of my child _____

I DO NOT consent to have pictures taken of my child_____

Signed_____ Date_____

Parent or Guardian (under 18 years)