

Children's Advocacy Rooms of the Circuit Court of Cook County

Name of Parent/Guardian: _____ Case#:/Type: _____ Date: _____

Name of Judge/Room#: _____ Time In: _____

Name(s) and Age(s) of Child(ren) being Registered 1. _____ age ____ mos./yrs. 2. _____ age ____ mos./yrs. 3. _____ age ____ mos./yrs. 4. _____ age ____ mos./yrs. 5. _____ age ____ mos./yrs.	If applicable, list Allergies: Allergies: _____ Medications: _____ Animals: _____
If applicable, please specify the following for all children: Behavior Issues: _____ Special Needs/Fears: _____ Restrictions: _____	If Registered Child(ren) is/are Allergic to any items listed below, please check: <input type="checkbox"/> Milk <input type="checkbox"/> Orange Juice <input type="checkbox"/> Peanut Butter <input type="checkbox"/> Other _____ <input type="checkbox"/> Bananas
Do you grant permission to give your Child(ren) snacks? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Children's Address: _____
 (Street) (City) (State) (Zip Code)

Parent/Guardian's Address: _____
 (Street) (City) (State) (Zip Code)

Telephone No.: _____ Pager or Cell Telephone Number: _____

In the event of an **EMERGENCY** or if I am **DETAINED** as a result of my court visit, I release my child(ren) to:
Name of Authorized Agent: _____ **Telephone No.:** _____ **Relationship:** _____ or
Name of Authorized Agent: _____ **Telephone No.:** _____ **Relationship:** _____

MEDICAL

- The Children's Advocacy Room will not administer any medications to children.
- If any minor injury occurs: minor cuts, scratches, etc., the Childcare staff will administer first aid.
- Should any serious accident occur where my child needs immediate emergency medical attention, I authorize emergency care to be rendered.

RELEASE

In consideration of your acceptance of my child(ren) into the Children's Advocacy Room, I hereby release the Our Children in the Courts Foundation and the County of Cook, Illinois (including its directors, officials, employees and agents), and the Clerk of the Circuit Court (including that office's directors, officials, employees and agents) from any and all claims, liabilities and causes of action that I or my child or children may have as a result of activities in or associated with the Children's Advocacy Rooms. I understand that you are relying upon the foregoing release in accepting my child(ren) into the children's room and in making the Children's Advocacy Rooms available without charge, and I intend for you so to rely.

I certify that I have read and understand the above medical/release and that the information filled in above is correct.

Signature of Parent/Guardian upon In-Take: _____ Date: _____

Signature of Staff upon In-Take: _____ Date: _____

TO BE COMPLETED UPON OUT-TAKE/PICK-UP

Signature of Parent/Caregiver/Authorized Agent upon Out-Take/Pick-up: _____ Time Out: _____

Signature of Staff upon Out-Take/Pick-up: _____

Boy(s) _____ Book(s) _____	AA _____ Return _____ Digital Pic(s) _____	C _____ Toy(s) _____	H _____ New _____ SS Surveys _____	O _____ Girl(s) _____ CS Surveys _____
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