Parents' Night Out Registration Form

Parents' Night Out (PNO), a program of SCOPE under the auspices of the SKN Foundation will be held for children with special needs and their siblings, ages of 5 years through 21 years, to be organized once every month. This program will allow parents to take some time off from child care and allow their children to interact in a group environment with other children. To participate in this program, families must complete a Registration and Participation Form along with a Medical Clearance.

Please return this completed form to: The SKN Foundation
4 Lanning Way
Hillsborough, NJ 08844

Participant Name: _____ M___ F___

Date of Birth: _____/_____/_____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell: (_____)_____

Email: _____

Parent/Guardian Information

Primary Name: _____ Relationship: _____

Primary Phone: (___)_____ ( ) Home ( ) Cell

Email: _____

Secondary Name: _____ Relationship: _____

Secondary Phone: (___)_____ ( ) Home ( ) Cell

Email: _____

Will you be bringing any siblings? _____ If so, please fill out the additional information below.

Name: _____ M___ F___

Phone: (_____)_____ Email: _____

The activities at the center will be led by trained volunteers and healthcare professionals. We believe that your child may also benefit with some care provided by a trained professional that has worked with them before.

Do you know of any therapist, doctor, caregiver, etc. who would be willing to work with your child at the location? If so, please provide their details.

Name: _____ Phone: (_____)_____

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Participant Medical Form

Please read the information below prior to completing the Medical Form	PRINT CLEARLY

This form should be completed by the participant's legal guardian and reviewed by a licensed healthcare professional and MUST be signed the bottom of this page. This form should be completed and sent to the SKN Foundation at least 2 WEEKS before the starting date. It is advised that you photocopy this form for your records. You will receive a confirmation email notifying you when your child is eligible to participate in the program.

Participant Information

Last Name	First Name	Middle Name	
Street		DOB (mm/dd/yy)	Age
City	State	Zip Code	☐ Male ☐ Female

Primary Contact for Health-Related Illnesses or Emergencies

Full Name	Relationship to Participant	Phone Number

Additional Contacts for Health-Related Illnesses or Emergencies

Full Name	Relationship to Participant	Phone Number
Full Name	Relationship to Participant	Phone Number

Medical Insurance Information

This participant is covered by medical insurance	☐ Yes ☐ No

Include a copy of your insurance card.

Insurance Company	Policy Number	Subscriber	Phone Number

Health Care Provider Information

Name of Primary Doctor	Phone Number
Name of Dentist	Phone Number
Name of Other Provider	Phone Number

Allergies— Add additional information about allergies, including specific allergies, reaction, and recommended treatment.

- ☐ No known allergies
- ☐ Food
- ☐ Medication
- ☐ Environment (insects, seasonal, etc.)
- ☐ Other

Parents' Night Out

Participant Medical Form

Seizure/Epilepsy

- ☐ No previous history of seizures
- ☐ Previous history of seizures
- ☐ Controlled by medication

Additional Information:

Date of last seizure: _____ Type of Seizure: _____

Time Length of Seizures: _____ Known Triggers:_____

Please attach a seizure action plan for PNO supervisors, if applicable..

Diet/Nutrition

Please include any special information about participant's diet here, including allergies, food restrictions, selective eating, etc.

At PNO, pizza will be served to the children for dinner. Please check the appropriate box.

☐ My child will eat pizza. ☐ My child will NOT eat pizza. If your child will bring food from home, please indicate any specific needs/requests: _____

Profile and Daily Living Skills

Social Abilities: (Please check all that apply)

- ☐ Participates and plays well with others
- ☐ Prefers limited contact with others
- ☐ Engages in aggressive behaviors
  - ☐ Rarely ☐ Occasionally ☐ Often
- ☐ Destroys property
  - ☐ Rarely ☐ Occasionally ☐ Often
- ☐ Has some difficulty around other children
- ☐ Does not get along with others
- ☐ Engages in self injuring behavior
  - ☐ Rarely ☐ Occasionally ☐ Often
- ☐ Tantrums
  - ☐ Rarely ☐ Occasionally ☐ Often

Any additional information? _____

Toileting Skills:

How independent is your child in toileting? ☐ Independent ☐ Verbal prompts ☐ Partial assistance ☐ Total assistance

Any additional information? _____

Communication:

In what way(s) does your child communication with others? ☐ Full speech ☐ Single words ☐ Attempts words ☐ Non-verbal

Any additional information? _____

Mobility:

How does your child move from place to place? ☐ Walks independently ☐ Walks with assistance ☐ Uses walker or crutches ☐ Wheelchair

Any additional information? _____

Parents' Night Out

Participant Medical Form

General Health History

Has/Does the participant:

1) **Ever been hospitalized?** ☐ Yes ☐ No
   When: _____
   Reason: _____

2) **Ever had surgery?** ☐ Yes ☐ No
   When: _____
   Reason: _____

3) **Have chronic illness?** ☐ Yes ☐ No
   _____
   _____

4) **Had a recent injury?** ☐ Yes ☐ No
   _____
   _____

Has/Does the participant:	Yes?	No?	Please Explain "Yes" answers below
Had asthma/shortness of breath?			
Have diabetes?			
Had seizures?			
Have headaches?			
Wear glasses, contacts, or protective eyewear?			
Had fainting or dizziness?			
Passed out/head chest pain during physical exercise?			
If female, had problems with periods/menstruation?			
Ever had back/joint problems?			
Have any problems with diarrhea or constipation?			
Have any skin problems?			
Travelled outside the country within the past 9 months?			
Had an infectious disease and/or mononucleosis during the past 12 months?			
Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder?			
Ever been treated for emotional or behavior difficulties or an eating disorder?			

Has/does the participant take any medication? ☐ Yes ☐ No

If answered "Yes," please list the medication below, as well as the reason they are being taken.

_____

_____

_____

_____

Parents' Night Out

Participant Medical Form

Additional Information
Please provide in the space below any additional information about the participant's health that you think important or that may affect the participant's ability to fully participate in the Parents' Night Out Program. **Attach additional information, if appropriate.** Any plans that are not necessary or relevant to your child's care can be omitted. ☐ **Behavior support plan** ☐ **Seizure Action Plan** ☐ **Asthma Action Plan** ☐ **Caregiver's notes and suggestions** ☐ **Allergen Action Plan**

Parents' Night Out

Behavior Support Plan

Behavior Summary

What are some behaviors that your child engages in? Please list them below. (Problem Behavior)

What is the behavior that you would like to replace the above behaviors with? Please list them below. (Replacement Behavior)

Accommodations, Interventions, and Responsibilities

Accommodations to assist the student in displaying the replacement behavior:

- ☐ Clear, concise directions
- ☐ Modify assignments
- ☐ Avoid strong criticism
- ☐ Frequent reminders/prompts
- ☐ Review rules and expectations
- ☐ Predictable, routine schedule
- ☐ Frequent breaks/vary activities
- ☐ Provide cooling off period
- ☐ Specifically define limits
- ☐ Teacher/staff proximity
- ☐ Communicate regularly with parents
- ☐ Avoid physical contact
- ☐ Reprimand the student privately
- ☐ Supervise free time
- ☐ Other: _____

Interventions and who is responsible for them:

1._____

_____

2._____

-_____

3._____

_____

4._____

_____

Positive and Negative Consequences

Positive Consequences for Appropriate Behavior

- ☐ Verbal praise
- ☐ Earned privileges
- ☐ Tangible rewards
- ☐ Immediate feedback
- ☐ Earned tokens/points
- ☐ Free time
- ☐ Positive call or note home
- ☐ Other_____

Negative Consequences for Inappropriate Behavior

- ☐ Loss of points/tokens
- ☐ Loss of privileges
- ☐ Time out
- ☐ Phone call home
- ☐ Escort to another area
- ☐ Work detail
- ☐ Other _____

Parents' Night Out

Seizure Action Plan

Seizure Information			
Seizure Type	Length	Frequency	Description

Seizure Triggers or warning signs

Student's response after a seizure

Basic First Aid: Care and Comfort

Please describe basic first aid procedures:

Does your child need to leave the room after a seizure? ☐ Yes ☐ No If Yes, please describe the process for returning him/her to the room.

Emergency Response

A seizure emergency for this child is defined as:

Seizure Emergency Protocol (Check all that apply and explain)

- ☐ Contact doctor at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify Doctor
- ☐ Other

Medication

Seizure Type	Length	Frequency	Description

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Asthma Action Plan

Management Plan

Identify the things that can start an asthma episode:

- ☐ Animals
- ☐ Bee/Insect Sting
- ☐ Chalk Dust
- ☐ Change in temperature
- ☐ Molds
- ☐ Strong Odors
- ☐ Pollen
- ☐ Stroke
- ☐ Respiratory Infections
- ☐ Exercise
- ☐ Dust
- ☐ Food: _____
- ☐ Other: _____

Comments: _____

_____

Basic First Aid: Care and Comfort

Peak Flow Monitoring:

Personal Best Peak Flow Reading:_____

Monitoring Times: _____ _____ _____ _____

Control of Child Care Environment (Please list any environmental control measures, pre-medications, and/or dietary restrictions that the child needs to prevent as asthma episode.)

Emergency Response

An emergency for this child is defined as: (please include any symptoms or information about peak flow reading)

Emergency Protocol (Check all that apply and explain)

- ☐ Contact doctor at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify Doctor
- ☐ Other

Medication

Name	Amount	When to Use	Description

Parents' Night Out

Allergen Action Plan

Management Plan

Identify the things that can cause an allergy reaction:

- ☐ Animals
- ☐ Pollen
- ☐ Bee/Insect Sting
- ☐ Food: _____
- ☐ Other: _____

Comments: _____

_____

_____

Emergency Response

An emergency for this child is defined as: (please include any symptoms or information about peak flow reading)

Emergency Protocol (Check all that apply and explain)

- ☐ Contact doctor at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify Doctor
- ☐ Other

Medication

Name	Amount	When to Use	Description

Parents' Night Out

Participant Medical Form

Authorization for Health Care/Medical Release (signed by parent/legal guardian)

This health history is correct and accurately reflects the status of the participant to whom it pertains. The person described has permission to participate in all activities as noted by me and/or an examining physician. I give permission to the physician selected by the SKN Foundation to order treatment related to the health of the participant for emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for and order injections, anesthesia, or surgery for this participant. I understand the information on this form will be shared on a "need to know" basis with the participant's caregiver. I give permission to photocopy this form. In addition, the SKN Foundation has permission to obtain a copy of the participant's health record from providers who treat said participant and these providers may talk to the program staff about the participant's health status. By signing below, I acknowledge that all medical information provided is complete and accurate, a physician has reviewed the medical information, and I have read and understood all policies regarding medication administration.

Signature of Legal Guardian: _____ Date: _____ Relationship: _____

Licensed Professional Health Provider (signed by healthcare provider)

I have reviewed the participant's health history and it is my opinion that the participant is physically and emotionally fit to participate in the Parents' Night Out Program.

Name of Licensed Provider: _____ Signature: _____ Date: _____

Office Address: _____

Street City State Zip Code

Telephone: _____

Parents' Night Out

Participation Form

Permission to Participate

I authorize my child to participate in the Parents' Night Out Program hosted by the SKN Foundation, in any and all activities unless otherwise noted by me or my child's healthcare provider.

Signature of Legal Guardian: _____ Date: _____ Relationship: _____

Waiver of Liability

I hereby release and hold harmless the SKN Foundation, its employees, volunteers, advisors, representatives, and executives from all liability for personal injury, including death and injury, as well as all property damage or loss arising out of my/my child's participation in this program. I understand that this release and indemnification releases liability for the conduct of the SKN Foundation and its employees, volunteers, advisors, representatives, and executives.

Signature of Legal Guardian: _____ Date: _____ Relationship: _____

Photo Release

I give permission to the SKN Foundation to take and use photographs and audio and/or video recordings of the Parents' Night Out Program for fundraising and/or marketing purposes. On occasion, with permission, participant photographs may be included in promotional videos, websites, albums, or newsletters. The SKN Foundation respects the privacy of Parents' Night Out participants and does not allow unauthorized visitors to photograph or video the program or its participants.

Signature of Legal Guardian: _____ Date: _____ Relationship: _____

I do not give permission to the SKN Foundation to take and use photographs and audio and/or video recordings of my child in the Parents' Night Out Program for any purpose at all.