



Sibling Support Center Registration Form

TIME IN: _____ TIME OUT: _____

SIBLING NAME _____ BIRTHDATE _____ AGE _____ GENDER _____

ALLERGIES/OTHER IMPORTANT HEALTH INFORMATION _____

SIBLING NAME _____ BIRTHDATE _____ AGE _____ GENDER _____

ALLERGIES/OTHER IMPORTANT HEALTH INFORMATION _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PARENT OR GUARDIAN NAME _____

ADDRESS _____

(If different from above)

PHONE NUMBER (where you can be reached while your child is in the Sibling Support Center):

E-MAIL ADDRESS _____ DL/ID# _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

STAFF MAY RELEASE MY CHILD TO MYSELF AND/OR:

Name: _____ Phone: _____

PATIENT NAME AND CLINICS THAT WILL BE VISTED TODAY: _____

By signing below, I agree to and confirm:

- My child is 3-11 years old and toilet trained.
- I will only leave my child for a maximum of 90 minutes.
- I will not leave Cook Children's Medical Center campus.
- I understand that the Sibling Support Center does not accept appointments and accept that services may not be available if the Sibling Support Center has reached capacity at the time of my arrival.
- I DO or DO NOT want my child's information shared with other sibling support programming. (circle one)

Printed Name of Patient/Parent or Legally Authorized Representative

Relationship

Signature of Patient/Parent or Legally Authorized Representative

Date

Time

SIBLING SUPPORT CENTER PARTICIPATION CONSENT AND RELEASE FORM

I, _____, parent and/or legally authorized representative of _____, a minor child, hereby request, agree and authorize Cook Children's Health Care System and/or its trustees, directors, officers, employees, agents, volunteers, and medical staff as follows:

1. To take, use and/or release my photograph or my child's photograph for news releases, public information, training, or exhibit purposes to such extent and through such media facilities as designated employees, agents or representatives of Cook Children's Health Care System may deem appropriate. I understand that no royalty, fee or any other compensation of any kind shall become payable to me by reason of such release or the use of any photograph;
2. To allow my child to remain at the SIBLING SUPPORT CENTER for no more than ninety (90) minutes and participate in SIBLING SUPPORT CENTER activities;
3. To provide my child with any non-emergency medical treatment that is deemed necessary while at the Sibling Support Center. In the event of an emergency or other medical treatment becomes necessary for my child, which cannot be attended to at the Sibling Support Center, I consent to my child being transported for emergency health care. More specifically, I consent to any necessary emergency examination, x-ray, laboratory procedure, medication, infusion, transfusion of blood products, anesthesia, and any other medical/surgical treatment that may be required until I am notified and can personally consent to my child's care and treatment. I agree to assume financial responsibility for any medical care and treatment, either through my child's health insurance carrier or personally as guarantor; and
4. To release my child's health information to staff so that appropriate care can be provided to my child and activities can be planned according to my child's health status and physical condition.

I hereby release COOK CHILDREN'S HEALTH CARE SYSTEM and its trustees, directors, officers, employees, agents, volunteers, and medical staff from any and all claims from personal injury, property damage or any other nature which might arise as a result of my/my child's visit to the SIBLING SUPPORT CENTER. In addition, I shall refrain from instituting, pursuing or aiding any claim, demand, action or causes of action growing out of, or hereinafter to grow out of my/my child's use of the SIBLING SUPPORT CENTER. Further, I do hereby agree to indemnify, defend, and hold COOK CHILDREN'S HEALTH CARE SYSTEM, its trustees, directors, officers, employees, agents, volunteers, and medical staff harmless from and against any and all liability for personal injury of any kind, including sickness, disease, death, or damage to property, that may result from my child's participation and visit to the Sibling Support Center.

I UNDERSTAND THIS IS A LEGAL RELEASE OF LIABILITY AND CONSENT FORM. I FURTHER REPRESENT THAT MY CHILD BETWEEN THE AGES OF THREE (3) and (11). I UNDERSTAND MY CHILD MAY ONLY REMAIN AT THE SIBLING SUPPORT CENTER FOR NINETY (90) MINUTES. I AGREE NOT TO LEAVE COOK CHILDREN'S MEDICAL CENTER CAMPUS WHILE MY CHILD IS AT THE SIBLING SUPPORT CENTER.

I HAVE READ THIS FORM CAREFULLY AND HAVE HAD ALL QUESTIONS ANSWERED BEFORE SIGNING.

Printed Name of Patient/Parent or Legally Authorized Representative	Relationship	
Signature of Patient/Parent or Legally Authorized Representative	Date	Time