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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: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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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 B Mild

\_\_\_ Hemophilia A Moderate

\_\_\_ Hemophilia B Moderate

\_\_\_ Hemophilia A Severe

\_\_\_ 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.):

\_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**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,

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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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? \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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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

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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:** \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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