



# Child Care Enrollment & Emergency Medical Authorization

PROCLUB.COM  
425.861.6247



**Welcome to Discovery Bay!** It is our goal to ensure that PRO Sports Club is a comfortable “home away from home” and to help your child develop both healthy exercise habits and an active lifestyle. We focus on making each day a happy and meaningful experience for both you and your child(ren). If you have any questions, please feel free to contact us at (425) 861-6247.

## Parent/Guardian

\_\_\_\_\_  
Name (First) (Last) Membership Number

\_\_\_\_\_  
Phone (Home) (Emergency) (Alternate)

## Child #1

**OFFICE USE ONLY**

\_\_\_\_\_  
Name (First) (MI) (Last) **New Child #**

Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Choose One:  MEMBER  NON-MEMBER  
(Month) (Day) (Year)  Spa User or Guest  
 Non-Member Child of Member

Comments: \_\_\_\_\_

## Child #2

**OFFICE USE ONLY**

\_\_\_\_\_  
Name (First) (MI) (Last) **New Child #**

Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Choose One:  MEMBER  NON-MEMBER  
(Month) (Day) (Year)  Spa User or Guest  
 Non-Member Child of Member

Comments: \_\_\_\_\_

## Authorized Individuals

Individuals listed below are authorized for drop-off and pick-up of child(ren) listed above. Photo ID is required.

First Name	MI	Last	Relation to Child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments: \_\_\_\_\_

## Emergency Information

In case of an emergency and parent/guardian is not available at the numbers listed above.

Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Name \_\_\_\_\_  
Phone \_\_\_\_\_

>> Please complete page 2 regarding allergies and medical conditions >>

# Medical Information

In the event of my absence during a medical emergency, I (Parent's Name) \_\_\_\_\_ hereby give my permission for the prior mentioned child(ren) to be transported to a hospital or other medical facility as advised by medical personnel and/or to receive medical and surgical treatment from a licensed physician or medical technician. Further, I understand that I, and not the PRO Sports Club, will be responsible for any payment of fees or costs associated with treatment rendered in such a medical emergency.

## Child(ren)'s Physician

Name \_\_\_\_\_ Practice/Group Name \_\_\_\_\_ Office Phone \_\_\_\_\_  
Date of last check-up/physical \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month) (Day) (Year)

## Child(ren)'s Dentist

Name \_\_\_\_\_ Practice/Group Name \_\_\_\_\_ Office Phone \_\_\_\_\_

## Hospital

If a hospital is needed, do you have a preference? \_\_\_\_\_

## Insurance

Policy provided by \_\_\_\_\_ Policy Name \_\_\_\_\_ Policy ID Number \_\_\_\_\_ Policy Group Number \_\_\_\_\_



# Allergy/Medical Information

Mark any allergies and medical conditions PRO Sports Club staff needs to be aware of. \*Please remind the instructor of all allergies when you bring your child to our Programs.

### Food & Drink Allergies:

- Dairy Products
- Chocolate
- Nuts
- Fruits
- Other: \_\_\_\_\_

### Medication(s):

- Penicillin
- Medicine: \_\_\_\_\_
- Medicine: \_\_\_\_\_
- Medicine: \_\_\_\_\_
- Other: \_\_\_\_\_

### Medical Condition(s):

- Tubes in ears
- Other: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Comments: \_\_\_\_\_

>>I understand that any of these foods may be within the reach of my child(ren) when in the Discovery Bay. Initials \_\_\_\_\_ <<<

# Waiver and Release of Liability: (Read carefully before signing!)

I AGREE THAT THIS WAIVER AND RELEASE OF LIABILITY SHALL APPLY TO EACH VISIT I MAKE TO PRO SPORTS CLUB, INCLUDING FUTURE VISITS, REGARDLESS OF ANY DATE OF ISSUANCE OR EXPIRATION DATE ON THE GUEST OR PERMANENT MEMBERSHIP CARD, AND REGARDLESS OF THE DATE THAT THIS FORM IS SIGNED BELOW. I UNDERSTAND AND ACKNOWLEDGE THERE IS RISK INVOLVED IN BEING IN AND AROUND PRO SPORTS CLUB'S FACILITIES, INCLUDING, BUT NOT LIMITED TO, UTILIZING EQUIPMENT OR PARTICIPATING IN ANY EXERCISE OR FITNESS ACTIVITY. IN CONSIDERATION FOR BEING ALLOWED TO UTILIZE PRO SPORTS CLUB'S FACILITIES, I AGREE I WILL ASSUME THE RISK AND FULL RESPONSIBILITY FOR ANY AND ALL INJURIES, LOSSES, DEATH, COSTS, OR OTHER DAMAGES, THAT MIGHT OCCUR TO ME AND/OR TO MY FAMILY WHILE ON THE PREMISES OF PRO SPORTS CLUB OR PARTICIPATING IN ANY OFF-SITE PRO SPORTS CLUB PROGRAM OR ACTIVITY; AND TO THE MAXIMUM EXTENT ALLOWED BY LAW, I AGREE TO WAIVE AND RELEASE ANY AND ALL CLAIMS, SUITS, OR RELATED CAUSES OF ACTION AGAINST PROFESSIONAL RECREATION ORGANIZATION, INC., ITS OWNERS, OFFICERS, EMPLOYEES, OR AGENTS (COLLECTIVELY PRO SPORTS CLUB), FOR NEGLIGENCE, INJURY, LOSS, DEATH, COSTS, OR OTHER DAMAGES TO ME, MY HEIRS OR ASSIGNS, WHILE ON THE PREMISES OF PRO SPORTS CLUB OR PARTICIPATING IN ANY OFF-SITE PRO SPORTS CLUB PROGRAM OR ACTIVITY. I FURTHER AGREE I WILL INDEMNIFY, DEFEND AND HOLD PRO SPORTS CLUB HARMLESS, TO THE MAXIMUM EXTENT ALLOWED BY LAW, FROM NEGLIGENCE, INJURY, LOSS, DEATH, COSTS, OR OTHER DAMAGES TO ME, MY HEIRS OR ASSIGNS, OR THIRD PARTIES FOR CLAIMS, SUITS, OR RELATED CAUSES OF ACTION ASSERTED AGAINST PRO SPORTS CLUB ARISING FROM MY CONDUCT AND/OR MY FAMILY'S CONDUCT WHILE ON THE PREMISES OF PRO SPORTS CLUB OR PARTICIPATING IN ANY OFF-SITE PRO SPORTS CLUB PROGRAM OR ACTIVITY AND THIS WAIVER AND RELEASE SHALL BIND THE MEMBERS OF MY FAMILY AND MY SPOUSE OR REGISTERED DOMESTIC PARTNER, IF I AM ALIVE, AS WELL AS MY ESTATE, FAMILY, HEIRS, ADMINISTRATORS, PERSONAL REPRESENTATIVES OR ASSIGNS IF I AM DECEASED, AND SHALL BE DEEMED AS A "RELEASE, WAIVER, DISCHARGE AND COVENANT" NOT TO SUE PRO SPORTS CLUB. I FURTHER AGREE TO RELEASE, INDEMNIFY, DEFEND AND HOLD PRO SPORTS CLUB HARMLESS FROM ANY LIABILITY WHATSOEVER FOR FUTURE CLAIMS PRESENTED BY MY CHILDREN OR ANY OTHER MINOR CHILDREN AND/OR THEIR PARENTS, WHOSE VISIT TO PRO SPORTS CLUB IS SPONSORED BY ME, FOR ANY INJURIES, LOSSES OR DAMAGES TO THEMSELVES OR ANY FAMILY MEMBER OR REGISTERED DOMESTIC PARTNER. IF ANY TERM OF THIS WAIVER AND RELEASE SHALL BE FOUND ILLEGAL, UNENFORCEABLE OR IN CONFLICT WITH ANY APPLICABLE LAW, THE VALIDITY OF THE REMAINING PORTIONS SHALL NOT BE AFFECTED THEREBY.

I have read this waiver and release of liability. \_\_\_\_\_ Initials

**BY MY SIGNATURE BELOW I UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.**

Parent/Guardian Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Please print*

PRO Sports Club Staff \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
*Please print*



# Medication Authorization & Agreement

Please note, if all information is not filled in completely, medication will not be given. Medication must be in original packaging and labeled with child's name.

## FAMILY INFORMATION:

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Parent's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Day Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Parent's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Day Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

## MEDICATION RELEASE:

I [Parent's Names] \_\_\_\_\_ hereby grant permission for [Child's Name] \_\_\_\_\_ to receive medication prescribed by our child's physician.

Medication Name: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Dosage Amount: \_\_\_\_\_ Duration: **TIME** **START DATE (mm/dd/yyyy)** **STOP DATE (mm/dd/yyyy)**  
\_\_\_\_:\_\_\_\_  AM  PM \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_:\_\_\_\_  AM  PM \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Possible Side Effects/Anticipated Reactions: \_\_\_\_\_

Special Storage Requirements/Instructions (if applicable): \_\_\_\_\_

Medication Name: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Dosage Amount: \_\_\_\_\_ Duration: **TIME** **START DATE (mm/dd/yyyy)** **STOP DATE (mm/dd/yyyy)**  
\_\_\_\_:\_\_\_\_  AM  PM \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_:\_\_\_\_  AM  PM \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Possible Side Effects/Anticipated Reactions: \_\_\_\_\_

Special Storage Requirements/Instructions (if applicable): \_\_\_\_\_

**Professional Recreation Organization (dba PRO Sports Club) has agreed to care for your child in one of our child care activities. You have indicated that your child has the following medical condition requiring the administration of medication by our staff:** \_\_\_\_\_

Please indicate by your signature below that you have read and understand the following conditions:

1. PRO Sports Club accepts your child for care with your understanding that PRO Sports Club employees are not trained medical professionals to recognize symptoms of your child's medical condition. You have requested that PRO Sports Club employees consent to the dispensing of medication, if needed, to your child.
2. PRO Sports Club has authorized employees during the operating hours noted above to follow your instructions for administration of the medication prescribed by your child's physician and to administer the medication, if, in their judgment, the medication is required according to symptoms described by your child's physician. You agree to hold harmless and indemnify PRO Sports Club and its employees from all claims or liability pertaining to administration of the medication to your child.
3. Acceptance of your child into a child care program at other days or times will not be denied. However, at non-approved times, PRO Sports Club cannot provide employees trained in dispensing medication.

## SIGNATURES: By my signature below I understand and agree to the above terms and conditions.

\_\_\_\_\_  
Parent's Name (Printed) (Signature) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

\_\_\_\_\_  
Parent's Name (Printed) (Signature) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year



# Certificate of Immunization Status (CIS)

DOH 348-013 January 2010

<b>Office Use Only:</b>	
Reviewed by: _____	Date: _____
Signed Cert. of Exemption on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Registry.

<b>Child's Last Name:</b> _____	<b>First Name:</b> _____	<b>Middle Initial:</b> _____	<b>Birthdate (mm/dd/yyyy):</b> _____	<b>Sex:</b> _____	<b>I certify that the information provided on this form is correct and verifiable.</b>
Symbols below: ◆ Required for School and Child Care/Preschool ● Required for Child Care/Preschool Only				<b>Parent/Guardian Name (please print):</b> _____	

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Hepatitis B (Hep B)</b>				
	1			
	2			
	3			
or Hep B - 2 dose alternate schedule for teens				
	1			
	2			
<b>Rotavirus (RV1, RV5)</b>				
	1			
	2			
	3			
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
	1			
	2			
	3			
	4			
	5			
<b>◆ Tetanus, Diphtheria, Pertussis (Tdap, Td)</b>				
	1			
	2			
<b>● Haemophilus influenzae type b (Hib)</b>				
	1			
	2			
	3			
	4			
<b>● Pneumococcal (PCV, PPSV)</b>				
	1			
	2			
	3			
	4			

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Polio (IPV, OPV)</b>				
	1			
	2			
	3			
	4			
<b>Influenza (flu, most recent)</b>				
<b>◆ Measles, Mumps, Rubella (MMR)</b>				
	1			
	2			
<b>◆ Varicella (chickenpox) or verify disease 1-4 ▶</b>				
	1			
	2			
<b>Hepatitis A (Hep A)</b>				
	1			
	2			
<b>Meningococcal (MCV, MPSV)</b>				
	1			
<b>Human Papillomavirus (HPV)</b>				
	1			
	2			
	3			
<b>Office Use Only: Immunization information updated and verified with parent/guardian permission:</b>				
Printed Staff Name _____		Date _____		
Printed Staff Name _____		Date _____		
Printed Staff Name _____		Date _____		
Printed Staff Name _____		Date _____		

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified. **Mark option 1, 2, 3, OR 4 below – see, back #5.**

**1)  Chickenpox disease verified by printout from CHILD Profile Immunization Registry**  
Must be marked by printout (not by hand) to be valid.

**2)  Chickenpox disease verified by Health Care Provider (HCP)**  
If you choose this box, mark 2A OR 2B below.  
 2A)  Signed note from HCP attached OR  
 2B)  HCP signed here and print name below:  
 \_\_\_\_\_  
 Licensed health care provider (HCP) Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)  
 HCP Printed Name: \_\_\_\_\_

**3)  Chickenpox disease verified by school staff from CHILD Profile Immunization Registry**  
If you choose this box, staff must initial that parent or guardian approves: \_\_\_\_\_ (initial) \_\_\_\_\_ (date)

**4)  Chickenpox disease verified by parent\***  
If you choose this box, fill in the date or child's age when he or she had the disease:  
 Age/Date of disease: \_\_\_\_\_  
 \*Can ONLY verify for some grades, see back #5 (4).

**If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.**

**Documentation of Disease Immunity**

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked. Signed lab report(s) MUST also be attached.

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Hib	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Measles	<input type="checkbox"/> Varicella	_____

Licensed health care provider (HCP) Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (MD, DO, ND, PA, ARNP)  
 HCP Printed Name: \_\_\_\_\_

**Instructions for completing the Certificate of Immunization Status (CIS): printing it from the Immunization Registry or filling it in by hand.**

**#1 To print with info filled in:** First, ask if your health care provider's office puts vaccination history into the CHILD Profile Immunization Registry (Washington's statewide database). If they do, ask them to print the CIS from CHILD Profile and your child's information will fill in automatically. **Be sure** to review all the information, **sign and date the CIS** in the upper right hand box, and return it to school or child care. If your provider's office does not use CHILD Profile, ask for a copy of your child's vaccine record so you can fill it in by hand using steps #2-7 (below):

**EXAMPLE**

**#2 To fill in by hand:** Print your child's name, birthdate, sex, and your own name in the top box.

**#3** Write each vaccine your child received under the correct disease. Write the vaccine type under the "Vaccine" column and the date each dose was received in the "Month," "Day," and "Year" columns (as mm/dd/yyyy). For example, if DTaP was received Jan 12, March 20, June 1, '11, fill in as shown here ▶

Vaccine	Dose	Date		
		Month	Day	Year
<b>◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT)</b>				
DTaP	<b>1</b>	01	12	2011
DTaP	<b>2</b>	03	20	2011
DTaP	<b>3</b>	06	01	2011

**#4** If your child receives a combination vaccine (one shot that protects against several diseases), use the Reference Guide below to record each vaccine correctly. For example, record Pediarix under Diphtheria, Tetanus, Pertussis as **DTaP**, Hepatitis B as **Hep B**, and Polio as **IPV**.

**#5** If your child has had chickenpox (varicella) disease and not the vaccine, **use only one** of these four options to record this on the CIS:

- 1)  If your child's CIS is printed directly from the CHILD Profile Immunization Registry (by your health care provider or school system), and disease verification is found, box 1 is automatically marked. To be valid, this box must be marked by the Immunization Registry printout (not by hand).
- 2)  If your health care provider (HCP) can verify that your child has had chickenpox, mark box 2. Then mark either 2A to attach a signed note from your HCP, or 2B if your HCP signs and dates in the space provided. Be sure your HCP's full name is also printed.
- 3)  If school staff access the CHILD Profile Immunization Registry and see verification that your child has had chickenpox, they will mark box 3. Then, they must initial and date that they got parent or guardian approval to mark this box (i.e. make this change) to the CIS.
- 4)  If your child started kindergarten in the 2008-2009 school year or later, you **CANNOT** use this box. If your child started kindergarten before the 08-09 school year, mark this box if you know he or she has had chickenpox. If you mark box 4, you must also write the approximate age or date your child had chickenpox. To find out which grades require chickenpox vaccine (or history), visit: <http://www.doh.wa.gov/cfh/immunize/schools/vaccine.htm>

**#6** Documentation of Disease Immunity: If your child can show immunity by blood test (titer) and has not had the vaccine, have your health care provider (HCP) fill in this box. Ask your HCP to mark the disease(s), sign, date, print his or her name in the space provided, and **attach signed lab reports**.

**#7** Be sure to **sign and date the CIS** in the upper right hand box, and return to school or child care.

**#8** If a school or child care makes a change to your CIS, staff will print their name in the middle bottom box and date to show that you gave approval.

Vaccine Trade Names in alphabetical order (For updated lists, visit <a href="http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf">http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf</a> )									
Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine	Trade Name	Vaccine
ActHIB	Hib	Engerix-B	Hep B	Ipol	IPV	Pentavalente	DTaP + Hep B + Hib	TriHIBit	DTaP + Hib
Adacel	Tdap	Fluarix	Flu (TIV)	Infanrix	DTaP	Pneumovax	PPSV or PPV23	Tripedia	DTaP
Afluria	Flu (TIV)	FluLaval	Flu (TIV)	Kinrix (Knrx)	DTaP + IPV	Prevnar	PCV or PCV7 or PCV13	Twinrix (Twnrx)	Hep A + Hep B
Boostrix	Tdap	FluMist	Flu (LAIV)	Menaetra	MCV or MCV4	ProQuad (PrQd)	MMR + Varicella	Vaqa	Hep A
Cervarix	HPV2	Fluvirin	Flu (TIV)	Menomune	MPSV or MPSV4	Quadracel (Qdrel)	DTaP + IPV	Varivax	Varicella
Comvax (Cmvx)	Hep B + Hib	Fluzone	Flu (TIV)	Pediarix (Pdrx)	DTaP + Hep B + IPV	Recombivax HB	Hep B		
Daptacel	DTaP	Gardasil	HPV4	PedvaxHIB	Hib	Rotarix	Rotavirus (RV1)		
Decavac	Td	Havrix	Hep A	Pentacel (Pntcl)	DTaP + Hib + IPV	RotaTeq	Rotavirus (RV5)		

Vaccine Abbreviations in alphabetical order (For updated lists, visit <a href="http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf">http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/us-vaccines-508.pdf</a> )							
Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name	Abbreviations	Full Vaccine Name
DT	Diphtheria, Tetanus	Hep A (HAV) Hep B (HBV)	Hepatitis A Hepatitis B	MPSV or MPSV4	Meningococcal Polysaccharide Vaccine	Rota (RV1 or RV5)	Rotavirus
DTaP	Diphtheria, Tetanus, acellular Pertussis	Hib	<i>Haemophilus influenzae</i> type b	MMR / MMRV	Measles, Mumps, Rubella / with Varicella	Td	Tetanus, Diphtheria
DTP	Diphtheria, Tetanus, Pertussis	HPV	Human Papillomavirus	OPV	Oral Poliovirus Vaccine	Tdap	Tetanus, Diphtheria, acellular Pertussis
Flu (TIV or LAIV)	Influenza	IPV	Inactivated Poliovirus Vaccine	PCV or PCV7 or PCV13	Pneumococcal Conjugate Vaccine	TIG	Tetanus immune globulin
HBIG	Hepatitis B Immune Globulin	MCV or MCV4	Meningococcal Conjugate Vaccine	PPSV or PPV23	Pneumococcal Polysaccharide Vaccine	VAR or VZV	Varicella

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