Joy's SCHOOL OF DANCE, INC.

Camp Hope Therapy Team

Occupational, Physical and Speech Therapy for Children

Ballerina Dreams

Participant's Application and Health History

GENERAL INFORMATION

Participant: _____

D.O.B.: _____ Age: _____ M F School: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Alternative #: _____

Email: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

How did you hear about the program?: _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

What medications is your child currently taking, including over-the-counter medications?

_____

_____

Describe your child's abilities / difficulties in the following areas. (Please include assistance required or equipment needed):

FUNCTION (*i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

_____

_____

_____

_____

SOCIAL (*i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc*)

_____

_____

_____

_____

GOALS (*i.e. Why are you applying for participation? What would you like to accomplish?)*

_____

_____

_____

_____

PHOTO RELEASE

☐ I DO

☐ I DO NOT

Consent to and authorize the use and reproduction by the Joy's School of Dance and Camp Hope Therapy Team of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian