HFM
Hemophilia Foundation
of Maryland

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Proudly Serving the Maryland Bleeding Disorder Community

Child Program Registration Form

Effective March 1, 2015 – March 1, 2016

PART 1 – GENERAL INFORMATION
TO BE COMPLETD BY PARENT OR GUARDIAN

Child Information:

Name: ____

Address: ____

City: ______________________ State: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Sex (Please Circle): Male Female Date of Birth: ______________________

Age: ______________________ Grade in School: ______________________

Parent/Guardian Information:

Parent/Guardian's Name: ____________________________________

Address: ____

City: ______________________ State: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Email Address: ____________________________________

Parent/Guardian's Name: ____

Address: ____

City: __________________________________State: __________________________________

Home Phone:___________________________Cell Phone: ____________________________

Email Address: ____

Person to contact in case of Emergency if Parent/Guardian cannot be reached:

Name: ________________________________Relationship to Child: ___________________

Home Phone:___________________________Cell Phone: ____________________________

Diagnosis:

Does your child have a bleeding disorder? (Please Circle) Yes No

If Yes, please place a check next to your child's diagnosis:

____Hemophilia A Mild

____Hemophilia A Moderate

____Hemophilia A Severe

____Hemophilia B Mild

____Hemophilia B Moderate

____Hemophilia B Severe

____Von Willebrand Disease (Circle Type): 1 2 3

Other (Please Describe): ____

If your child has been diagnosed with a bleeding disorder, is he/she treated at a Hemophilia Treatment Center? _____ Yes _____ No

If yes, at which Hemophilia Treatment Center does your child receive treatment (i.e., Johns Hopkins, Children's National Medical Center, CHOP, etc.):

____

PART 2 – QUESTIONNAIRE
TO BE COMPLETD BY PARENT OR GUARDIAN

The following information is very important to your child's success in HFM's programs and services. Please attach additional pages if necessary. The more information we have, the better prepared we will be for your child.

____ ____

Name of person completing this form **Relationship to Child**

If there is another professional we can contact concerning your child, please complete contact information here:

Name: _________________________________Address: _______________________________

Phone: _________________________________Email: _________________________________

I give permission to the Hemophilia Foundation of Maryland to speak to the above named professional solely for the purpose of gathering information regarding eligibility for participating in HFM programs and to plan for my children's success in HFM programs.

Parent or Guardian Signature:____

Print Name Here: ____

Date: ____

(Note: Release of information consent expires on March 1, 2016)

Does your child understand and follow simple directions? ____Yes ____No If No,

please explain:____

____

____

Does your child use words to express needs and feelings? ____Yes ____No If No,

please explain: ____

____

____

Does your child have language difficulties or problems: ____Yes ____No If No, please explain:____

____

____

What grade is your child in?_______ Has your child repeated a grade? ___Yes ____No

If so, which grade? ____

Does your child receive special help in school? ____Yes ____No If Yes, please explain: ____

____

____

Has your child received disciplinary action at school? ____Yes ____No If Yes, please explain: ____

____

____

Have there been any stressful life events in the past year? ____Yes ____No If Yes, please explain:____

____

____

How does your child get along with other children? (taking turns, group activities, disputes) ____

____

____

What, if any, concerns do you or others that care for your child have about their behavior?____

____

____

____

Does your child have any specific fears, anxieties or worries? ____Yes ____No

If Yes, what are they? ____

____

____

What are your child's strengths?____

____

Does your child have any food allergies or dietary concerns? ____Yes ____No If Yes, please explain:____

____

____

Does your child have any other allergies?_____________________________________

____

Does your child have any disabilities or limitations that may affect his participation in any activity? ____Yes ____No If Yes, please explain: ________________________

____

____

In the last 12 months, has your child taken medications for behavior or mental health concerns? ____Yes ____No

In the last 12 months, have your child been hospitalized for behavior or mental health concerns? ____Yes ____No

If Yes, please explain: ____

____

____

Is there anything important to you or to your child that you would want us to know

about? ____

____

____

* All children who attend an HFM event have the right to feel cared for in a safe and nurturing environment. All participants are expected to promote the HFM values of acceptance, mutual respect, and cooperation. We understand that no child is perfect and everyone has a bad day now and then, however, there are some behaviors that cannot be tolerated in any HFM setting.

With this in mind, the parent/guardian of a child exhibiting any of the below listed behaviors during an HFM sponsored event, will be notified, and must pick up their child immediately. Future participation in HFM events by a child exhibiting these behaviors will be at the discretion of HFM staff and Board members.

- Cursing or inappropriate language
- Aggressive behavior towards anyone (i.e., hitting, pushing, intimidation, bullying, etc.)
- Destruction of property
- Stealing

We ask that parents share these expectations with each of their children prior to their participation in HFM childcare. Thank you for helping us create a positive environment for each and every child.

Name of Person Completing this Form_________________________________

Date: __________________________