Reset

THE UNIVERSITY OF IOWA

Child Pick Up – Handicare/Caring Hands and More

Return to
UI Family Services Office
121-50 USB
319-353-2384 (fax)

Child's Full Name: _____ Birth Date: _____

Parents/Guardians with Whom the Child Resides

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____

Home/Cell #: _____ Work Phone: _____ Email: _____

Department Name & Address: _____

Employer: **The University of Iowa** Work Hours: _____

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____

Home/Cell #: _____ Work Phone: _____ Email: _____

Department Name & Address: _____

Employer: **The University of Iowa** Work Hours: _____

Child Pick Up – Authorized Individuals*:

*(*required to have at least one local person within 30 miles of Coralville. Only Parents/Guardians identified above and individuals authorized herein will be allowed to pick up participating children)*

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____

Home/Cell #: _____ Work Phone: _____ Email: _____

Employer's Name & Address: _____

Department: _____ Work Hours: _____

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____

Home/Cell #: _____ Work Phone: _____ Email: _____

Employer's Name & Address: _____

Department: _____ Work Hours: _____

This consent will be in effect and will be updated annually by a parent or legal guardian beginning on (date)_____

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Updated: 10/8/2014

Parental Emergency Medical/Dental Authorization

Child's Full Name: _____ Birth Date: _____

Medical and Dental

In the event that my child (listed above) may require medical, dental, and/or surgical care and I am unavailable to provide consent, I hereby give my consent for appropriate emergency care, including surgical treatment.

NOTE: Every effort will be made to notify parents/guardians immediately in case of emergency.

****Required Information****

Child's Doctor: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Child's Dentist: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Known Allergies and reactions:

Date of last Tetanus: _____

Present Medications:

Insurance Company: _____ Policy Holder's Name: _____

Policy Holder's ID#: _____

I agree to pay the entire costs and fees contingent on any emergency medical or dental care and/or treatment for my child as secured or authorized under this consent. I release the Program of any liability unless negligence is proven. This form will be presented upon admission for treatment.

This consent will be in effect and will be updated annually by a parent or legal guardian beginning on (date)_____

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Travel, Photo, Sunscreen and Topical Ointment and Health Assessment Release

Travel

I/We do ◯ , do not ◯ give consent for my child to participate in field trips with Handicare, Inc., including walks for infants.

I/We do ◯ , do not ◯ reserve the right to be notified before each field trip that involves travel out of town. **I am aware that Handicare may take children to local parks without prior notice**.

Photo

I/We do ◯ , do not ◯ understand that Handicare may from time to time take photographs of participating children for Handicare's own promotional purposes, commercial or otherwise.

I/We do ◯ , do not ◯ consent to the taking of such photographs and authorize Handicare to reproduce, exhibit or distribute such photographs in any medium (e.g., print publications, video tapes, CD-ROM, Internet/WWW) for any purpose that Handicare deems appropriate, including promotional or advertising efforts.

I/We do ◯ , do not ◯ release Handicare from liability for any violation of any personal or proprietary right I may have in connection with such use and I/we understand that all such recordings, in whatever medium, shall remain the property of Handicare.

Media Photos

I/We do ◯ , do not ◯ further consent to our child being photographed and/or videotaped by the media (newspaper, television) while at Handicare. These photos and/or videos may be printed in the newspaper or broadcast on television.

I/We do ◯ , do not ◯ release Handicare and any such media from liability for any violation of any personal or proprietary right I/we may have in connection with such use, and I/we do ◯ , do not ◯ understand that all such recordings, in whatever medium, shall remain the property of the media who created them.

Sunscreen and Topical First Aid Ointment Release

I/We do ◯ , do not ◯ authorize Handicare, Inc., to apply sunscreen and/or topical first aid ointment to my child when determined by Handicare, Inc., staff that is appropriate for these to be applied.

Vision and Hearing Screening and Health Assessment Release

Handicare, Inc., offers learning experiences to many groups, including the Grant Wood Area Education Agency, the Lion's Club, and students in the University of Iowa Nurse Practitioner program (collectively, the "Groups"). Children are picked randomly for these beneficial assessments conducted by one or more Groups.

I/We do ◯ , do not ◯ give consent for the Groups to perform a short developmental/health assessment on my child in order to practice their skills.

This consent will be in effect and will be updated annually by a parent or legal guardian beginning on (date)_____

Parent/Guardian's Signature:_____ Date: _____

Parent/Guardian's Signature:_____ Date: _____

Updated: 10/8/2014