

"Friends helping Friends"

Capital Region Friendship Circle 44 Rose Court Albany, NY 12209 www.capitalfriends.org capitalregionfriends@gmail

Phone: 518-488-8992

Your Child
Application Date//
Name
Address
City Zip Code
Phone
Birth date//
School
Grade as of 2017-2018 school year

PARENTSHINEORMATION

	INFURMATION		
Mother's name	Mada ave Call		
Mother's E- mail (please print)			
Father's name	Father's Cell		
Title First	Last		
Father's E- mail (please print)			
Father's Occupation	Mother's Occupation		
Emergency Contact (other than paren	t)		
Name	Relation to child		
Phone	Cell		
HCBS/Waiver Enrolled: Yes or No MSC contact information:			
Please list any medical conditions that we should be aware of (attach sheet if needed)			
In case of medical emergency requiring im paramedics to take my child to the nearest	mediate emergency care, I authorize the hospital, if necessary.		
Signature of Parent / Guardian	Date/		
Health insurance: Name	Number		
What are your child's favorite activities			
What makes your child happy or upset			
Does your child occasionally exhibit any of	the following behaviors?		
Biting Cursing Grabbing Hitt What is your best method of handling the	ring Kicking Pulling Hair Other situation?		