Township of Howell
S.T.A.R. and S.H.A.R.P.
Registration & Physical Packet

Program Information:

Participant's Name____

Street Address____ Zip Code________________

Phone Number______________________________________ Date Of Birth______________

Age____________________ Sex____________________ Current Grade__________________

Parent's Name__________________________ Parent's Cell Number____________________

Work Number____

Emergency Contacts: (Please Provide Alternate Contact Person)

Name____

Relation____________________________ Phone Number____________________________

Education and Personality Traits:

Name of School/Program Currently Enrolled In______________________________________

Describe Fine Motor Skills (writing, coloring, grasping)___________________________________

Describe Gross Motor Skills (walk, run, jump, etc.)_____________________________________

Ability To Communicate Feelings & Needs____

Enjoys Individual Activities_____________________ Group Activities__________________

Enjoys Arts & Crafts________________ Sports________________ Other________________

Describe Swimming Abilities____

List Specific Fears (dark, bugs, noise, ect.)____

Describe Typical Angry Response____

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Personal Physical Information:

1. Family Physician____

   Address________________________________ Phone Number_________________

2. Has the participant been under the care of a physician recently?________ Date________

3. Is the participant taking any medication?_____________________________________

   If YES name of medication____

   Medication taken for____

4. Does the participant have any know allergies?_________________________________

   Allergies to foods?___________ What foods?_______________________________

   Allergies to drugs?___________ What drugs?_______________________________

5. Any medical reasons or implications for limited physical or educational activity during the program?____

6. Does the participant have or did he/she have any of the following:

   Chicken Pox______________________ Rheumatic Fever_______________________

   Hayfever__________________________ Asthma___________________________

   Convulsive Disorders__________________ Emotional Problems_________________

   Thyroid Condition____________________ Kidney Problems____________________

   Ear Infections______________________ Excessive Bleeding___________________

   Diabetes_______________ Is The Participant Insulin Dependent? YES NO

   Heart Condition___________ ANY RESTRICTION?__________________________

   If YES, doctor's note should be on file

7. Does the participant wear: Glasses__________ Hearing Aid_________ Other_________

8. Please Describe Any Other Pertinent Information That Will Assist Our Staff__________

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** I hereby verify all medical conditions have been disclosed and accept full responsibility for these conditions. In case of an emergency, I give my permission to call 911 and provide this information. I understand the recreation staff will not administer any medications.*

*** The Township of Howell Insurance Policy maintained by the Township is secondary in coverage. Any and all claims must first be submitted to the claimant's primary health insurance carrier.*

**** I grant the Township of Howell the right to use any and all photographs of myself and/or my child participating in a Department sponsored activity. By registering with the Township of Howell, I acknowledge that I have read, understood, and agreed with the above disclaimer."*

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(Signature of Parent/Legal Guardian) *(Date)*