FOUR FRIENDS
A Special Needs Ministry

Longview Heights Baptist Church
4501 Goodman Road
Olive Branch, MS 38654
Phone: 662-895-1900 Email: mkirby@longviewheights.org

Please complete 1 form for EACH attendee with Special Needs. Date completed:_____

Name of Attendee:		
	Last Name	First Name

Age:		**Birthday:**		**Grade**:		Male :	Female:

Address:				
	Street	City	State	Zip

Parent/Guardian:		Home Phone :
E-Mail:	Work:	Cell:

Parent/Guardian:		Home Phone :
E-Mail:	Work:	Cell:

Address:			
(If different than above)	Street	City	Zip

Siblings who will attend:

Name	Age	Birth date	Brother	Sister

Additional comments to any question can be added on last page of Registration Form

Attendee's primary diagnosis:
Attendee's secondary diagnosis:

Any recent surgeries or procedures? (Please help us better serve your child by providing as much information as possible.

Has your child had any health condition related to the following? (Please Check)

	Asthma		Skin Sensitivity		Diabetes		Cardiovascular		Gastrointestinal		Joint Pain		Hearing
	Seizures		Headaches		Fainting Spells		Bleeding Disorder		Kidney/Bladder		Vision		Balance

If YES, please describe below:

Special Diet:	Yes __ No _	Please Specify:
Allergies:	Yes __ No _	Please Specify:

Is medication to be given to child during respite program?	Yes _____ No _____	Please specify below:

MEDICATION	DOSE	TIME TO BE GIVEN	MEDICATION	DOSE	TIME TO BE GIVEN

Any Emergency Medication to be given? Yes ___ No ___ Please specify below:

Epi Pen Yes ☐ No ☐	Benadryl Yes ☐ No ☐	Albuterol Inhaler Yes ☐ No ☐	Glucagon Yes ☐ No ☐
Other Yes ☐ No ☐ Please specify:			

Name of Attendee:	
Physician:	**Phone:**
Dentist:	**Phone:**
Medical Insurance:	**Policy :**

Please Note: Whenever the health and safety of your child is in question, 911 will be called.

Further Information

Communication: Please describe such as: talks in sentences, few words, babbles, gestures, etc.

Can attendee understand what others say, please describe:

Personal Care / Bathroom:

	Independent		Minimal Supervision		Needs Complete Care		Diapers		Depends / Training Pants		Other-Please specify

Behavior: Check all that apply and if necessary please give more details in the space provided below.

	Shy		Outgoing		Plays Alone		Plays in Group		Adapts Well to New Situations		Adapts to New Situations with Difficulty		Responds well to correction
	Responds to correction w/ difficulty		Sometimes destructive		Sometimes threatens others		Sometimes hits, bites, hurts others/self		Sometimes runs away		Hyperactive or ADD		Likes to "Help" Others

Attendee responds to separation from his / her parents by
Attendee is best comforted by
Attendee indicates wants / needs by
Activities attendee especially enjoys and participates in are

If you need more room to answer any questions on page 1 or 2, or if you wish to write any comments, a blank page at the end of this questionnaire is included.

Emergency Contacts (Other than doctor)
In case of emergency, and if parents cannot be contacted, the following persons may be called **AND** are authorized to pick up my child. (At least one contact must be provided. Identification must be shown before attendee will be released.)

Name:	Phone:	Cell:
Address:		
Relationship:		

Name:	Phone:	Cell:
Address:		
Relationship:		

Permission/Authorization Agreement:
Please read the following statements carefully and **initial** in the designated spaces indicating that you have read and agree to the provisions:

	I have fully disclosed to LHBC Special Needs Ministry all pertinent facts about attendee's special needs and accept full responsibility for failure to do so.
	If my child is enrolled in any LHBC program, I authorize the staff to provide any required special treatment or procedures to attendee while in respite care. I will provide written instructions and all necessary supplies for these procedures.
	I will supply necessary foods, drinks, snacks and diapers / wipes for attendee.
	In case of emergency or accident, I understand that 911-EMS will be called. I authorize EMS to administer any medical treatment, medication or appliance deemed necessary by EMS. I also authorize transportation by EMS to the nearest appropriate medical facility as determined by EMS. I understand I will be responsible for payment of all EMS, hospital and physician charges for emergency services to attendee.

I do_____ do not _____ give permission for attendee to be photographed for use in publicity related to LHBC.

Handwritten Signature - I have read and initialed the above permission/authorization statements and agree to the terms designated in each.

Signed **Date**

_____

FORM MUST BE NOTARIZED BELOW

Date:_____

Name of Notary (Printed):_____

Signature of Notary :_____

My Commission Expires: **Seal:**