Group Participant Registration Form

Please complete the following information, and sign and date below.

Child's name_____ Date of birth_____
Parent/Legal Guardian name(s)_____
Address_____
Home phone _____Cell_____
Email_____

Known Allergies of the Child: _____
_____

Funding Information

___ Delaware County Board of Developmental Disabilities (PAS is required)
___ Self-Pay

Emergency Information

Emergency Contact 1_____Phone:_____Relationship:_____
Emergency Contact 2_____Phone:_____Relationship:_____
Physician Name:_____ Physician Phone:_____
Physician Address:_____

Name of the group your child is being enrolled in:_____

Please return both forms, along with check payable to HealthSmart! Consulting if self-pay, to:

HealthSmart! Consulting
8595 Columbus Pike, Suite 227
Lewis Center, OH 43035

Call 614-397-0624 with any questions
Email: patty@healthsmartconsult.com

I attest by signing below that the above information is true and accurate. I authorize HealthSmart! Consulting to provide services and bill and release required information to my funding source for services rendered.

Signature of person completing this form:_____
Printed name of person completing this form:_____
Relationship to client:_____ Date form completed:_____

Parental/Guardian Consent Form

Participant's name:_____ Date of Birth:_____

I_____, give my son/daughter _____
Parent or Guardian Name Child's Name
permission to participate in a group activity with HealthSmart! Consulting at The Flourish Center.

Emergency Medical Treatment:

I understand that it is highly preferred that parents remain on the premises during group sessions. If I am not present and in the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:
Name & relationship: _____
Phone: _____ Family doctor: _____ Phone: _____
Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

HealthSmart! Consulting may occasionally take photos of group activities to be used only by HealthSmart! Consulting and Flourish Integrated Therapy, LLC/The Flourish Center for websites, In-Clinic, etc. (childrens' names will not be included). Do you give consent to HealthSmart! Consulting to photograph your child as part of group classes?

_____YES _____NO

I fully understand and agree to the policies and procedures for group participation with HealthSmart! Consulting and consent to my child's participation in the program.

_____
Parent/Guardian Signature Date