2025 / 2026
The CARE Station Registration
Individual Recreation Plan

Consumer's Name_____**Tele#**_____

(Please Print) **Cell#**_____

Address_____

Town_____ State_____ **Zip Code**_____

Age_____ **Date of Birth**_____

I DO HEARBY GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THE PROGRAM AT BLOOMFIELD RECREATION DEPARTMENT AND IN CASE OF AN ACCIDENT OR INJURY TO WAIVE ALL CLAIMS AGAINST THE SPONSORS OR ANY SUPERVISORS DESIGNED BY THEM.

PERMISSION TO PUBLISH: In permitting the entrant to participate, I am specifically granting permission for you to use the name, likeness, voice and words of the entrant in television, radio, films, newspaper, magazines and other media, and in any form not heretofore described, for the purpose of advertising or communicating the purpose and support such activities. I, the undersigned, have read and fully understand the provisions of the above release and have explained them, if applicable, to said entrant. I hereby agree that I and said entrant will be bound thereby.

_____
Parent's or Guardian's Signature

EMERGENCY MEDICAL AUTHORIZATION

In the event that I am unable to be reached by telephone, I do authorize:

NAME_____ **TELE. #**_____

To act on behalf, or if neither can be reached, do hereby grant permission to a licensed physician or hospital to perform diagnosis, treatment, and surgery on the aforesaid minor for any emergency illness or injury, as deemed necessary by such competent medical opinion.

_____
Parent's or Guardian's Signature

If you have any questions, please call 725-4485.

PLEASE RETURN THIS FORM DIRECTLY TO:

Bloomfield Recreation Department
84 Broad Street
Bloomfield, NJ 07003 2001

CLIENTS EDUCATIONAL QUESTIONNAIRE

Name of Consumer (Please Print) _____

Name of School _____

Name of Teacher _____

Type of Class/ Classification of child _____

Consumer's Instructional Grade Level: **Math _____**
Reading _____
Language Arts _____

PLEASE NUMBER THE FOLLOWING FROM 1 TO 5 (1 IS BEST, 5 IS LOWEST)

1. **Works independently _____**
2. **Reacts well to authority _____**
3. **Socializes well with peers _____**
4. **Socializes well with older children _____**
5. **Socializes well with younger children _____**
6. **Asks for help appropriately _____**
7. **Can work in a group _____**
8. **Can stay on task (Also, please list approximate time) _____**

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MISCELLANEOUS INFORMATION

NOTE TO ALL PARENTS: Please pay close attention to this section. This information will be reviewed by the program director and any pertinent information will be passed along to the staff members responsible for your child's safety and well-being. This section is not designed to just find out any confidential information and does not just concern medical problems. Its purpose is to help make your child's experience as enjoyable and fun-filled as possible. Please fill out the comment areas as best as possible. The more we know about your child's likes, dislikes, what he/she is good at, etc., the more enjoyable program will be.

COMMENT AREA

Does your child have any fears (loud noise, etc.)? Can they go on trips outside of the program and can they ride a bus (45 minutes max.)? Any restrictions (physical ability - vision, climbing stairs, etc.)?

_____
_____
_____
_____
_____

Is your child involved in any behavior modification programs and if so how can we continue the program?

_____
_____
_____
_____

Is your child toilet trained or currently being trained? Are they in diapers or pull-ups? Are there any key words we should know that are used at home to let us know your child has to go to the bathroom?

_____
_____

Any other comments? Food restrictions, specific behavior, phrases used at home, or any other miscellaneous information concerning your child's needs?

Please feel free to let us know if you would like any information to be kept strictly confidential and please use the remainder of this page to continue with any comments. Thank you.

ROUTINE MEDICAL ADMINISTRATION

Consumer's Name: _____ Date of Birth: _____

Medication Name	**Administration Time**	**Dosage**
_____	_____	_____
_____	_____	_____
_____	_____	_____

If there are any side affects to the above-mentioned medications, please give details.

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Parent/Guardian **Date**

NOTE: No medications will be administered at this program without prior written permission from both the parent and doctor, along with exact directions for administering the said medication.

QUESTIONNAIRE

Consumer's Name:

_____

1. **Please list any behavioral or management problems.**

_____
_____
_____

2. **Please describe any successful management techniques such as a token economy, behavior modification charts, contracts or time-outs that you have used with your child. (Please attach a copy of any charts that are relevant.)**

_____
_____
_____

3. **Does this child display any oppositional concern? Yes _____ No_____**
If yes, please explain. _____
_____

4. **Is the child impulsive? Yes_____ No_____**

_____

5. **Please describe the social relationships your child exhibits with his/her peers.**

_____
_____
_____

6. **What are the child's recreational strengths and weaknesses?**

_____
_____

7. **Additional Comments:**

_____
_____
_____

THANK YOU FOR YOUR HELP AND INFORMATION.