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CIMT Registration Form:

Constraint Induced Movement Therapy consists of casting the unaffected arm for children with hemi-plegia in order to facilitate the use of the affected arm. The procedure is typically risk free, but there may be skin break down or reaction to the casting. However, we will use a stockinet against the skin to protect the child's skin and fiberglass casting materials. The cast will be applied on Monday and removed by a circular saw on Friday of the same week. This will cut down on the any potential of atrophy and it will also allow the child to take a break. Studies have shown that the results are most effective if done for a three week time span with breaks on the weekends. Please visit our website at www.crosswaytherapy.com for references.

Your child must have current immunization records prior to registration

Camper information

DOB _____ Age _____ Rising Grade _____ Male ___ Female ___
Last Name _____ First Name _____ Called _____
Address _____
City _____ State _____ Zip _____
Phone Number _____ Family E-mail _____

Mother/Guardian _____ Father/Guardian _____
Address _____ Address _____
City _____ City _____
Mother/Guardian Home # _____ Father/Guardian Home # _____
Mother/Guardian Cell # _____ Father/Guardian Cell # _____
Mother/Guardian Work # _____ Father/Guardian Work # _____

Medical History

Please list the cause if know of your child's hemiplegia, whether is was perinatal CP, neonatal stroke, or other

Allergies: _____

Medications: _____

Insurance information: Name of Carrier: _____

Group Policy: _____ Name of Insured: _____

Immunizations: Please mark if current and provide documentation of the record: _____

Date of last tetanus shot _____

Description of camp activities from which camper should be exempted from for health reasons _____

Description of current physical, mental or psychological conditions requiring medication, treatment or special considerations while at camp _____

Record of past medical treatment, operations or serious injury _____

Describe three goals that you have for your child as a result of CIMT therapy?

1) _____

2) _____

3) _____

Does your child have a neurologist or specialist working with you? If yes, please list

Child's Physician _____ Phone # _____

Date of Last Exam _____

Emergency Contacts

Name _____ Phone # _____ Relationship to Camper _____

Name _____ Phone # _____ Relationship to Camper _____

Waiver

This health history is complete and accurate to the best of my knowledge. I understand that Crossway Pediatric Therapy assumes no responsibility for injuries or illnesses which may result from his/her participation in the CIMT camp classes and activities. I agree to hold harmless the staff and volunteers of Crossway Pediatric Therapy for accidents or injuries arising out of the campers participation in the activities. Crossway Pediatric Therapy adheres to OSHA standards, ADA and HIPAA guidelines. If my child requires special accommodations, I understand that I must contact Shelley Portaro, director to request the accommodations.

Registration dates:

Summer Camp: registration and deposit of \$125 for each session due by June 1 and the remainder by June 15. Deposits will be refunded if participant numbers are not met. Past due balances will result in the forfeiture of the camper's slot.

Tax Information and Receipts: Tax ID# 32-0095955. Please make checks payable to Crossway Pediatric Therapy. We also accept MasterCard and Visa. Please contact Shelley Portaro for receipts.

Prompt Pick Up: Unless an emergency situation arises, there will be a \$5 per 5 minutes late fee for children that are not picked up by the close of the camp.

I HAVE READ AND AGREE TO ALL THE POLICIES SET FORTH BY CROSSWAY PEDIATRIC THERAPY SUMMER CAMP AND CLASS PROGRAM.

SIGNATURE _____ DATE _____