IDYD DREAMER REGISTRATION

DREAMER INFORMATION

Name of Child:			Nickname/Preferred Name:
DOB:	Gender: M F	Phone:	Email Address:
Current address:			
City:	State:		ZIP Code:
With Whom Does the Child Reside:			

SCHOOL INFORMATION

Name of School:		Grade:	GPA:
City:	State:	ZIP Code:	
Behavior at School:			

LEGAL GUARDIAN INFORMATION

Name of Guardian:		Email Address:	
Address (if different from above):		Phone:	Cell:
City:	State:	ZIP Code:	
Relationship:			
Best Way to Reach You While Child is at IDYD:			

DECEASED PARENT INFORMATION

Name of Deceased Parent:	
Cause of Death:	Date of Death:
Does the Child Understand: Y N Unknown	What was the Child's Response:
Did Child Assist with the Funeral: Y N Unknown	If so, how?

CHILD RESPONSE

Have you noticed any changes in Child's behavior since the death in the following areas? If so, please explain.

Eating patterns:	Sleeping patterns:	Grades at school:
Behavior at School:	Behavior at home:	Increased fear/worries:
Other? Since the death, I worry about my child's:		

SIBLING(S) INFORMATION

Name/Age:	Name/Age:	Name/Age:
Name/Age:	Name/Age:	Name/Age:

MEDICAL INFORMATION

Physician's Name:	Physician's Phone Number/Address:
Please list any medical allergies, food allergies, medications being taken, medical problems, or other pertinent health information:	

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IDYD DREAMER REGISTRATION

PERMISSION FOR PARTICIAPTION, RELEASE OF LIABILITY

I, the undersigned, certify that I am the parent or legal guardian of the above-mentioned Child. I hereby authorize my minor child named above to attend and participate in the programs of Identify Your Dream Foundation (IDYD), including any off-site programs or field trips for which I have registered him/her. I understand that my minor child must obey all established rules and follow the instructions of the person in charge of the program. I consent to and understand that the person in charge of the programs or their agents have the right to dismiss my child who is in their opinion a hazard to the safety and well-being of others, I understand that if my child is sent home under such circumstances I will be responsible for all associated costs incurred, including the cost of special travel arrangements.

Prior to the participation of my minor child, I acknowledge that there are certain risks associated with certain activities, including, by way of example, physical injury due to activity-related accidents, and physical injury due to transportation-related accidents, illness or even death. Furthermore, in addition, I acknowledge that there may be other risks inherent in these activities of which I may not be presently aware. Accordingly, I acknowledge that participation in such activities involves certain dangers and risks which may expose my child to hazards of bodily injury or property damage, and which may result in my child being unable to contact me or be unable to receive immediate medical care and assistance if injury occurs.

By signing this parental consent and liability form, I expressly warrant that my child named above is capable of withstanding both the physical and mental demands associated with any activities for which s/he is registered. I also expressly assume all risks to my child's participation in these activities and programs, whether such risks are known or unknown to me at this time. In recognition of these risks and realities, and in consideration of my child being offered the opportunity to participate in and benefit from IDYD's programs and activities, I agree on behalf of myself and my child to release, waive, and disclaim any and all liabilities of or claims against, Identify Your Dream Foundation, its officers, board members, agents, employees, and all private persons or organizations volunteering services without charge to transport, supervise, or chaperone my child while participating in such activities and programs, including, but not limited to any or all liabilities or claims for personal injury, property damage, court costs, attorneys' fees and interest, however, caused or accrued, as a result of my child participating in the IDYD sponsored event.

Signature of Parent:	Date:

MEDIA RELEASE

I hereby give IDYD and their legal representatives and assigns, the right and permission to photograph, digitally record, videotape, or audio tape, my above named child while s/he is attending participating in any program with IDYD. I further agree that any or all of the material recorded may be used, in any form, in publications, including electronic publications, or in audio-visual presentations, promotional literature, advertising, or in other similar ways, and that such use shall be without payment of fees, royalties, special credit, or other compensation. I understand that all such recordings, in whatever medium, shall remain the property of IDYD.

Signature of Parent:	Date:

MEDICAL AUTHORIZATION / CONSENT FOR MEDICAL TREATEMENT OF A MINOR

I recognize that there may be occasions where the minor child named above, may be in need of first aid or emergency medical or dental treatment as a result of an accident, illness, or other health condition or injury. Therefore, I authorize any IDYD staff member, or adult volunteer, in whose care the minor child has been entrusted, to consent to any X-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor by the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. In so doing, I agree to pay all fees and costs arising from this action to obtain medical treatment.

As parent or legal guardian of my minor child (Participant named above), I am responsible for the health care decisions of my minor child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for dental, medical, and/or hospital care or treatment to be rendered to my minor child is legally sufficient and that no consent from any other person is required.

By signing below, I authorize any IDYD Staff Member or Adult Volunteer, in whose care the minor child has been entrusted to authorize any hospital or physician or other health care provider to bill the following insurance company or companies for the payment of any services rendered to the minor child. I agree to assume responsibility for the charges for such care as rendered to the above named minor child.

I authorize any hospital, physician, or other health care provider to release information from the minor child's medical record to my insurance company, in connection with the completion of any insurance claim form.

Signature of Parent:	Date:

AUTHORIZATION AND REVOCATION

I have read, understood and agreed to the information above. All releases, authorizations and permission granted above shall remain in effect unless revoked in writing by the undersigned to Identify Your Dream Foundation, P.O. Box 1272, Royal Oak, Mi. 48068.

Signature of Parent:	Date: