104 Maryland Street • Buffalo, NY 14201
Phone: (716) 845-0485 • Fax: (716) 845-0486
www.thebellecenter.org

TheBelleCenter
Life in a positive light.

Date Processed: _____

Processed by: _____

Registration Form Day Care

Check One
☐ Day Care (Ages 6 Weeks - 4 years)

Participant Information:

First Name: _____ **Last Name:** _____ **Nickname:** _____

Date of Birth: _____/_____/_____ **Age:** _____ **Gender:** ☐Male ☐Female

Ethnicity: _____

Participant's School: _____ **Particpant's Grade:** _____

Swimming Ability: 1 2 3 4 5 6 7 8 9 10 (0=Never Swam; 10=Excellent)

Hobbies: _____

Household Information: BMHA Housing Resident ☐ Subsadized Housing Resident ☐

Participant lives with: ☐ Mom ☐ Dad ☐ Grandparnets ☐ Foster Parent ☐ Legal Guardian

Parent/Guardian (1) Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____

Home Phone: _____ **Cell Phone:** _____ **Other:** _____

Is the current head of household… ☐ Male ☐ Female? ….a single parent? ☐ Yes ☐ No

Dismissal/Pick-Up Information:

My child has my permission to walk home unaccompanied from The Belle Center: ☐ Yes ☐ No

Individuals authorized to pick up child who are NOT the parents/guardians:

1. **Name:** _____ **Relation:** _____ **Phone:** _____
2. **Name:** _____ **Relation:** _____ **Phone:** _____

Media Release:

I understand and agree that photographs may be taken during recreation programs and that I hereby give permission to have my son's/daughter's photo taken and authorize the use and reproduction of said photos by The Belle Center. All negatives and prints shall become the sole property of The Belle Center. ☐ Yes ☐ No

Medical Information:

Does participant have health insurance? ☐ **Yes** ☐ **No** **Insurance Carrier:** _____

Policy #: _____ **Group #:** _____

Name of Family/Child Physician: _____ **Physician Phone:** _____

Does participant have any serious health issues? ☐**Yes** ☐ **No**

Please Explain: _____

Does participant have any allergies?

Please Explain: _____

List reactions (if any): _____

Is participant taking any medications? ☐ **Yes** ☐ **No**

Medications: _____

Additional information about participant's behavioral, physical, emotional or mental health The Belle Center should be aware of: _____

Emergency Contact 1: _____ **Relationships:** _____ **Phone:** _____

Emergency Contact 2: _____ **Relationships:** _____ **Phone:** _____

Liability Waiver/Medical Treatment Consent:

In consideration for my and/or my family members' participation in The Belle Center's program that I wish to register for, I voluntarily RELEASE Erie Regional Housing Development Corporation and the officers, agents, employees, and volunteers (hereinafter referred to as "releases") from any and all liability for injuries or death or property damage to me and/or my family members resulting from, arising out of, or in any way connected with my and/or any of my family member's participation in The Belle Center's recreation programs or use of The Belle Center's facilities in connection with this/these program(s). I understand that this waiver and release is applicable even through the negligent activities of the releases may have contributed to the injury or death or property damage suffered by me or any of family members participating in this/these program(s). I further agree to identify and hold harmless the releases from and against any and all liability, claims, causes of action, and/or losses of any nature or kind (including litigation-related expenses such as attorney and expert witness fees) resulting from participation in this/these program(s) whether caused by any neglect act or omission of the releases.

I further understand that serious accidents may occur in The Belle Center program(s) that I am registering for, that I am registering for, that participants in this/these program(s) may sustain mortal or serious personal injuries, and/or property damage, as a consequence of their participation in this/these program(s). Knowing the risk of said events, nevertheless, I hereby agree to assume those risks and to release and hold harmless to the fullest extent allowed by law all of those persons mentioned above who through passive or active negligence or carelessness might otherwise be liable to me for damages.

It is further understood and agreed that this waiver, release, hold harmless, and identification agreement is to be binding on me, any of my participating family members, and all of our heirs, representatives, and assigns.

I hereby authorize qualified physicians to render medical treatment of care that they deem necessary for me or my family members in case of illness or accident during such program(s). In the event of injury of a child participant, and if parent cannot be reached, emergency services and/or the Buffalo Fire Department will be contacted to transport the injured to a nearby local hospital.

Field Trip Acknowledgement:

I hearby grant permission for our son/daughter to participate and attend ALL of the Field Trips provided by and for The Belle Center. Permission slips will be completed prior to field trip.

To Complete Registration:

1. **Return Registraion Form with Registration Fees - DSS-$5, All others $15**: ERHDC-The Belle Center, 104 Maryland Street, Buffalo, NY 14201
2. I understand that this is a **Contract For Services**.
3. **Financial Information Release**: financial information will *only* be released to those who sign below. Anyone not named below will obtain information from those signed.

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____

Start Date: _____ Reg. Fee Pd: $_____ Check #: _____ Date Paid: _____