



Bodhi Tree Language Center

5403 SE Center Street, Portland, OR 97206
503-788-0336 · <http://www.BodhiTreeLanguageCenter.org>

Immersion Program for Preschoolers

Registration Form

Child(ren)'s Information

Name	Gender <i>Male or Female</i>	Start Date	Birth Date	Days <i>T, W, Th</i>	Session <i>Full/Half Day</i>	Program <i>Toddler; Preschooler</i>	Language Mandarin Chinese; Japanese

NOTE: See the Website (<http://www.BodhiTreeChineseSchool.org>) for exact days and hours, and other details, of each program. The **preschool program** is for children 3-5 years old. Preschoolers must be potty-trained. The **toddlers program** is for children 2 years old. Toddlers must be accompanied by parent or guardian.

Mother's Information (or Primary Legal Guardian)

Name	
Address	
Telephone at Home	
Telephone at Work	
Occupation	
Email address:	

Father's Information (or Secondary Legal Guardian)

Name	
Address	
Telephone at Home	
Telephone at Work	
Occupation	
Email address:	

Consent for Emergency Medical Treatment and Program Participation

I hereby authorize the Bodhi Tree Center (the "CENTER") to procure proper medical, dental, and hospital care for my CHILD, _____, in the event of injury or illness while my child is in the care of the CENTER. I understand and agree that I am financially responsible for any care or services provided. I hereby waive all liability of the CENTER and its staff and from any and all accidents, mishaps, or other injuries not covered by the insurance in force. Also, I hereby grant permission for my child to participate in all activities of the CENTER. I agree to bring and call for my child promptly on the days and times that he/she is scheduled for. I understand that the CENTER cannot assume responsibility for children left at CENTER facilities before and after program hours. In case my child is ill or cannot attend, I agree to notify the school with as much advance notice as possible.

Signature of Parent of Legal Guardian

Name of Above Signed (Please Print)

Date

Medical, Dental, and Emergency Contact Information

Family Physician

Address

Telephone

Family Dentist

Address

Telephone

Insurance Carrier/Provider

Policy Number and Group Number

Emergency Contact #1

Relationship to child

Address

Telephone (Home)

Telephone (Work)

Telephone (Other)

Emergency Contact #2

Relationship to child

Address

Telephone (Home)

Telephone (Work)

Telephone (Other)

Health History

Does your child have any of the following health concerns or conditions? Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Physical injuries (recent) |
| <input type="checkbox"/> Bowel/Bladder problems | <input type="checkbox"/> Seizure disorders |
| <input type="checkbox"/> Diabetes (attach diet) | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Emotional/behavioral problems or learning concerns | <input type="checkbox"/> Vision/Hearing problems |
| <input type="checkbox"/> Handicapping conditions | <input type="checkbox"/> Other chronic or recent illness or surgical procedure |
| <input type="checkbox"/> Hay fever | |
| <input type="checkbox"/> Heart problems | |

Please provide specific information about any above identified health concern, including indications about treatment needed while your child is participating at the CENTER:

Date of child's last **tetanus booster**: _____

Does your child have any activity restrictions? If so, please specify:

Does your child have any dietary restrictions or needs (e.g. cannot eat eggs or nuts, is vegetarian, etc.)? If so, please specify:

Please list any and all other pertinent health information that we should know about:

Authorization for Administration of Over the Counter Medication

For the relief of minor health problems that might temporarily affect your child's comfort at the CENTER, a small supply of over the counter medication may be available. These medications are administered as needed. Your physician does not need to sign for the medications listed below. **The Health History is checked for Allergies and other Health Concerns before any medication is given.** Medications available for use may include the following:

- | | |
|--|---|
| <input type="checkbox"/> Asprin pain/fever relievers | <input type="checkbox"/> Antiseptic (Bactine) |
| <input type="checkbox"/> Non-aspirin pain/fever relievers such as Tylenol or Advil | <input type="checkbox"/> Sunscreen |
| <input type="checkbox"/> Throat lozenges | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cough syrup | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cough drops | |

If you want your child to receive over the counter medication, if needed, and at the discretion of CENTER staff, please sign below. If this list contains medication that you do NOT want your child to receive, please strike out that medication before signing.

I authorize the CENTER to administer over the counter medication (limited to those on the list above and not struck out) under direction of CENTER staff:

Signature of Parent of Legal Guardian

Name of Above Signed (Please Print)

Date
