

Cedar Rapids Vision in Motion

3255 Williams Blvd SW
319-364-2311 (P) or 319-364-9828 (F)

CLASS APPLICATION FORM

Child's Name _____ Date _____
First Last

Date of Birth _____ Grade (in fall) _____ VIM class attending _____

Parent #1

Name _____

Home Address _____

Home Phone _____

Cell Phone _____

Other Phone _____

Parent #2

Name _____

Home Address _____

Home Phone _____

Cell Phone _____

Other Phone _____

Does the child reside with both parents? Y / N Other _____

Who has permission to pick up child? _____

Who **does not** have permission to pick up the child? _____

Emergency Contact Information: Please supply the names of at least 2 people other than parent/guardian who can be contacted in case of emergency and has permission to pick up your child.

Name _____

Name _____

Address _____

Address _____

Phone _____

Phone _____

Relation to child _____

Relation to child _____

Parent's/guardian signature: I am authorizing the above stated persons to pick up my child in the case that I am unable to do so or in the case of an emergency.

Parent or Guardian Signature

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General Permission Form

Child's Name: _____

In signing this form, you are giving permission and agreeing to the following:

My child may:

- Use all the equipment in the various Vision in Motion programs and participate in all the activities at the Cedar Rapids Vision in Motion Center, unless exceptions are noted here:
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- Be included in evaluation, photographs, or videos connected with the Cedar Rapids Vision in Motion Center. These pictures or videos may be used for advertisement and other forms of public relations for an indefinite period.

_____ Agree _____ Decline _____ Parent Signature

I agree to the enrollment of my child in the Cedar Rapids Vision in Motion programs and have been advised of the policies regarding in its fees and services.

Parent/Guardian Signature: _____ Date _____

I hereby give permission to the staff at Cedar Rapids Vision in Motion to take whatever steps may be necessary to obtain medical care for my child. These steps may include, but are not limited to:

- Administer basic First Aid and CPR
- Attempt to contact parent/guardian, emergency contact person, and/or the child's physician

Name of child's physician: _____

Address: _____

Phone # _____ Hospital Affiliation: _____

(Please inform us of any changes that may occur)

- If Cedar Rapids Vision in Motion staff can not contact the above stated persons, the staff will do the following:
 - Contact another physician
 - Call an ambulance or take the child the nearest medical facility
- While participating in the Cedar Rapids Vision in Motion programs, I understand I am responsible for all medical care and cost for my child.

Parent/Guardian Signature: _____ Date _____