CHILDREN'S PAVILION
RONALD MCDONALD HOUSE SIBLING CENTER
REGISTRATION AND RELEASE FORM

*Date:*_____ *Expiration (office use only):* _____

1st Child's Name:	Gender:	Birthdate:	Age:
2nd Child's Name:	Gender:	Birthdate:	Age:
3rd Child's Name:	Gender:	Birthdate:	Age:
Parent / Legal Guardian Name:			
Permanent Address:			
City:	State:	Zip:	
Cell Phone:	Home Phone:		

Please list if this child has any special **behavioral or developmental** information/needs:
Please list if this child has any special **medical information**, i.e. asthma, medications, allergies, restrictions, etc.:

Toilet Training:
Is your child toilet trained (no diapers or pull-ups)? ☐Yes ☐No

Health Screening:
Are child's immunizations up-to-date? ☐Yes ☐No
If you answered NO, is your child currently displaying any symptoms of illness? ☐Yes ☐No

Has your child been exposed to the following communicable diseases in the PAST MONTH?

- Chicken Pox ☐Yes ☐No
- Measles ☐Yes ☐No
- Mumps ☐Yes ☐No
- ●Pertussis ☐Yes ☐No
- ●Tuberculosis ☐Yes ☐No

If you checked YES to any of the above, is your child currently displaying any symptoms of illness? ☐Yes ☐No

Has your child had any of the following symptoms within the last 48 HOURS?

- Runny nose ☐Yes ☐No
- Sore throat ☐Yes ☐No
- Cough ☐Yes ☐No
- Fever ☐Yes ☐No
- Pink Eye ☐Yes ☐No
- ●Diarrhea ☐Yes ☐No
- ●Vomiting ☐Yes ☐No
- ●Rash ☐Yes ☐No
- ●Lice ☐Yes ☐No

Patient Information:

Patient Name:	
Outpatient Floor and Pod:	
Inpatient Unit:	Inpatient Room Number:

Optional:
In order to make this a positive experience for your child it would be helpful if you answered the following questions:

What do you believe your well child understands about what is happening for his/her sibling while being cared for in the hospital or clinics?

What conversations have you had and what questions have they had?

This form shall remain effective for a period of ninety (90) days from the date of the below signature.

Emergency Treatment Consent:

I, the undersigned, hereby consent to VCU Health or any of its staff or agents, providing any emergency treatment deemed necessary for the benefit of child listed above, while visiting the Sibling Center, in my absence. If my child is injured, every reasonable effort will be made to locate me. I understand that my child will only be taken to the Emergency Department if the condition is serious as determined by VCU Health. If my child does need to be seen in the Emergency Department, I agree to provide VCU Health with any and all insurance or third party payor coverage information for purposes of payment. If I am uninsured, I agree to be financially responsible for all charges for Emergency Room treatment.

By signing this Registration and Release Form, I agree that I will not leave the premises of the hospital building of VCU Health while my child is visiting the Sibling Center. Further, I agree to hold VCU Health, its officers, directors, employees, and agents, harmless for any expenses related to personal injury or property damage that is not a result of VCU Health's direct and gross negligence. Finally, I understand that the Sibling Center reserves the right to remove my child from the premises due to disciplinary problems or illness related concerns.

_____ _____

Parent/Legal Guardian Print Name Date

_____

Parent/Legal Guardian Signature