

Polfit Wellness, Inc.
2563 W. Woodland Drive
Anaheim, CA 92801



Polfit Wellness, Inc.

phone: 714 828-1293
fax: 714 527-7354
polfit@yahoo.com
www.polfit.com

Registration and Medical Information Form

Date: _____

Child's Name: First _____

Gender: M _____

Last _____

F _____

Date of Birth: _____

Age: _____

Parent's/Guardian Name: _____

Address (home): _____

Phone#: Home _____

Work _____

Cell _____

Fax#: _____

E-mail: _____

Local Address/Hotel (Name/Phone) _____

1. What is the child's diagnosis:

2. What is medical/surgical history:

History of botox injections (dates)_____

History of inhibitive/serial casting (dates)_____

History of any hips surgery (dates)_____

History of fractures (dates)_____

3. What is the child

Height_____ **Weight**_____

4. Medical status:

Seizures (how often and date the last one)

Scoliosis_____

Heart problems/hypertension/past heart surgeries (dates)

Lungs problems_____

Vision/hearing _____

Shunts_____

Tracheal/G-Tube_____

Kidney problems_____

Allergies_____

In case of legs length discrepancy please bring your child's shoes with lift.

5. Please list any medication your child is currently taking and the reason for it

6. Please mark any of the below your child's abilities:

- rolling ___ with assistance
 ___ without assistance
- crawling ___ with assistance
 ___ without assistance
- sitting ___ with assistance
 ___ without assistance
- standing ___ with assistance
 ___ without assistance
- walking ___ with any device
 ___ without any device

7. Is your child using any medical equipment?

- orthoses ___ hands ___ legs ___ feet
- walker ___ front ___ reverse ___ pony walker
 ___ hart walker
- crutches ___ - wheelchair ___

8. Communication: How do you communicate with your child?

How does your child communicate with you?

Is your child able to follow simple commands?

9. Please describe the type of therapy your child is obtaining at home?

	How often	how long
- physical therapy	_____	_____
- occupational therapy	_____	_____
- speech therapy	_____	_____
- horse back riding therapy	_____	_____

10. Please provide us with any of the below information about your child.

- eating habits / refluxes _____
- water / fluid intake _____
- nap time _____

11. Has your child been advised against exercising? If yes when and why?

Date

Signature

* Please print this form, fill it out and send or fax it to us.

Requirements for acceptance to Polfit Wellness, Inc.:

1. A \$500.00 minimum deposit is required for registration to the program. The remaining balance of the program fee is due 14 days before the therapy starts. If the registration is canceled, the \$500.00 minimum deposit is non-refundable.

Polfit Wellness, Inc. accepts Cashier's Checks, Money Orders and Personal Checks. We are currently unable to accept Credit Cards.

2. Orthopedic surgeon prescription: including child's name, diagnosis, and medical clearance for participation in the four-week intensive rehabilitation program.

3. Copy of report of recent bilateral hip x-ray's taken within six months of application to the program.

Please choose the session you plan to participate in the program:

Preference: First _____ Second _____

Morning _____ or afternoon _____

Date

Signature

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Registration and Program Fee, and Cancellation Policy

The fee of the Polfit Four Weeks Intensive Program is \$7,600.00. The fee includes the \$500.00 non-refundable deposit that is due with the Participant's application and reserves the Participant's space in the session. The balance of \$7,100.00 is payable two weeks prior to the commencement of the session.

If you need to cancel your reservation after the deposit has been received, within 60 days before the scheduled session, the deposit will be credited to your account for one calendar year for any available session without penalty.

However, when a cancellation is within 0-60 days prior to a scheduled session, spaces are rarely filled because of prior planning for other families. Polfit Wellness, Inc. will try to accommodate your families' needs, but cannot guarantee a change.

If the Participant is unable, or otherwise fails to participate in the program, or to complete to complete the program, for any reason, then the Participant shall not be entitled to a refund of any portion of the Program Fee. However, under certain extenuating circumstances, Polfit Wellness, Inc. reserves the right to determine if a partial credit may be granted for application to a future session within one year.

Participant is solely responsible for any and all costs and charges associated with travel, meals and lodging for the Participant during the Program Session.

Date

Signature

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