Innovative Therapy Services
Pediatric Speech-Language Services Inc.

Regina Learning Center-Youth Program

1090 Homestead Road
Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156

Registration Form

APPLICANT INFORMATION							
Last Name		First		M.I.		Date	
Street Address				Apartment/Unit #			
City		State		ZIP			
Phone		E-mail Address					
Date Available		Social Security No.		Desired Salary			
Are you a citizen of the United States?	YES ☐	NO ☐	If no, are you authorized to work in the U.S.?	YES ☐	NO ☐		
Have you ever been convicted of a felony?	YES ☐	NO ☐	If yes, explain				

EDUCATION								
High School				Address				
From		To		Did you graduate?	YES ☐	NO ☐	Degree	

REFERENCES			
Please list three personal references			
Full Name		Relationship	
Email:		Phone	
Address			
Full Name		Relationship	
Email:		Phone	
Address			
Full Name		Relationship	
Company		Phone	
Address			

Regina Learning Center-Youth Program

1090 Homestead Road
Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156

Registration Form

PREVIOUS EMPLOYMENT		
Company	Phone	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference?	YES ☐ NO ☐	
Company	Phone	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference?	YES ☐ NO ☐	
Company	Phone	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference?	YES ☐ NO ☐	

DISCLAIMER AND SIGNATURE	
I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.	
Parent Signature	Date

Innovative Therapy Services
Pediatric Speech-Language Services Inc.

Regina Learning Center-Youth Program

1090 Homestead Road
Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156

Registration Form

Parent(s)/Guardian(s):____

Street Address: ____

City:____________________State:________Zip code:________________

Primary Number:_________________Secondary Number: ________________

Email Address: ____

Emergency Contact: ____

Relationship to Participant(s): ___________________________________

List any court-appointed restrictions:

____

____

Those authorized to pick up my child are:

____

Innovative Therapy Services
Pediatric Speech-Language Services Inc.

Regina Learning Center-Youth Program

1090 Homestead Road
Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156

Registration Form

Youth Medical Form (*Please fill out for each child*)

Child's Name: ____

Does your child experience any of the following (if yes, please explain):

1. Allergies Yes or No Explain________________________________
2. Heart Condition Yes or No Explain________________________________
3. Diabetes Yes or No Explain________________________________
4. Headaches Yes or No Explain________________________________
5. Seizures Yes or No Explain________________________________
6. Motion Sickness Yes or No Explain________________________________
7. Fainting Yes or No Explain________________________________
8. Upset Stomach Yes or No Explain________________________________
9. Other: (please list)______________Explain:________________________________

Does your child have a reaction to(if yes, please explain):

1. Bee Stings Yes or No Explain________________________________
2. Penicillin Yes or No Explain________________________________
3. Medications Yes or No Explain________________________________
4. Poison Ivy/Oak Yes or No Explain________________________________
5. Peanuts Yes or No Explain________________________________
6. Other: (please list)______________Explain:________________________________

Regina Learning Center-Youth Program

1090 Homestead Road
Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156

Registration Form

Youth Medical Form cont.

A. Please answer the following:

1. Does your child have any condition that would prevent him/her in participating in any activities? Yes or No **(If yes, explain)**

____

2. Does your child take any prescription medications? Yes or No **(If yes, explain)**

____

3. Does your child have any sight or hearing impairment? Yes or No **(If yes, explain)**

____

4. Has your child been diagnosed with any mental health condition? Yes or No **(If yes, explain)** ____

Please indicate any other pertinent information that the youth staff should know about your child:

____

____

____

By signing below, I confirm that all the information listed on this form is truthful and accurate. I understand that the youth ministry is concerned about the health and safety of my child and will follow the guidelines of this form in concerns to my child. I understand that neither RLC-youth program, nor does Innovative Therapy Services accept any responsibility in the event that my child gets hurt or sick.

PLEASE SIGN:

Innovative Therapy Services
Pediatric Speech-Language Services Inc.

Regina Learning Center-Youth Program

1090 Homestead Road
Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156

Registration Form

___

(Parent/Guardian) **(Date)**

___

(Parent/Guardian) **(Date)**

Innovative Therapy Services
Pediatric Speech-Language Services Inc.

Regina Learning Center-Youth Program

1090 Homestead Road
Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156

Registration Form

PERMISSION SLIP

PERMISSION/MEDICAL RELEASE FOR

NAME____**PHONE** ____________________________

ADDRESS______________________________**CITY** _____________________________________

Zip Code _________________**Birth date**_____/_____/_____**Grade** _____________________

School ____

PARENT/GUARDIAN'S NAME ____

I GIVE PERMISSION FOR MY CHILD TO JOIN THE YOUTH OF **Regina Learning Center**, IN ANY OF THE ACTIVITIES OR TRIPS SPONSORED BY THE RLC and its affiliates-ITS, ITS STAFF AND SPONSORS. I HEREBY RELEASE THEM FROM RESPONSIBILITY AND LIABILITY FOR ANY ILLNESS OR INJURY THAT MY CHILD MAY SUSTAIN DURING THIS ACTIVITY. IN THE EVENT OF AN EMERGENCY, I HEREBY AUTHORIZE AN ADULT LEADER OF THIS ACTIVITY AS AGENT FOR ME, TO CONSENT TO ANY X-RAY EXAMINATION, MEDICAL, DENTAL, OR SURGICAL DIAGNOSIS, TREATMENT, AND HOSPITAL CARE ADVISED AND SUPERVISED BY A PHYSICIAN, SURGEON, DENTIST (AS APPROPRIATE), LICENSED TO PRACTICE UNDER THE LAWS OF THE STATE WHERE SERVICES ARE RENDERED, EITHER AT A DOCTOR'S OFFICE OR IN ANY HOSPITAL. I EXPECT TO BE CONTACTED AS SOON AS POSSIBLE.

PARENT'S
SIGNATURE:____

Today's Date Month_______________________Day________________Yr_________________

Regina Learning Center-Youth Program

1090 Homestead Road
Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156

Registration Form

EMERGENCY PERSONS & PHONE NUMBERS:

NAME:____

PHONE#____________________________

NAME:____**PHONE#**_______________________

MEDICAL INFORMATION: (REQUIRED FOR ALL OFF-CAMPUS ACTIVITIES)

ALLERGIES

____

MEDICATIONS BEING TAKEN

____

PHYSICAL HANDICAPS

____

MEDICAL INSURANCE CO.

____

NAME OF POLICY HOLDER______________________________**POLICY #** _______________________

YOU WILL NOT BE ALLOWED TO GO ON ANYYOUTHTRIPOFF-CAMPUS WITHOUT A PERMISSION SLIP SIGNED BY YOUR PARENT/GUARDIAN ON FILE.

Regina Learning Center-Youth Program

1090 Homestead Road
Santa Clara, CA 95050
Phone: (408) 241-2229
Fax: (408) 241-3156

Registration Form

Youth Signature Date