Kids THRIVE
(Teaching Healthy Routines InterVEntion)

CHILD REGISTRATION FORM

Last Name ________________________________ M.I. ______ First Name ________________________________

Date of Birth ________/______/__________ Age: ___________ Gender: ☐ Male ☐ Female

Home Address ____
Street *City* *State* *Zip*

Home Phone ____________________ Work Phone _____________________ Other/Cell Phone ________________

Name of Current School: ______________________________

Mother's Information:	**Father's Information:**
Last Name: ______________________________	Last Name: ______________________________
First Name: _________________ M.I: _____________	First Name: _________________ M.I.: _____________
Street Address: ___________________________	Street Address: ___________________________
City: ________________ State: _____ Zip: _________	City: ________________ State: _____ Zip: _________
Home Phone: (_____)_________________________	Home Phone: (_____)_________________________
Cell Phone: (_____)__________________________	Cell Phone: (_____)__________________________
Email: _________________________________	Email: _________________________________
Date of Birth _____________________________	Date of Birth _____________________________
Marital Status:	Marital Status:
☐Single ☐Married	☐Single ☐Married
☐Divorced ☐Separated	☐Divorced ☐Separated
Occupation: _____________________________	Occupation: _____________________________
Highest Level of Education:	**Highest Level of Education:**
☐ No Schooling	☐ No Schooling
☐ Not a high school graduate	☐ Not a high school graduate
☐ High School / GED	☐ High School / GED
☐ Some College	☐ Some College
☐ College Graduate	☐ College Graduate
☐ Post-graduate degree	☐ Post-graduate degree
Other: ____________	Other: ____________

Person to contact in case of emergency:

Name ____ Telephone # _________________________

Relationship to child ____

Home Address____
Street *City* *State* *Zip*

MEDICAL INSURANCE INFORMATION

Name of Insurance ____

Member ID number _______________________________________ Group # _____________________________

Name of Subscriber ____

Employer ____

Relationship to Patient: ◻ Parent ◻ Spouse ◻ Partner ◻ Other

Address (if different from patient) ____
Street *City* *State* *Zip*

OTHER INFORMATION

Doctor's Name: __________________________________ Phone #: ____

Medicaid #: _____________________________________

Average Yearly Income:

☐ Less than $20,000 ☐ $40,000 - $49,999

☐ $20,000 - $29,999 ☐ $50,000 - $59,999

☐ $30,000 - $39,999 ☐ $60,000+

Please answer the following questions below:

1. Why is your family interested in being part of the Kids Thrive Program?

2. List all activities, events, trips, etc. your family and child will be participating in during the months of July through September?

3. Would your child's pediatrician be willing to cooperate with the program and/or provide relevant clinical information?

4. Have you tried a similar program with your child previously? I so, why do you think he or she did not continue to see progress?

5. Please list the reasons why you would like to join Kids THRIVE? What would you like to learn? What challenges might you expect? (Please have the child that is participating in the program complete this section)

Authorization and Consent

Signature of the child participant ____

Signature of Parent or Guardian ______________________________________

Relationship to the Child Participant_____________________________________ Date ___________________

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Authorized Staff Signature **Date**

Once we have reviewed the application form, we will contact the individuals to confirm acceptance into the program. Completing this registration form does not guarantee entrance into the program.