GO BABY GO APPLICATION

Today's Date: _____

Please enter your Child's information below.

CHILD'S NAME _____
(First) (Last)

BIRTH DATE _____ **MEDICAL DIAGNOSIS** _____
(Month) (Day) (Year)

HEIGHT (Inches) _____ **WEIGHT (lbs)** _____

Please list any known allergies:

_____

Please list any current medical equipment, if any:

_____

Please list child's strengths:

_____

Please list child's challenges:

_____

Primary means of mobility:

_____

Can child sit unsupported for 10-15 minutes? ☐ **Yes** ☐ **No**

Does your child have any visual limitations? ☐ **Yes** ☐ **No**
If YES, please explain:

_____

Can your child hold his/her head up by himself/herself? ☐ **Yes** ☐ **No**
Can your child use two hands to hold a toy? ☐ **Yes** ☐ **No**
Does your child receive services at LifeScape? ☐ **Yes** ☐ **No**

GO BABY GO APPLICATION

Please enter Parent/Guardian information below.

PARENT/GUARDIAN NAME _____

EMAIL ADDRESS _____

MAILING ADDRESS _____
(Street) (City) (State) (Zip)

PHONE NUMBER _____ (Be sure to include area code)

SIGNATURES

NAME _____

RELATIONSHIP _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____

GO BABY GO AUTHORIZATION TO RELEASE INFORMATION

CHILD'S NAME: _____ DOB: _____
(First Name) (Last Name)

I authorize the exchange of private health information (PHI) between the parties below for the purpose of the ***Go Baby Go*** program at LifeScape. The authorization will expire after one year.

I authorize physician notes, therapy notes and verbal information to be exchanged between the following parties **(initial all that apply):**

_____ ***Go Baby Go*** build team including providers and volunteers

_____ LifeScape

_____ Primary Physician (print name/clinic/address or phone)

_____

_____ Non-LifeScape Therapist or other providers (print name/address/phone)

_____

_____ I also authorize the ***Go Baby Go*** program to take pictures of the above child; these pictures may be used for publicity, marketing, social media, or training for the ***Go Baby Go*** program and/or LifeScape.

I understand I may revoke this authorization at any time.

1. I authorize the facilities named in this release to disclose information as noted above. 2. I understand that sensitive information may be released such as mental health, alcohol and drug usage, and HIV. 3. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. 4. I understand that this authorization is voluntary, and I may refuse to sign. 5. I also understand that unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits. 6. I understand that the exchange of information may include electronic transmissions. 7. I authorize you to release information created 12 months after this authorization is signed, as well as previous information.

_____ _____ _____
Individual or legal guardian (print) Individual or legal guardian (sign) Date