



Saturday Club

CHILD'S ANNUAL INFORMATION FORM FOR 2008/2009

King County Program Center in Seattle

Kitsap County Program Center in Bremerton

Please feel free to use a second sheet of paper to detail any of your answers.

Child's Name: _____

Child's Age: _____ Birthdate: _____ Gender: _____ Ethnicity(optional): _____

School: _____ Grade _____ Teacher's name: _____

Parent/Guardian Name(s): _____ E-mail _____

Home Address: _____ ZIP _____

Phone Numbers: Home (____) _____ Work (____) _____ Cell/Pager (____) _____

Local person authorized to act in your behalf if you cannot be reached (must be 18 years or older):

Name _____ Relationship to child _____

Phone (____) _____ Address _____

In the event my child or ward is photographed while participating in a Camp Fire USA program, the picture may be used for Council purposes. YES NO

1. How does your child communicate (i.e., verbally, sign language, picture cards, etc.)? Please list some "key" communication cues that will be helpful to our staff:

2. What sounds, gestures, or other expressions does your child make that are normal for your child but might be alarming to someone who doesn't know your child (i.e., what should we **not** be concerned about)?

3. Using the bathroom: Please explain if there are specific needs (needs to be reminded and when; needs assistance in going, will your child let us know when he/she needs to go, etc.):

4. What are the best ways for staff to help your child with eating lunch? Are there special nutritional needs?:

5. What kinds of **indoor** activities does your child like and dislike?

6. What kinds of **outdoor activities** does your child like and dislike?

7. When your child is upset, what works to comfort him or her? _____

8. Does your child have any particular fears or phobias? _____

9. In general, what kinds of sounds, surroundings, activities, and other children's behaviors might upset or frighten your child? _____

10. In an outdoor setting, what types of things generally upset your child (i.e., dogs, airplanes, skateboarders, etc.)? _____

11. Are there any particular behaviors of which staff should be aware, and how are these behaviors usually managed by you? _____

12. What else would you like us to know about your child? _____

13. Would you like your child to be included in plans for field trips and other special events? Yes No
14. What other activities besides Saturday Club does your child participate in? _____

15. What other organizations are you and your family members involved with? _____

This form is kept on file for all Saturday Club sessions during the academic year. Please let us know of any changes that occur. All information is kept strictly confidential. **YOUR SIGNATURE CONFIRMS THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE CURRENT SATURDAY CLUB REGISTRATION POLICIES .**

Parent/Guardian Signature _____ **Date** _____

REQUIRED

Camp Fire Programs are available to all people without regard to race, gender, creed, religion, national origin, sexual orientation, economic status, or mental or physical disabilities. If you use a TDD/TTY, you can call us through the Washington Relay Service at 800 833 6388. TeleBraille users, call 800 833 6385.





Saturday Club



HEALTH HISTORY – 2008/2009

King County Program Center in Seattle
Kitsap County Program Center in Bremerton

Please provide the following information about your child’s medical needs:

1. Is your child on medication? Yes No List **ALL** medicines: _____

**IMPORTANT NOTE: Our Staff WILL NOT administer medicines to your child. If your child requires medication, please contact our Program Director.
King County Program Center in Seattle – 206 826-8928
Kitsap County Program Center in Bremerton - 360 377-5513**

2. Seizures: No Yes Type: _____ Date of last seizure: _____
Duration: _____ Frequency: _____ Controlled by medication? Yes No
Describe seizure & recovery period afterwards: _____

3. Asthma: Yes No Triggers (i.e., pets, foods, dust, etc.): _____

4. Allergies: (Including foods, insects, pollen or anything else): _____

If reaction occurs: _____

5. Skilled medical care or apparatus (feeding tube, wheelchair, etc. Explain in detail): _____

Doctor: _____ Phone: _____
Address: _____
Date of last visit: _____

Dentist: _____ Phone: _____
Address: _____
Date of last visit: _____

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