



## Kids' Castle Medical & Registration

**The Kids' Castle is for children ages 1-9.**

**Please, no crawlers.**

**We ask that you utilize the Castle once the child is walking.**

**Please Print:**

Child's Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_



Check to  
verify that proof of  
age was provided at  
time of registration

**Parents must remain in the building while  
children are in our care .**

**PARENT/GUARDIAN INFORMATION**

Mother's Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Father's Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Guardian's Name \_\_\_\_\_ Phone (H) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**IN CASE OF EMERGENCY, SPECIFY AUTHORIZED PERSONS TO PICK UP YOUR CHILD:**

Name _____	Relation _____	Phone _____
Name _____	Relation _____	Phone _____
Name _____	Relation _____	Phone _____

**The following information will remain confidential with the Kid's Castle staff and will be filed with the City of Cuyahoga Falls in accordance with Ohio Revised Code 149.39.**

Does the child have any disabilities or physical conditions the Kids' Castle staff should be familiar with?  
(Attention Deficit, Sensory Impairment, Allergies and level of sensitivity, etc. )

\_\_\_ No

\_\_\_ Yes, please explain:

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Any medical information we should be aware of:

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## EMERGENCY CARE

In the event that reasonable attempts to contact the parent or guardian have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by emergency medical personnel. In the event the designated practitioner is not available, by another licensed personnel, physician or dentist.

### Preferred Physician:

Dr. \_\_\_\_\_ Phone number \_\_\_\_/\_\_\_\_/\_\_\_\_

If transportation to a hospital is required, I prefer to have my child transported to

**Preferred Hospital:** \_\_\_\_\_  
or any hospital reasonably accessible.

This does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained before surgery is performed.

**Initials** \_\_\_\_\_

### Diapers/Restroom/Clothing Policy

Children must be in a clean diaper at the time they are dropped off. Parents will be called upon to change diapers if necessary during their child's stay. The Kids' Castle staff is not responsible for changing diapers. Children wearing diapers must have clothing over them.

I will allow the staff to assist my child in the restroom, as needed. **Yes No**  
I want to be called if my child needs assistance in the restroom **Yes No**

For their safety, all children entering the Kids' Castle must be wearing shoes.

**Initials** \_\_\_\_\_

I have read the above statements and all of the policies  
of the Kids' Castle and agree to abide by them.

\_\_\_\_\_  
Parent/Legal Guardian signature.

\_\_\_\_//\_\_\_\_//\_\_\_\_

THE  
**NATATORIUM**  
COMMUNITY • WELLNESS • RECREATION  
CITY OF CUYAHOGA FALLS

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