California Regional Training Institute

BAHÁ'Í CHILDREN'S CLASS REGISTRATION FORM

Participant's Name: _____

Address: _____

Home Phone #: _____

Participant's Age: _____ **Grade Level:** _____ **Birth date:** _____

Participant's School Name: _____

Parent/Guardian: _____
Name *day phone* *email address*

_____
Name day phone email address

Who is authorized to pick your child up from their children's class? *Only those individuals listed below will be allowed to pick your child(ren) up after their children's class meeting.*

_____

_____

_____

I understand that my child must be picked up by an authorized adult listed above unless one of the boxes below has been checked:

☐ I authorize my child to walk home.

☐ I authorize my child to take the city bus.

Media Release/License

The undersigned parent or guardian of _____ , a minor, grants the California Regional Training Institute or its designated representative, permission to use my child's name, likeness or image in any printed or electronic material for the purpose of documenting, reporting and promoting the programs of the Institute.

Parent/Guardian's printed name _____ signature _____

California Regional Training Institute

BAHÁ'Í CHILDREN'S CLASS
Medical Release Form

I, the undersigned parent or guardian of _____, a minor, do hereby authorize the California Regional Training Institute, or its designated representative, agent(s) for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. As the parent/guardian of a minor under the age of 18, I understand that this authorization enables representatives of the California Regional Training Institute to arrange medical care for my dependant minor in the event I am unavailable.

I understand that I am responsible for payment of any and all medical expenses incurred on behalf of my dependent minor. This authorization shall remain effective from _____ [date] to _____[date], when my child is attending the [weekly/daily/monthly, etc] children's classes..

Parent/Guardian Signature: _____Date:_____

Emergency Contact Name and Telephone: _____

Family Physician Name and Telephone: _____

Medical Insurance Company: _____

Policy Number: _____

Additional Emergency Contact *(in the event parent cannot be reached):* _____

Telephone: _____

List Allergies, Handicaps, Limiting Health Conditions, Medications, Reactions to Medications

Instituto Regional de Entrenamiento California

HOJA DE REGISTRO PARA CLASES DE NIÑOS

Nombre del participante: _____

Direccion: _____

Telefono de la Casa #: _____

Edad: _____ **Nivel de Grado:** _____ **Fecha de Nacimiento:** _____

Escuela donde Estudia : _____

Padres/Guardián: _____

Nombre *# de Telefono* *dirección electrónica*

_____

Nombre *# de Telefono* *dirección electrónica*

Quién está autorizado para recoger al nio después de clase? *Unicamente los que estan anotados en las lineas de abajo pueden recoger al niño (o niños) depués de terminar las clases..*

_____

_____

_____

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Padres/Guardián en letra de molde _____

Firma de Padres/Guardián _____

Instituto Regional de Entrenamiento California

CLASES BAHA'IS PARA NIÑOS
Formulario de Autorización Médica

Yo, el padre de familia ó guardian abajo firmante de _____, un menor de edad, por la presente autorizo al California Regional Training Institute (Instituto Regional de Entrenamiento California) , o su representante designado, o agente(s), a aprobar examen de radiografia, anestesia, diagnostico medico o quirugico, o tratamiento y cuidado hospitalario que considere conveniente por, y prestado bajo la supervision general o especifica de un medico o cirujano licenciado bajo las provisiones del Acto de Practica Medica (Medicine Practice Act) en el personal medico de un hospital licenciado, sea tal diagnostico prestado en la oficina de dicho medico o en dicho hospital. Como padre de familia/guaridan de un menor de edad menor la edad de 18 años, entiendo que esta autorizacion permite que los representantes del Instituto Regional de Entrenamiento California a organizar cuidados medicos para mi menor dependiente en caso que esto sea disponible.

Yo entiendo que soy responsable por el pago de todo y qualquier gastos medicos incurridos en nombre de mi menor dependiente. Esta autorización seguirá en vigor desde_____(fecha) a_____(fecha) mientras mi hijo/a asiste a las clases de niños [semanales/diarias/mensuales, etc.]

Firma de Padre de Familia: _____Fecha:_____

Contacto de Emergencia: Nombre y Teléfono: _____

Medico Nombre y Teléfono: _____

Seguro Medico: _____

Número de police: _____

Contacto de Emergencia Adicional: *(en caso que no se pueda contactar al padre de familia):* _____al Teléfono: _____

Lista de Alergias, Incapacidades, Condiciones Limitantes de Salud, Medicaciones, Reacciones a Medicaciones