POWER UP REGISTRATION FORM

Child's Name (Last, First, Initial)

Prefer to be called

Address (Street/PO Box)

School, Age, and Grade

City, State, Zip

Birth Date (Month/Day/Year)

Phone (Area Code and Number)

Sex   Age and Sex of siblings

Mother's Name (Last, First, Initial)

Address (Street/PO Box)

City, State, Zip

Phone (Area Code and Number)

Email

Marital Status

Occupation

Place of Employment

Does Mother live with child 50% of the time?
Yes   No

Father's Name (Last, First, Initial)

Address (Street/PO Box)

City, State, Zip

Phone (Area Code and Number)

Email

Marital Status

Occupation

Place of Employment

Does Father live with the child at least 50% of the time?   Yes   No

Confidential Health Questionnaire:
Has Your Child:
A. Had any history of psychiatric or behavioral problems?   Yes   No
B. Been institutionalized for mental illness within the last 12 months?   Yes   No
C. Is he/she now undergoing, or within the last 6 months did he/she undergo treatment by a psychiatrist or psychologist?   Yes   No
D. Does your child take any medications?   Yes   No
If yes, please specifiy what kind and the reason for taking it.

Do you feel your child has any particular problem at present? Be specific.

Names and Numbers of persons to be called if parents cannot be reached.