



The DREAM Program, Inc.

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The DREAM Form!

(General and Health Information)

(First Name of Child) (Last Name of Child) (Birth Date) (Gender: M/F)

(Child's Email Address) (Child's Cell Phone)

(First Name of Parent(s)/Guardian(s)) (Last Name) Phone Number (Cell/Home/Work) Email Address

(First Name of Parent(s)/Guardian(s)) (Last Name) Phone Number (Cell/Home/Work) Email Address

(Home Address) (Street Address) (Apartment Number)

(City) (State) (Zip Code)

Emergency Contacts (other than parent & guardian):

1. _____
(Name) (Phone) (Relation to Child)

2. _____
(Name) (Phone) (Relation to Child)

3. _____
(Name) (Phone) (Relation to Child)

What rules do you have for your child's behavior that you would like to be carried over to DREAM?

Other Mentoring Programs: Is child in another mentoring program? (please circle one) YES NO

If YES what program? _____

OPTIONAL: DREAM has partnered with Mobius, the Mentoring Movement to match children of prisoners with mentors. With this program, federal money is made available to support mentoring programs when a child of a prisoner is matched with a mentor. That is why we are asking if the child in your care, who currently has a DREAM mentor (or is entering the DREAM program), has a parent in prison.

If you feel comfortable, please answer the following two questions:

Does the above child have a parent in prison? (please circle one) YES NO

Does the above child have a parent on furlough? (please circle one) YES NO

The DREAM Form!, Cont.

Medical Insurance Information

(or a copy of your Child's insurance Card)

Name of Child's Physician: _____ Physician Phone Number: _____

Insurance Company: _____ Policy/Group Number: _____

Name of Primary Member: _____ Medicaid Number: _____

Weight in lbs: _____

When was your child's last immunization for Tetanus? _____

Does your child currently have any health concerns? Please check from list below:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures	<input type="checkbox"/> Braces
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Fainting	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Glasses/contacts lenses
<input type="checkbox"/> Lyme disease	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Lungs
<input type="checkbox"/> Ears, Nose, Throat	<input type="checkbox"/> Digestion	<input type="checkbox"/> Other _____

If you checked any of the above, please explain:

Swimming ability of child: Strong Medium Weak Non-swimmer

Any **restrictions on activity** for medical reasons? Yes No

If YES, please explain:

Allergy Information

Is your child allergic to:	Yes	No
Any medication (please specify: _____)....	<input type="checkbox"/>	<input type="checkbox"/>
Bee stings, insect bites or plants.....	<input type="checkbox"/>	<input type="checkbox"/>
Food (please specify: _____)....	<input type="checkbox"/>	<input type="checkbox"/>
Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify: _____)...	<input type="checkbox"/>	<input type="checkbox"/>

If your child does have allergic reactions, please answer the following questions:

• Can your Child have a reaction just from being near the allergen (inhaled), or does s/he have to touch or ingest it?

• Please describe what happens to your child if exposed to each allergen:

- _____

- Does your child feel the allergic reaction coming on? _____
 - What do you give your child if s/he has a reaction? _____

The DREAM Form!, Cont.

Prescribed Medications

A copy of the prescription OR the original prescription bottle MUST be included

Does your child have any conditions requiring prescription medication? ___Yes ___No

If YES, please describe: _____

Will it be necessary to administer the medication while at Camp? ___Yes ___No

Medications and dosage: _____

How is it stored? _____

When and how is it taken? (time(s) of day, with or without food) _____

Lice Check

It is DREAM policy that every child will be checked for lice before going to Camp. This check will be discrete and confidential. If lice are found, the parents will be notified. Appropriate treatment with an over-the-counter lice shampoo will be provided and the child's clothes and belongings will be washed. If you have any questions or concerns, please contact the DREAM office.

I give permission for my child, to receive the following "**over-the-counter**" medications on an "as-needed" basis. Unless directed otherwise, medication would be administered as directed by package labeling. Please mark your preference with a check mark below:

	Yes	No
• Tylenol / Acetaminophen for pain, headache, fever	___	___
• Advil / Ibuprophen for pain, headache, fever	___	___
• Caladryl/Calamine lotion for itching	___	___
• Throat lozenges	___	___
• 1% Hydrocortisone creamrash:	___	___
• Robitussin DM for cough without fever	___	___
• Benadryl / Diphenhydramine for severe itchiness	___	___
• Imodium for diarrhea	___	___
• Mylanta for upset stomach	___	___
• Tylenol Cold & Sinus for cold symptoms	___	___
• Neosporin or other antibiotic ointment or cream	___	___
• Dimetapp for nasal allergy symptoms	___	___
• Ipecac syrup to induce vomiting in case of ingestion of poisonous substance only if directed by Poison Control Center	___	___

Are there any additional **over-the-counter** medications that need to be administered, either on a scheduled basis and/or as needed basis? If so, please list name of medication, dose, and the time of day it is administered. **Please send the medication with your child on overnights if it is not listed above.**

1 _____

2 _____

CONSENT TO TREAT

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. I (parent or legal guardian) hereby give permission to the DREAM staff and/or volunteers to provide routine health care, administer medications, to seek emergency medical treatment if necessary, and to provide or arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the DREAM staff and/or volunteers to secure and administer treatment, including hospitalization, for my child.

Parent / Legal Guardian Signature: _____ Date: _____

Parent / Legal Guardian Printed Name: _____