



Child Pick Up - Handicare/Caring Hands and More

Email completed forms to:
livewell@uiowa.edu

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:

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: