**The DREAM Program, Inc.**
41 Dearborn St.
Roxbury, MA 02119
617.699.8408
www.dreamprogram.org

# The DREAM Form

**The DREAM Program, Inc.**

(General and Health Information)

First Name of Child ______ Last Name of Child ______ Birth Date ______ Gender: ______

Child's Email Address ______ Child's Cell Phone ______ School Child Attends ______ Current Grade ______

First Name of Parent(s)/Guardian(s) ______ Last Name ______ Relationship to Child ______

Phone Number (Cell/Home/Work) ______ Email Address ______

First Name of Parent(s)/Guardian(s) ______ Last Name ______ Relationship to Child ______

Phone Number (Cell/Home/Work) ______ Email Address ______

Home 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

**Do you have rules for your child's behavior that you would like to be used during DREAM?**

______________________________

______________________________

______________________________

**Other Mentoring Programs:**

Is child in another mentoring program? ☐ **Yes** ☐ **No**

If YES what program?______________________________

**Optional**:

Federal funding has been made available to mentoring programs who match children of incarcerated parent with mentors. If you feel comfortable, please answer the following questions.

Does the above child have a parent in prison? ☐ **Yes** ☐ **No**

Does the above child have a parent on furlough? ☐ **Yes** ☐ **No**

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# The DREAM Form

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(Medical Insurance Information)

| ______________________________ | ______________________________ |
|---|---|
| Name of Child's Physician | Physician Phone Number |
| Insurance Company | Policy/Group Number |
| Name of Primary Member | Medicaid Number |

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

| | | |
|---|---|---|
| □ Asthma | □ Seizures | □ Braces |
| □ Diabetes | □ Heart disease | □ Bed wetting |
| □ Fainting | □ High blood pressure | □ Glasses/contacts lenses |
| □ Lyme disease | □ Hearing impairment | □ Lungs |
| □ Ears, Nose, Throat | □ Digestion | □ Other________________________ |

If you checked any of the above, please explain:

_______________________________________________________________

What year was your child's last immunization for Tetanus? ________________________________________

Swimming ability of child: □ **Strong** □ **Medium** □ **Weak** □ **Non-swimmer**

Weight in lbs________________________________________________________________________

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

If YES, please explain:

_______________________________________________________________

**Allergy Information**

Please mark appropriate box based on you child's allergies.

| | | | |
|---|---|---|---|
| Any medication | □ **Yes** | □ **No** | If yes, what___________________________ |
| Bee stings, insect bites or plants | □ **Yes** | □ **No** | If yes, what___________________________ |
| Food | □ **Yes** | □ **No** | If yes, what___________________________ |
| Latex | □ **Yes** | □ **No** | If yes, what___________________________ |
| Other | □ **Yes** | □ **No** | If yes, what___________________________ |

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?____________________________________________

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# The DREAM Form

**The DREAM Program, Inc.**

(Medication and Health Information)

**Prescription Medication**

Is your child able to swallow a pill to take medication? ☐ **Yes** ☐ **No**

Does your child have any conditions requiring prescription medication? ☐ **Yes** ☐ **No**

If YES, please describe:____________________________________________

******REMINDER: A copy of the prescription OR the original prescription bottle <u>MUST</u> be included.******

Will it be necessary to administer the medication while at DREAM or on an overnight trip?

☐ **Yes** ☐ **No**

Medications and dosage:____________________________________________

How is it stored?________________________________________________

When and how is it taken? (time of day, with or without food, etc.)________________________

________________________________________________________________

**Over-the-Counter Medication**

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 / Ibuprofen for pain, headache, fever | ☐ | ☐ |
| • Caladryl/Calamine lotion for itching | ☐ | ☐ |
| • Throat lozenges | ☐ | ☐ |
| • 1% Hydrocortisone cream: | ☐ | ☐ |
| • 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.________________________________________________________________

**Lice Check**

It is DREAM policy that every child will be checked for lice before going on overnight trips. 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.

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# The DREAM Form

**The DREAM Program, Inc.**
(Consent to Treat)

**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.

______________________________________________________________

**Signature of Parent or Guardian** **Date**

______________________________________________________________

**Printed Name of Parent or Guardian**

DREAM operates with a core value of inclusion, and strives to be supportive of all participants regardless of their race, color, sex, sexual orientation, gender identity, religion, disability, age, veteran status, ancestry, or national or ethnic origin.

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# Release Waiver

**The DREAM Program, Inc.**

In consideration of my child, (please print name) ____________________________________'s, participation in The DREAM Program (which meets regularly on a predetermined day of the week and occasionally on other days of the week) I hereby agree on behalf of myself, my heirs, legates, executors, administrators, and personal representatives, to release and hold harmless all chaperones and mentors, Boston University, Northeastern University, Harvard University, Tufts University, Madison Park Development Corporation and is corporate entities (Adams Orchard LP, Madison Trinity LP, Orchard Gardens, Inc., MTV, Inc., Orchard Gardens Resident Association, Trinity Financial, Lower Roxbury Community Corporation, Haynes House II Associates LP, Madison Park III LP, Madison Park IV LP, Beryl Gardens LP, Ruggles Shawmut LP), Maloney Properties, Inc., Winn Management Company LLC, Cornu Management, Inc., Boston Housing Authority, Cambridge Housing Authority, Somerville Housing Authority, Massachusetts Promise Fellowship, and any and all other persons and organizations assisting The DREAM Program, Inc., from liability for any injury to my child, to my child's property and any and all claims in any manner arising from or associated with my child's participation whether the liability, loss or damage is caused in whole or in part by their failure to use reasonable care in their activities associated with The DREAM Program, Inc. I understand that in case of emergency, The DREAM Program's staff and all other chaperones and mentors have my total permission to use their best judgment in matters of treatment and to have my child treated accordingly.

______________________________________________________________

**Signature of Parent or Guardian** **Date**

______________________________________________________________

**Signature of Child** **Date**

# Media/Surveys Release

**The DREAM Program, Inc.**

I hereby grant to The DREAM Program, Inc. ("DREAM") permission to periodically administer surveys to me and my child. I also hereby grant to The DREAM Program, Inc. ("DREAM"), or any of its agents, the right and permission, in respect of the surveys, photographs, and video which DREAM or its agents have taken of me or my children, or in which I/we may be included with others, to copyright the same in its own name or otherwise; to use, reuse, publish and re-publish in the same in whole or in part, in conjunction with any printed matter in any and all media now or hereafter known, and for any purpose whatsoever, for illustration, promotion, art, advertising and trade, or any other purpose; and to use my name, my children's names, and any statement made by me or my children, in connection therewith if DREAM so chooses. I have read the foregoing and fully understand the contents hereof. This release shall be binding upon me and my heirs, legal representatives and assigns.

______________________________________________________________

**Signature of Parent or Guardian** **Date**