| 2224 W. 12th Ave.  Stillwater, OK 74074  405-377-3380  405-377-3499 fax | | | |
| --- | --- | --- | --- |
| Program registration for minor participant | | | |
| participant information | | | |
| Full Name: | | | Preferred Name: |
| Age: | Grade: | | School: |
| Email Address: | | | |
| May we contact the program participant via email at a later date with a follow-up survey?  Yes  No | | | |
| What program are you signing up for?  Safe Sitter  Safe@Home  Other: | | | |
| Date and Location of the Class You Wish to Attend: | | | |
| How did you hear about this program? | | | |
| Emergency contact Information | | | |
| Parent/Guardian Full Name: | | | |
| Home Address: | | | |
| Cell Phone: | | Work Phone: | Home Phone: |
| Email Address: | | | |
| May we contact you via email at a later date with a follow-up survey?  Yes  No | | | |
| back up emergency contact information | | | |
| Full Name: | | | |
| Cell Phone: | Work Phone: | | Home Phone: |
| Relationship to Program Participant: | | | |
| Healthcare information | | | |
| Primary Physician Name and Phone: | | | |
| List any allergies the participant has (medicine, food, etc.): | | | |
|  | | | |
| List any healthcare concerns the instructor should know about the participant: | | | |
|  | | | |
| List any special accommodations that need to be considered for the participant: | | | |
|  | | | |
| **No medications should be brought to class.** Please administer any necessary medication before coming to class. If medications must be administered during class, a legal parent or guardian must be present to administer medication.  **CDC guidelines will be followed and enforced. If the need arises, we reserve the right to require participants, facilitators, and guests who are not fully vaccinated against COVID-19 to wear a mask/facial covering over their mouth and nose for the duration of any in-person program/event at the discretion of PCYS staff.** | | | |
| authorization for emergency medical care | | | |
| **I understand the above listed minor (“the participant”) should not attend in-person programs or events when he/she is ill or recently exposed to a contagious disease.**  If the participant should become ill or injured while under the supervision of Payne County Youth Services, Inc., its employees, volunteers, or representatives, I authorize the participant to receive first aid and other emergency care. The parent/guardian must be available via phone or in person at all times that the participant is participating in any program/event with PCYS.  important information and signature required on back of this page | | | |
| confidentiality statement | | | |
| Federal law and regulations protect the confidentiality of participant records maintained by this program. Generally, the participant attends the program and no disclosure of any participant information is released unless:   1. The participant consents in writing. 2. The disclosure is allowed by a court order. 3. The disclosure is made to medical personnel in a medical emergency, or if a person is deemed to be in imminent danger. 4. The disclosure is made to qualified personnel for research, audit, or program evaluation.   Violation of Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.  Federal law and regulations do not protect any information about a crime committed by a participant either at the program/event or against any person who worked for the program/event or about any threat to commit such a crime.  Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal Regulations.)    Since part of the cost of this program may be paid by federal, state, or local sources, these sources have the right to review client/participant files to verify that these services have been delivered appropriately. This review is done for accounting or evaluative purposes only with no files or confidential information removed from this agency. Others having review access of your information are agency staff, consultants, and accountants.  In response to public health concerns, classes may be offered via Zoom or another virtual platform. PCYS will take all available precautions to ensure confidentiality is maintained on our side, however, complete confidentiality is not possible to guarantee using various devices and is somewhat dependent upon the device and carrier used by each participant.  **By signing this form, you are acknowledging your understanding of limits of confidentiality, and your responsibility to ensure you are in a private location while you participant in this program in a virtual format.** | | | |
| **By signing this form, I agree that I have thoroughly read and fully understand the Authorization for Emergency Medical Care and the Confidentiality Statement. Furthermore, I agree that the information presented on this form is true and accurate to the best of my knowledge.**  ***(Signature must be in ink.)*** | | | |
| Signature of Parent/Guardian: | | | Date: |
| Printed Name: | | | |
| **PHOTO RELEASE**  I, , hereby grant Payne County Youth Services Inc. (PCYS) permission to use my and/or my minor child’s likeness in a photograph in any and all of its publications, including but not limited to all of PCYS’s printed and digital publications and on various social media platforms. I understand and agree that any photograph using my and/or my minor child’s likeness will become property of PCYS and will not be returned.  I acknowledge that since my participation with PCYS is voluntary, I will receive no financial compensation.  I hereby irrevocably authorize PCYS to edit, alter, copy, exhibit, publish, or distribute this photo for purposes of publicizing PCYS’s programs or for any other related, lawful purpose.  I hereby hold harmless and release and forever discharge PCYS from all claims, demands, and causes of action which I or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.  Signature: Date Signed: | | | |