Community
Based
Activity
Program

1341 Pacific Avenue Forest Grove, OR 97116
Tel/Fax: 503.359.2512

PARTICIPANT REGISTRATION FORM - 2021

APPLICANT INFORMATION

Name:	Date of Birth:	Age:	Going into _____Grade
Primary Phone:	Email:	Shirt size: - ADULT or YOUTH ❑ S ❑ M ❑ L ❑ XL	
Address:	City:	State, Zip:	
Mother's Name:	Employer:	Work Phone:	
Father's Name:	Employer:	Work Phone:	

EMERGENCY CONTACT (other than parent/guardian)

Name:	Relationship:	Day Phone:
Name:	Relationship:	Day Phone:

SOCIAL INFORMATION

Name of School:		Teacher:
Address:	City, State:	Phone:
IEP: ❑ No ❑ Yes	* If yes, please include a copy of the child's extended school year IEP goals.	
Behavior Plan: ❑ No ❑ Yes	Parent's method of discipline:	

List any emotional or behavioral concerns (note: providing this information helps us determine how best to support your child).

Favorite Activities:

PERSONAL NEEDS AND GENERAL INFO

Does your child use any of the following?

❑ Hearing Aids ❑ Wheelchair ❑ Walker ❑ Other_____

How can staff assist your child with mobility?

What is your child's swimming experience? ❑ Doesn't swim ❑ Fair ❑ Good ❑ Excellent

DESIRED OUTCOMES FOR YOUR CHILD IN CBAP

Educational:	Social:
1.	1.
2.	2.
3.	3.

MEDICAL HISTORY

Please check all past and current conditions that apply:

❑ Attention Deficit	❑ Head/Brain injury	❑ Mobility
❑ Anaphylaxis	❑ Heart disease/defect	❑ Muscular Dystrophy
❑ Asthma	❑ Hearing Impaired/Deaf	❑ Operations
❑ Autism	❑ Hemophilia	❑ Physically Disabled
❑ Balance Problems	❑ Hospitalization	❑ Seizures
❑ Cerebral Palsy	❑ Hyperactivity	❑ Stroke
❑ Developmentally Delayed	❑ Incontinence	❑ Speech
❑ Down Syndrome	❑ Injured Muscles	❑ Spina Bifida
❑ Diabetes	❑ Joint or ligament pain	❑ Visually Impaired/Blind
❑ Dietary Restrictions	❑ Learning Disabled	❑ Other _____
❑ Epilepsy	❑ Mental Illness	
❑ Fetal Alcohol Syndrome		

If you checked any of the above, please describe more fully here:

Allergies and Reactions:

Child under care of Dr.? ❑ No ❑ Yes	If yes, describe:	
Medication:	Dosage:	Reason:
Medication:	Dosage:	Reason:

- All medications must be in the original containers with prescription label intact and legible. The label must have the child's name, dispensing instructions, and the doctor's name before administration by our staff. No substituting medications with other family members allowed. Oral medication will be given only at lunchtime.
- If your child becomes ill at school, you will be notified and expected to pick up your sick child immediately.
- We encourage proper personal habits such as clean and trimmed nails, clean ears, hair, clothing, etc.

INSURANCE INFORMATION

Carrier:	Group No.:	Personal ID:

MEDICAL AUTHORIZATION AND GENERAL PERMISSION

In case of Emergency, give the Child's…	Doctor:	Phone:
	Dentist:	Phone:

Who is authorized to pick up your child other than the enrolling parent?

Name:	Age, Description:
Name:	Age, Description:

If emergency medical care is necessary, I give you permission for any treatment deemed necessary by a physician and/or hospital of your choice and I will assume full financial responsibility.

I hereby grant permission for my child to participate in all your activities including community trip transportation to and from the school. I also grant permission to use photographs of my child for publicity and news release purposes.

I hereby release, indemnify and hold harmless the Community Based Activity Program, Inc. and it's staff from any loss or damage to clothes or other personal articles as well as hold you, your agents and employees harmless from any and all claims, damages, or other liabilities for injuries to or damage to by my child that are not a result of gross negligence by the Community Based Activity Program, Inc., it's agents or employees.

I hereby warrant to the Community Based Activity Program, Inc. that I am entitled to legal custody and possession of my child, and accordingly am authorized to place my child in your care and custody, and am authorized to sign this enrollment form.

Name of parent/legal guardian (print):	Date:
Signature of parent/legal guardian:	Date:

DEMOGRAPHIC INFORMATION - OPTIONAL

(INFORMATION USED FOR REPORTING PURPOSES ONLY)

_____Hispanic or Latino _____White _____ Black or African American _____Native Hawaiian/Other Pacific Islander
_____Asian _____American Indian or Alaska Native _____Two or More Races _____ Other

Are you or a member of your family eligible for free or reduced lunch programs? _____ Yes _____No