

FIRST Place Science and Technology Facility

Public Program Registration Information

Include deposit, immunization, and proof of physical with this form. See back for details.

Program: \_\_\_\_\_

Dates: \_\_\_\_\_

Location: \_\_\_\_\_

Participant Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Grade next school year: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Email: \_\_\_\_\_

If parent(s)/guardian(s) not available in an emergency, contact:

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

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Can this person authorize treatment should the child require immediate medical treatment?  Yes  No

Health History

Does your child have a history of :

Heart Defect/Diseases  Yes  No

Convulsions  Yes  No

Diabetes  Yes  No

Bleeding/Clotting Disorders  Yes  No

Asthma  Yes  No

Hayfever  Yes  No

Allergies to:

Poison Ivy  Yes  No

Insect Stings  Yes  No

Penicillin  Yes  No

Other Drugs: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

If your child has food or drug allergies, or other special needs, please list and describe them in the space given.

\_\_\_\_\_

Note: If child requires special and/or constant attention due to these special needs, parents are required to provide an assistant to be with the child at all times. (No additional fee will be charged for assistant.)

Are there any activities that are encouraged or limited by your physician?  Yes  No  
If yes, describe:

\_\_\_\_\_

Any disability or recurring illness?

If yes, describe:

\_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone (required): \_\_\_\_\_  
Name of Dentist: \_\_\_\_\_ Phone (required): \_\_\_\_\_

Is Tetanus Booster current (within last 10 years)?  Yes  No

Does any medication need to be administered during program?  Yes  No

If yes, explain: \_\_\_\_\_

Health History Explanations (if needed): \_\_\_\_\_

Has your child/children attended a *FIRST Place* program before?  Yes  No

If yes, please provide the following information:

Child's Name: \_\_\_\_\_ Program: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Program: \_\_\_\_\_ Date: \_\_\_\_\_

**FIRST Place does not take responsibility for any injury sustained during this program. Basic safety precautions will be followed at all times. This health history is correct to the best of my knowledge, and my child has permission to engage in all scheduled activities as noted.**

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

**(If participant is a minor.)**

FIRST Place has an **Acceptable Behavior** policy which states that your child will use the internet in an acceptable manner and will not retrieve explicit material or search any areas that are considered off-limits to them when working on computers. Unacceptable use of computers, as well as unacceptable behavior and language, will not be tolerated. Any child violating this policy will be given one verbal warning, then discharged from camp if a second violation occurs. No refunds will be given in this instance.

**Signature of Participant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

**(If participant is a minor.)**

**What To Return With This Form:**

- Proof of child's immunization record
- Proof that your child has had a physical within the last 2 years. (In compliance with Safety Regulations of the State of New Hampshire. Failure to provide this information will cause your application to be returned to you unprocessed.)
- Check for deposit of \$50 or full program fee payable to "FIRST"

Mail or Deliver To: *FIRST Place*  
Public Programs  
200 Bedford Street  
Manchester, NH 03101