

PEDIATRIC ENROLLMENT & EMERGENCY CONTACT FORM

This contract is to (*check one*) Enroll Renew Enrollment for HSDC services for:

Client's Name _____ Date of Birth _____

Parent/Guardian Names _____ Other Language(s): _____
 Deaf Hearing Hard of Hearing
 Deaf Hearing Hard of Hearing

EMERGENCY CONTACT PERSONS

Primary Contact: person who will be nearby or most reachable in the event of an emergency.

Name _____ Relation to Client _____
 Deaf Hearing Hard of Hearing Other Language(s) _____
Home Phone _____ (*please check*) Voice TTY Videophone
Work Phone _____ (*please check*) Voice TTY Videophone
Cell Phone _____ (*please check*) Voice Text
Home Address _____ Email Address _____

Secondary Contact: person we should try next in the event of an emergency.

Name _____ Relation to Client _____
 Deaf Hearing Hard of Hearing Other Language(s) _____
Home Phone _____ (*please check*) Voice TTY Videophone
Work Phone _____ (*please check*) Voice TTY Videophone
Cell Phone _____ (*please check*) Voice Text
Home Address _____ Email Address _____

OTHER INDIVIDUAL AUTHORIZED TO PICK UP THE CHILD FROM HSDC

Name _____ Relation to Client _____
 Deaf Hearing Hard of Hearing Other Language(s) _____
Home Phone _____ (*please check*) Voice TTY Videophone
Work Phone _____ (*please check*) Voice TTY Videophone
Cell Phone _____ (*please check*) Voice Text
Home Address _____ Email Address _____

Is it OK to leave voicemail containing confidential healthcare information with the numbers provided? Yes No

PHOTO/PUBLICATIONS RELEASE (OPTIONAL)

I give HSDC or its legal representatives the absolute right and permission to include my child's name in articles, and to copyright and/or publish photographic portraits, pictures, or video of my child, and to use my child's photo in conjunction with a fictitious name for art, health, education, marketing, or any other lawful purpose. I waive my right to inspect and/or approve the finished product or the use to which it may be applied. I release, discharge, and agree to hold harmless HSDC or its legal representatives from any liability by virtue of any blurring, alteration, optical illusion, or use in composite form whether intention or otherwise, that may occur or be produced in the taking of said pictures or any processing tending towards the completion of the product.

Client/Parent/Guardian Name _____ Client/Parent/Guardian Signature _____
HSDC is a teaching facility. Students may observe, participate in, or administer treatment plans developed by your licensed clinician. If you have concerns, please consult the director.