



**2024–2025 school year  
Bloomsburg Area Y-Care Registration  
Form School Age Children K – 5<sup>th</sup>**

Child's Name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian's Name (please print): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email \_\_\_\_\_

Child's DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Parent/Guardian DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Emergency Phone \_\_\_\_\_

**YMCA Member:** Yes      No

Private Pay: \_\_\_\_\_ ELRC (Financial Assistance) Participant: \_\_\_\_\_

Program Site: \_\_\_\_\_ Bloomsburg Memorial Elementary School (held at BAY)

\_\_\_\_\_ W.W. Evans Elementary School

Date Child will start Y Care: \_\_\_\_\_

**Registration Fee: \$25.00 must be paid prior to starting the program.**

**Types of Care:**

- We offer 3 days only or 5 days only.
- You will be charged for the days that you attend. For example, if you attend 1 day then you will get charged for 3 days and if you attend 4 days then you will get charged for 5 days.

Member Rate		Non-Member Rate
3 days Before Care only	\$60 a week	\$85 a week
3 Days After Care only	\$60 a week	\$85 a week
3 days Before and After care	\$85 a week	\$100 a week

Member Rate		Non-Member Rate
5 days Before Care Only	\$80 a week	\$95 a week
5 days After Care Only	\$80 a week	\$95 a week
5 days Both Before and After	\$105 a week	\$110 a week

I, \_\_\_\_\_ agree to pay the Bloomsburg YMCA \$ \_\_\_\_\_ per week for my child's Y care service.

Method of Weekly Payment:     Credit Card     Bank Draft

**Payment Method on file will be billed the Friday during the week of Y-Care scheduled.**

**Cancellation of care must be received in writing one week in advance of removal date.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Weekly Schedule

Please check the number of days your child will be attending care each week. For the arrival and departure time please fill in approximately when the child will be in our care. Any schedule changes MUST be made in writing or email to Serena Hampton one week prior to change. If your child is attending before care for Memorial Elementary, they must arrive no later than 8am to walk to school. **Hours of operations 6:30am-8:30am and then 3pm-6pm.**

	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival Time					
Departure Time					



## **2024–2025 Registration Agreement:**

**I AGREE TO ADHERE TO THE BLOOMSBURG AREA YMCA Y-CARE REGISTRATION POLICIES OUTLINED IN THIS AGREEMENT AND GIVE MY CHILD PERMISSION TO PARTICIPATE FULLY IN THIS PROGRAM.**

**PLEASE READ EACH AGREEMENT, INITIAL TO THE RIGHT, AND SIGN FULL NAME.**

1. Registration must be completed before child may enter Y-Care and consists of the following: \_\_\_\_\_
  - a. non-refundable registration fee of \$25
  - b. Signed agreement form by parent and/or guardian.
  - c. Emergency form for each child enrolled
  - d. Health Assessments ~ must be current and are due within 30 days when the parent hands in the registration form
  
2. I agree to pay the weekly fee as stated on the registration form. \_\_\_\_\_
  
3. I understand that I must have a valid credit card or bank draft information on file when my child(ren) register for Y-Care. \_\_\_\_\_
  
4. I understand that weekly fees will be CHARGED during THE Friday of that week of care. Any schedule changes must be made in writing to Serena Hampton one week prior to change. \_\_\_\_\_
  
5. I understand that childcare services WILL BE TERMINATED if my account reaches 3 weeks of nonpayment \_\_\_\_\_
  
6. In the event that payment is rejected or not processed, I give the Bloomsburg Area YMCA permission to collect payment in full via the credit card or bank draft on file. \_\_\_\_\_
  
7. No child may be dropped off before 6:30 AM. For your child's safety, if parent/child arrives before 6:30 AM, parent must wait for staff to arrive. Failure to wait could result in childcare services being terminated. A \$5.00 per 5 min. fee will be charged if picked up after 6pm. If there is a

problem with pick up, parents must call to notify the Director of Youth Development & Family Engagement. A parent/guardian will be called after 15 minutes \_\_\_\_\_

8. An authorized ADULT MUST SIGN child (ren) in upon arrival and sign child (ren) out upon departure DAILY. YMCA staff will only assume full responsibility for child (ren) when signed in for the program. YMCA STAFF WILL CHECK AUTHORIZED PICK-UP PERSONS. PLEASE MAKE SURE PICK UP PERSONS HAVE PHOTO ID. \_\_\_\_\_
9. I understand that, whenever possible, I will be notified prior to medical treatment of my child. If notification is impossible, I understand that I am financially responsible for any medical or transportation expenses incurred on my child's behalf. \_\_\_\_\_
10. In consideration of the Bloomsburg Area YMCA, I waive all claims of any lost, stolen, damaged valuables. Please do not send anything of value to the program with your child. \_\_\_\_\_
11. If a child needs medication while in our care, parents must bring in a written note from the doctor stating the type of medication, the dosage and number of times the child needs to take it. With the doctor's signature on it. \_\_\_\_\_

In consideration of the Bloomsburg Area YMCA program listed above, I waive all claims for myself and for the participants listed above, for any injuries or illness, which may result from participation, including any transportation provided by the YMCA, staff, or agents. I further state that the above participant is in proper physical condition to participate in this program. If there is a question regarding the physical condition of the participant, a physician will be consulted by parent/guardian to review the situation prior to any participation.

I agree to adhere to the Bloomsburg Area YMCA Registration agreement and policies for the Y-Care Program as outlined and give my permission to participate fully in this program.

## CONDUCT POLICY

It is the intent of the Bloomsburg Area YMCA that each child enjoys the activities planned by understanding that he/she is responsible for his/her actions. With prior knowledge of our basic rules of safety and good conduct, each child is made aware of how to exercise self-discipline, and that the YMCA is here to help children and to know that we want him/her to succeed. As in any group activity, the inappropriate behavior of a few children can spoil the experience for the entire group. Therefore, the following conduct policies apply directly to each child and will be used in determining his/her eligibility to continue as a participant in the YMCA Before and After School Care Program. In accordance with the severity of the infraction and the number of times the infraction occurs, a child may (A) be suspended or (B) be terminated from the program for:

1. Repeatedly using foul language and/or being rude and discourteous to staff and/or peers.
2. Defacing YMCA property.
3. Bringing or using illegal substances: alcohol, drugs, weapons (as deemed by staff of the YMCA) or unsafe personal sports equipment.
4. Stealing or defacing the property of others.
5. Refusing to remain with his/her group, intentionally and repeatedly leaving his/her group activity.
6. Inappropriate physical contact: repeated hitting, biting, other physical altercations.
7. Intentionally or repeatedly going to unauthorized areas of the facility or leaving the premises without permission will result in the following actions: a search of the premises will be conducted; if the child is not found, the police and parent/guardian will be notified and the child will not be allowed to return to Y-Care. No refund will be given.
8. **Bullying of any kind will not be tolerated at all.**

In the event that a child has proven that he/she is unwilling to follow these policies, the parent/guardian will be notified and must meet with the Director of Youth Development & Family

Engagement in order to discuss the situation. The Director will consider a possible suspension or termination. NO REFUNDS will be given. It is our daily desire that every child enjoys his/her YMCA experience. It is for this reason that we have initiated policies we feel are fair, easily complied with and are of benefit to everyone involved.

Parent signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Emergency Contacts / Authorized Adults for Pick-Up

Please be advised that these emergency contacts will also be used in the event of extraordinary circumstances. Photo ID will be REQUIRED to pick up the child.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Is there anyone who is NOT legally authorized to pick up the child? YES  NO

State regulations state that the Bloomsburg Area YMCA must have court documentation of person(s) unauthorized to collect a child.

If a person is NOT legally authorized to pick up your child, court documentation must be attached.

I authorize treatment of my child in a first aid emergency at the nearest hospital or by a competent certified individual. I hereby release the Bloomsburg Area YMCA, the YMCA Summer Camp staff, and its volunteers from any claim that may arise because of any injury to my child at the Bloomsburg Area YMCA Summer Camp program.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



## Permission Agreements

Please read and initial the following permission statements indicating your agreement.

### MOVIES

\_\_\_\_\_ My child has permission to view G and PG rated movies at Bloomsburg Area YMCA. I understand that under no circumstances will a movie rated other than G or PG be shown during YMCA Y-Care Program.

### PHOTOGRAPHS

\_\_\_\_ I authorize the reproduction and use, for promotional purposes, of any photographic images taken of me and/or my child by the YMCA of Bloomsburg, Pennsylvania. I understand that I will not receive any compensation, money or otherwise, for the professional use of said photographic images.

\_\_\_\_ I authorize the reproduction and use, for promotional purposes, of any photographic images taken of me and/or my child by the YMCA of Bloomsburg, Pennsylvania on Facebook and other social media. I understand that I will not receive any compensation, money or otherwise, for the professional use of said photographic images.

OR

\_\_\_\_\_ I do not want any photographic images taken of me and/or my child by the YMCA.

Parent/Guardian Signature \_\_\_\_\_

Date: \_\_\_\_\_



# EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124 (a) (b), 3270.181 & 182; 3280.124 (a) (b), 3280.181 & .182; 3290.124 (a) (b), 3290.181 & .182

<b>CHILD'S NAME</b>			<b>DATE OF BIRTH</b>
<b>ADDRESS</b>			
<b>PARENT'S NAME/LEGAL GUARDIAN</b>		<b>HOME TELEPHONE NUMBER</b>	
<b>ADDRESS</b>			
<b>BUSINESS NAME</b>		<b>BUSINESS TELEPHONE NUMBER</b>	
<b>ADDRESS</b>			
<b>PARENT'S NAME/LEGAL GUARDIAN</b>		<b>HOME TELEPHONE NUMBER</b>	
<b>ADDRESS</b>			
<b>BUSINESS NAME</b>		<b>BUSINESS TELEPHONE NUMBER</b>	
<b>ADDRESS of Business</b>			
<b>EMERGENCY CONTACT PERSON(S)</b>		<b>TELEPHONE NUMBER WHEN CHILD IS IN CARE</b>	
<b>PERSON(S) TO WHOM CHILD MAY BE RELEASED</b>	<b>NAME</b>	<b>ADDRESS</b>	<b>TELEPHONE NUMBER WHEN CHILD IS IN CARE</b>
<b>NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER</b>		<b>TELEPHONE NUMBER</b>	
<b>ADDRESS</b>			
<b>SPECIAL DISABILITIES (IF ANY)</b>		<b>ALLERGIES (INCLUDING MEDICATION REACTION)</b>	
<b>MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION</b>		<b>MEDICATION, SPECIAL SITUATION</b>	
<b>ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD</b>			
<b>HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS</b>		<b>POLICY NUMBER (REQUIRED)</b>	
<b>PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT</b>			
<b>OBTAINING EMERGENCY MEDICAL CARE</b>		<b>ADMIN. OF MINOR FIRST-AID PROCEDURES</b>	
<b>WALKS AND TRIPS</b>		<b>SWIMMING</b>	
<b>TRANSPORTATION BY THE FACILITY</b>		<b>WADING</b>	

---

**SIGNATURE OF PARENT or GUARDIAN**

---

**DATE**

## SPECIAL NEEDS FORM

Child's name \_\_\_\_\_ Nickname \_\_\_\_\_

Does your child qualify to receive Special Education Services through the schools?  yes or  no

List any specific disabilities, allergies, or special health conditions of your child:

\_\_\_\_\_

Does your child have heart trouble?  yes  no

If yes, please explain:

\_\_\_\_\_

Does your child have seizures?  yes  no

If yes, please state type, frequency, and procedure(s) to follow during and immediately.

following the seizure: \_\_\_\_\_

Please describe your child's behavior prior to and after a seizure. \_\_\_\_\_

Does your child use any special equipment?  yes  no

Wheelchair

Braces

Crutches

Canes

Walker

Hearing Aid

Glasses

Pacemaker

Do you have any instructions? \_\_\_\_\_

Does your child need any special assistance?  yes  no

Does your child have any communication difficulties?  yes  no

If yes, please explain including extent of difficulties and any methods used to compensate for difficulties

(e.g. sign language, speech board, lip reading). \_\_\_\_\_

If your child is deaf, does he/she require an interpreter?  yes  no

# INDIVIDUALIZED EDUCATION PLANS (IEP) INFORMATION SHEET

Because of the diverse set of needs of the children in our program, it is important to gather as much information about the best ways to educate each child. IEP's and IFSP's are created by service providers working with children with special needs and include this information. The Keystone STARS Performance Standards therefore require each early learning provider to request copies of IEP's and IFSP's for the children in their care. Because of the importance of the IEP/IFSP to a child's learning, the program should have a copy before the child begins to attend, if possible. The information found on an IEP/IFSP is protected by privacy laws including the Health Insurance Portability and Accountability Act (HIPAA).

## Parent Sign-off Sheet

Child's Name: \_\_\_\_\_

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

- I am providing a copy of my child's IEP or IFSP.
- I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Child Enrollment Form**

**Agreement #:** 311-49-138-7

**ENROLLMENT FORM FOR CHILDREN IN CHILD CARE**

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

**PARENTS:** This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

**Please complete all areas to include signing and dating same.**

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED	
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL			
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER		
FIRST CHILD	<input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY										<input type="checkbox"/> BREAKFAST  <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other:										
BIRTH DATE	Enrollment Date: _____ Withdrawal Date: _____										
AGE											
SECOND CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY										<input type="checkbox"/> Same Meals as Above  <input type="checkbox"/> BREAKFAST  <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other:										
BIRTH DATE	Enrollment Date: _____ Withdrawal Date: _____										
AGE											
THIRD CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY										<input type="checkbox"/> Same Meals as Above  <input type="checkbox"/> BREAKFAST  <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other:										
BIRTH DATE	Enrollment Date: _____ Withdrawal Date: _____										
AGE											

**Signature**

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number of Parent or Guardian

CHILD CARE REPRESENTATIVE USE ONLY:

\_\_\_\_\_  
Name of Representative/Signature

\_\_\_\_\_  
Date

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

\*\*\*\*\*

**In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.**

**Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotope, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation.**



**We build strong kids, strong families, and strong communities.**

**Dear Parents,**

**Please make sure your child's physician completes this form in its entirety, especially all screenings, signatures and dates. This health assessment needs to be complete and returned within 30 days of enrollment in the Y-Care program. If we do not receive the health assessment by that date, then your child will be suspended from the program until the assessment is received.**

**Thank You,**

**Serena Hampton**

**Director of Youth Development &**

**Family Engagement**

Parents,

To resolve confusion at the front desk, we will need to be provided with a credit card or bank draft on file to be charged weekly. The charge will be scheduled in advance at registration and occur every Friday. This is needed to enroll your child/children into our Y-Care before and after school program.

We apologize for any inconvenience this may cause, but it will help us to better serve you.

If you have any questions or concerns, please feel free to contact us.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

† I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

**DO NOT OMIT ANY INFORMATION**

**This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.**

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):

† NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR THE MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY. † NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY): †

NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.

† NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?

† YES † NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE

**NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.**

**VISION (subjective until age 3)**



SCHEDULE AT <a href="http://WWW.AAP.ORG">WWW.AAP.ORG</a> † YES † NO	<b>HEARING (subjective until age 4)</b>					
	<b>LEAD</b>					

**RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD**

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

<b>MEDICAL CARE PROVIDER:</b>		<b>SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT TITLE:</b>
<b>ADDRESS:</b>		
	<b>PHONE:</b>	<b>LICENSE NUMBER: DATE FORM SIGNED:</b>