

Security Release/Emergency Contact Information:

Girls Incorporated releases children to authorized adults only! Please list the authorized people to pick up the above named child from Girls Incorporated of Winter Haven. Each person must be 18 years or older and will be the only ones permitted to pick up this child. In the event it becomes necessary to have an additional person added it is the responsibility of the parent/guardian to notify Girls Incorporated staff and provide authorization in writing on this form. It is further understood that each child is required to be signed out at the end of each day by the person picking her up. In the event of an emergency and the parent/guardian cannot be contacted the following persons are authorized to pick up the above named child. An emergency is defined as an illness, injury, severe discipline situation, or being late to pick up child. Each parent is required to provide three contacts with current working phone numbers (the information will be verified by a Girls Incorporated staff member).

| Name | Relationship | Home Phone Number | Work Phone Number |
|------|--------------|-------------------|-------------------|
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Permission Slip:

My child/children, _____ has my permission to ride Girls Incorporated vehicles when leaving Girls Incorporated premises. My child/children, also has my permission to participate in activities sponsored by Girls Incorporated. I understand completely that reasonable measures will be taken to safeguard my child's safety. Both my child/children and I agree not to hold Girls Incorporated of Winter Haven or the staff members responsible for injuries or accidents. I authorize Girls Incorporated staff to administer first aid.

**STATE OF FLORIDA
COUNTY OF POLK**

(This notary seal applies to all information stated on these forms).

Sworn to (or affirmed) and subscribed before me this ____ day of _____, _____ by

Parent/guardian name (print): _____

Parent/guardian signature: _____

NOTARY PUBLIC _____

STAMP

Notary Public name (print): _____

____ personally known to me ____ Produced identification: _____

Girls Incorporated of Winter Haven is a non-profit, United Way agency. Periodically it becomes necessary to have access to information pertaining to the people we serve. This form will assist us in obtaining information that has been required by United Way, our national organization, and other funding sources. All questions MUST BE answered.

Has your child/children experienced any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---------------------|-----|----|----------|-----|----|-------------|-----|----|
| Allergies | | | Asthma | | | Seizures | | |
| Severe Scoliosis | | | Hearing | | | Visual | | |
| High Blood Pressure | | | Heart | | | Sickle Cell | | |
| Cerebral Palsy | | | Stomach | | | Headaches | | |
| Muscular Dystrophy | | | Diabetes | | | | | |
| Bladder | | | | | | | | |

If so, should activities be limited, please explain: _____

Has your child ever had any of the following problems?

| | Yes | No | | Yes | No |
|---------------------------|-----|----|---|-----|----|
| Learning Disabilities | | | Attention Deficit Disorder (ADD) | | |
| Developmental Delay | | | Attention Deficit/Hyperactivity Disorder (ADHD) | | |
| Emotional Difficulty | | | Oppositional Defiant Disorder (ODD) | | |
| Limited Mobility | | | | | |
| Other Diagnosed Concerns: | | | | | |

Please list any additional health concerns, surgical procedures, or severe injuries that may affect your child/children's physical ability or stamina: _____

Family Information:

Child resides with both natural parents _____ City where parent/guardian works _____
 Child resides with mother only _____ City where parent/guardian works _____
 Child resides with father only _____ Housing: Rent ___ Own ___ Live with others ___
 Child resides with one natural and _____ who? _____ Temporary? _____
 One step parent/live in/significant other _____ Did you attend Girls Inc. as a child _____
 Child resides with other _____ who? _____
 Do you (parent) have any friends of relatives who attended Girls Inc. as a child? If so, list name: _____

Racial/Ethnic Information:

Asian American _____ Black American _____ Hispanic/Latino _____
 American Indian _____ White/European _____ Haitian/Caribbean _____ Other _____

Annual Household Income:

Below \$4,999 _____ \$20,000 – 24,999 _____ \$40,000 – 44,999 _____
 \$5,000 – 9,999 _____ \$25,000 – 29,999 _____ \$45,000 – 49,999 _____
 \$10,000 – 14,999 _____ \$30,000 – 34,999 _____ \$50,000 - Above _____
 \$15,000 – 19,999 _____ \$35,999 – 39,999 _____

Source of Income / Monthly Gross Estimate

Employment \$ _____ Social Security \$ _____ Disability \$ _____
 Alimony \$ _____ Unemployment \$ _____
 Child Support \$ _____ Other Income \$ _____

Girls Incorporated® of Winter Haven
P.O. Box 7285 - 2400 Havendale Blvd.
Winter Haven, FL 33883
Phone: 863-967-2864 or 863-967-2874
Email: LMcArthur-girlsinc@tampabay.rr.com

PERMISSION FOR MEDICAL TREATMENT

I, the undersigned, being the parent, legal next-of-kin, or legal guardian of:

Child's Name

Hereby authorize any necessary treatment for the above named child while participating in any of the activities of Girls Incorporated of Winter Haven in and out of Polk County Florida. I also guarantee payment of all charges incurred during this medical treatment (Physician, hospital, x-ray, lab, medication, ambulance, etc.)

MEDICAL INFORMATION

1. List all allergies to foods, medications, etc. _____
2. List medical history (include illnesses, surgeries, etc.) _____
3. List medications taken regularly (include dosage and schedule) _____

NOTE: an additional medical form must be completed for administering medications.

FAMILY PHYSICIAN: _____

Office address: _____ Phone number _____

INSURANCE INFORMATION

Please provide a copy of child's insurance card

Insured's name: _____ Employer: _____

Medical insurance company: _____ Group/Policy # _____

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